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The Role and Contribution of Lay Community Food Advisor Programmes to Public Health in Canada

Lynne Sylvia Eloise Richards

Doctor of Philosophy

Centre for Food Policy

Department of Sociology, School of Arts and Social Sciences

City, University of London

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Any remaining errors are my responsibility.

Declaration

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Lynne Sylvia Eloise Richards

Abstract

TITLE: The role and contribution of Lay Community Food Advisor Programmes to Public Health in Canada

INTRODUCTION: Having members within communities as ‘natural helpers’ may ensure good understanding of local health issues and better delivery of relevant messages. Lay Community Food Advisors (LCFA) may be an effective means to increase coverage of health promotion, empower individuals and communities, help to reduce social exclusion and address the gap in nutritional inequalities. LCFAs may increase awareness of healthy eating and help people translate advice into practice thereby positively influencing patterns of behaviour. However, there is limited evidence supporting these programmes, particularly from a Canadian perspective.

Research objectives:

To describe the context, drivers and (identify) strategic components of different programme models

To determine the role of programmes in addressing healthy eating behaviour (across the socio-economic spectrum)

To determine the wider role and impact of programmes in food and public health

RESEARCH DESIGN AND METHODOLOGY: A qualitative, case study approach of three key LCFA programmes in Ontario with both exploratory and explanatory aspects. Data collection included key informant interviews using semi-structured questionnaires, overt participant observation and document review.

Analysis: Thematic Analysis was utilised as an overarching approach to data analysis, NVivo qualitative tool was utilised for analysis of interviews. The Health Policy Triangle and Multiple Streams Framework were both used as frameworks for policy analysis.

FINDINGS: Programme models have been shown to be able to deliver on policy priorities and enable increased capacity at multiple levels: individual, community, organisational and policy. Programmes show examples of being both universally accessible and targeted in their approach, addressing a combination of food literacy and community engagement strategies. Programmes raise tensions around lay helping and issues of access and utilisation of programmes.

DISCUSSION: Programmes play a key role in meeting public health policy priorities. Programmes address food literacy set within a social and community context, but may be more challenged to address the underlying determinants of health and raise some tension around whether they can reduce or exacerbate inequalities. However, the absence of programmes can leave a greater gap. Though they remain for the most part downstream with some midstream activity, there are opportunities for more upstream effort.

CONCLUSION: Though localised, programmes can address food and public health policy objectives beyond food skills alone. Programmes and their role need to be viewed more broadly, with connections to the wider food system and environment and how they can be both policy levers and policy influencers. As well, programmes should not be seen as the solution to a complex problem that needs more than behavioural intervention, they must complement other strategies to improve public health across the system.

List of Abbreviations

CHW	Community Health Worker
DR-NCD	Diet-related non-communicable disease
EFNEP	Expanded Food and Nutrition Education Program
FAO	Food and Agriculture Organization
HIC	High-income country
LCFA	Lay Community Food Advisor
LHA	Lay Health Advisor
LMIC	Low and middle-income countries
NHS	National Health Service
NCD	Non-communicable disease
NGO	Non-governmental organisation
OMHLTC	Ontario Ministry of Health and Long Term Care
OMAFRA	Ontario Ministry of Food and Agriculture
OPHS	Ontario Public Health Standards
PHAC	Public Health Agency of Canada
CPNP	Canada Prenatal Nutrition Program
SDH	Social Determinants of Health
WHO	World Health Organization
WIC	Women and Children's Program

Foreward

My interest in how and why people eat what they do, and the effects on health has been shaped early. My journey began as a child, growing up amidst some key nutrition transitions - a health conscious mother who stayed at home and exposed us to home-cooked meals from scratch with plenty of health food influences and trends along the way. When she returned to work, there was a clear progression to more processed, quick to prepare meals while still holding on to the 'healthy' foods of the times, competing with big food and an ever-changing and often conflicting nutrition science. As a nutrition and dietetics student, I assumed that people just needed to learn what was healthy to eat to be healthy, that lack of knowledge and motivation was the problem; along the way, thinking within an individualised, personal responsibility frame.

In England, after a stint working for a major supermarket, I moved to the NHS, charged with developing a nationally accredited LCFA programme and then for regional government, in developing an accredited LHA programme; my interest in this area was sparked. I moved back to Canada just at a time of political change, and when the food charity model (as a means to counteract the effects of deteriorating social policies) was in its infancy in the UK. At this time, I found myself working in a grassroots organisation that was rather outspoken about the insufficiencies of a charitable model; this work paralleling the research has forced me to question things I never thought to before. I found myself constantly having to check-in with my personal views and preconceptions (and recognising that food choice is complex, so too are the causes of poor health). As my understanding grew, I developed a deeper passion for the role of programmes, society and government in the area of public health and food policy. This experience has provided me with insight into community work and health promotion in practice from a number of angles and in a number of contexts, contributing to this growth process.

It has been a long journey, including struggles with my own health that have extended this journey, and involving an ever-evolving understanding and knowledge and need for self-care. I look forward to continuing learning, being challenged and contributing to the field in the years to come.

PART ONE – SETTING UP THE PROBLEM

Introduction and Overview of the Thesis

The motives for this research stem from professional involvement in Lay Community Food Advisor (LCFA) programmes; both strategically and operationally, in the UK and Canada. Working in different environments: food industry, public health, local government and a community-based non-governmental organisation, both internally and externally on LCFA programmes, has helped shape the perspective and knowledge of the research field. Preliminary background research was conducted in both England and Canada at two separate points in time but the inception of this thesis began in the UK. At this time, peer support/ lay helper models in health were increasing in popularity and food had a high profile on the public health agenda, globally and nationally, making it a timely opportunity to study LCFA programmes (WHO, 2003; WHO, 2004a; DH, 2005). Interest in LCFA programmes grew based on the premise that despite these roles existing and growing in popularity, the extent of the research remained limited.

Throughout history, Lay Health Advisors (LHAs) have been incorporated into health system and community structures to increase capacity and more equitably meet health goals around the world (Cauffman et al, 1970; Turner and Shepherd, 1999; Lehmann and Saunders, 2007; Bhutta et al, 2010). The global academic literature is abundant on LHAs, but not so much in Canada and the LHA specifically related to food. Food and health issues are complex, and though it is recognised that policy action is needed beyond behaviour, food and health interventions are often focused here due to the problem commonly being framed through an individualised lens; focus on personal responsibility tends to win out over the social determinants of health (SDH).

Why this is important for Food Policy

The growing problem of food-related ill health and health inequalities is of global and national concern (PHAC, 2010a; WHO, 2013a; HC, 2017b). Solutions to preventing these issues are ever more challenging due to the complexities of the food system, environment, socio-economic issues as well as transitions influencing health. Public Health has a key role to play in addressing this problem with health promotion strategies. Traditional top-down approaches may have limited success in the community, but there is little evidence that bottom-up approaches have much impact in light of big food influences and underpinning health determinants. Food and the choices people make is a key public health issue needing to be

addressed (Tulchinsky and Varavikova, 2000 and 2014; WHO, 2004a; PHAC, 2008; WHO, 2013a). However, the conduit for which interventions work and bring about sustained behavioural change is a challenge (Capacci et al, 2012).

Unhealthy diets are of the major cause of non-communicable disease (NCD) including cardiovascular disease (heart disease, stroke), type two diabetes, cancer and contribute to the mortality, morbidity and disability of countries worldwide (WHO, 2003; WHO, 2005; Bhutta et al, 2010). Largely preventable and growing worldwide – both developing and developed countries are struggling with the burden of diet-related NCDs (DR-NCDs) (WHO, 2009; WHO, 2013a; Monteiro et al, 2017). Overweight and obesity contributes to a whole range of health problems and disease with the prevalence much higher in lower socio-economic groups (WHO, 2009). The connection between poverty and food security and poverty and health (mental, physical and social) is well known, and issues of food insecurity and obesity co-exist. So far there has been little success in countries being able to effectively decrease these burdens despite a number of individual to population level approaches (Lang et al, 2004; WHO, 2009; Durao et al, 2015; Segal and Opie, 2015).

Underlying determinants of the problem include social, economic, cultural, political and environmental factors. Rapid changes in diet and lifestyle have occurred due to industrialisation, urbanisation, economic development and globalisation (WHO, 2005; HC, 2017b). And the effects of a 'globalised' diet have become apparent with 'cheap' food becoming expensive when the results are translated to health, social and environmental costs (Caraher and Coveney, 2003). Globally, the nutrition transition has imposed a considerable burden on countries; prevention being the only way to address the 'epidemic of nutrition-related chronic diseases' (Popkin, 2002). This impact is not only to health care systems worldwide, but to community and individual costs that cannot be measured by economics alone (ODI, 2003; Lang et al, 2004). Increasingly, efforts by the health and non-health sector must be focused on prevention and the SDH due to increasing health care costs and widening of inequalities; poor diet being of particular concern within low socio-economic groups (Morris et al, 2000; O'Neill et al, 2004; Wanless, 2004; WHO, 2004c; Attree, 2006; PHAC, 2008; Dachner et al, 2010; Manuel et al, 2016).

Global priorities must recognise how health is shaped (WHO, 2004c; WHO, 2013a). Strategies to improve health must be implemented at local level to account for social, cultural and economic differences and complement national priorities (WHO, 1986; Wanless, 2004). Ways to include and reach a greater number of people in the community on health promotion are vital to be able to reduce health inequalities (WHO, 1986; Acheson, 1998; Marmot, 2010). This

should also include messages that are related and relevant to people's everyday lives (Winters et al, 2010). Tackling these priorities has proved challenging thus far, however, LHAs have been identified as actors in preventing NCDs including addressing the obesity epidemic and meeting health for all goals. With unhealthy diets being one of the main risk factors, LCFAs may provide a vehicle to improve diet. Over recent years, this emerging group of lay workers has been developing in order to assist people to eat healthier, by increasing awareness and helping to translate advice into practice. They may help increase coverage of health promotion; empower individuals and communities; help to reduce social exclusion and address inequalities in health (Kennedy, pc, 2004). However, there remains challenges and questions about programme design, role clarity and mechanisms for which to bring about change (Kennedy et al, 1998; Perez-Escamilla et al, 2008; Coufopoulos et al, 2010; Kennedy, 2010). Different models of LHA/LCFA programmes have existed but the problem persists and there is a gap in existing evidence which supports the role programmes play at local level and beyond, at improving health, particularly for those worst off.

The aim of this thesis is to explore LCFA programmes and their role at improving public health through the promotion of healthy eating behaviours. This is recognised as important, but how do programmes do so considering the current influences on food behaviour within micro, meso and macro contexts? How do programmes fit within food and health policy as a health promotion strategy to address diet-related ill health and nutritional inequalities? Are they merely about behaviour change or do they fit within a wider food and health policy framework? Can they be both policy keepers and policy influencers?

Significance of Study and Research Contribution

Although LCFA programmes have existed for some time, there is limited academic evidence for programmes, particularly in Canada. The literature points to a lack of long-term strategies and socio-ecological approaches within health promotion initiatives. As well, poverty and food insecurity is a growing problem as are the solutions. It is still not clear how well LCFA programmes can help people to overcome social, cultural, economic and environmental barriers to healthy eating and overall health. These programmes can change and develop in response to policy and community priorities. Much of the limitation to the literature is understanding the mechanisms and contextual factors of programmes; the value of this research is in understanding the inner workings of different programmes, and what works within a similar context. All the identified programmes in Ontario are long established and supported through Public Health resources. Despite this continued investment, there is a research gap as they are relatively unknown in the literature. As well, there are no programme

comparisons; these programmes seem to exist in isolation and run in parallel to one another. There is value in learning how these programmes have evolved, to contrast and compare key aspects, and to learn why they have been able to sustain policy and community changes over the years.

Research Questions (RQs)

RQ1. What contributes to programme function at strategic level; why and how are they sustained and what are their challenges?

RQ2. How does programme delivery occur; how do programmes work to address healthy eating across the socio-economic spectrum and is there a differential take-up?

RQ3. What are the programme outcomes at different levels: individual (for the LCFA and beneficiaries), organisational, community and policy level; what are their limitations and where are the opportunity gaps?

Methodology

A qualitative, case study approach of three key LCFA programmes in Ontario with both exploratory and explanatory aspects was the chosen research design. Data collection included: key informant interviews using semi-structured questionnaires, overt participant observation and document review. Thematic Analysis was used as a framework for field work analysis (Braun and Clarke, 2006). For policy analysis, the Health Policy Triangle (Walt and Gilson, 1994) was used to organise findings and the Multiple Streams Framework (Kingdon, 1995) was incorporated to discuss policy implications.

Findings

Programme models have been shown to deliver on policy priorities and enable increased capacity at multiple levels: individual, organisational, community and policy level.

Programmes have shown examples of being both universally accessible and targeted in their approach, addressing food literacy with community engagement strategies, but challenges remain to how improved long-term health can be achieved and for whom. Different models have illuminated approaches that push programmes in a positive health for all direction.

Discussion

Programmes play a key role in meeting public health policy priorities as well as challenging them. Programmes can address food literacy set within a social and community context, but may be more challenged to address the underlying SDH. Though they remain for the most part

downstream with some midstream activity, there are opportunities for upstream effort. Though localised, programmes can address food and public health policy objectives beyond food skills alone. Programmes and their role need to be viewed more broadly, with connections to the wider food system and environment and how they can be both policy levers and policy influencers. Programmes should not be seen as the solution to a complex problem that needs more than individual behavioural intervention, they must be part of and complement other strategies to improve health.

This research explores opportunities and limitations that exist with LCFA programmes, how they contribute to public health and implications for policy and practice applying a food and health policy analysis framework. This is first set out with an overview in Chapter One outlining personal experience and what is known about LHA/LCFA programmes with a literature review examining prior research. Chapter Two provides further context situating the LCFA in the wider literature. Chapter Three focuses on methodology, followed by findings and discussion from Chapter Four onwards, concluding with a final summary and reflections. Table 1.1 provides an overview of thesis chapters.

Table 1.1 Thesis Overview

PART ONE - SETTING UP THE PROBLEM
INTRODUCTION
Overview of Research
CHAPTER ONE
Lay Community Food Advisor Programmes
CHAPTER TWO
Situating the Lay Community Food Advisor in a wider literature
PART TWO - RESEARCH DESIGN AND METHODOLOGY
CHAPTER THREE
Methodology and Research Process
PART THREE - FINDINGS
CHAPTER FOUR
The context for different programme models
CHAPTER FIVE
The mechanism for different programme models
CHAPTER SIX
Programme outcomes
PART FOUR – DISCUSSION
CHAPTER SEVEN
Discussion
PART FIVE – CONCLUSIONS
CHAPTER EIGHT
Conclusions, Reflections and Recommendations

Chapter One. The Lay Community Food Advisor

1.1 Personal encounter with Lay Community Food Advisor Programmes

My personal encounter with Lay Community Food Advisor (LCFA) programmes began while working in the UK on Public Health programmes and when government policy had identified a new lay worker role (DH, 2004). Reflecting on this experience at the time raised questions among stakeholders of how this new LHA (Health Trainer) model would be implemented. Questions ranged from recruitment and training to the precise (and verifiable) competencies required for the role. At that time, my position involved developing and implementing an accredited training programme for LCFAs across three Primary Care Trusts in the UK National Health Service (NHS). Evaluation of this training revealed increased confidence and knowledge around healthy eating for the LCFAs. However, it also revealed a lack of clarity around the role and function of LCFAs across partners, organisations and LCFAs themselves, questions of recruitment criteria, uncertainty around level and length of commitment for programmes including funding, type of supervision and support for LCFAs. As well, it showed that LCFA expectations to be paid or paid more were increased once trained (Richards and Caraher, 2007). Background work also included questions raised about community engagement, for whom and with whom the LCFAs worked and the role programmes played in reducing social exclusion. A subsequent position involved developing an accredited training programme across Children's Centres for community parent volunteers. This programme was based on the Dublin and Thurrock Community Mothers' schemes, which paralleled the identification of a new City and Guilds national qualification. Discussion with stakeholders uncovered concerns of increasing standardisation and formalisation of programmes, moving these positions further away from their natural/lay helper intentions and their local, community connections. Yet by some stakeholders the aspect of being professional was considered desirable, and a lack of professionalism could be problematic within these roles.

Returning to Canada led to a position managing a multiple agency Canada Prenatal Nutrition Program (a federal government programme) linking to an LCFA programme (and experience of partnerships between Public Health and community agencies), as well as managing a family support programme that had different models across the country. The position also involved developing and implementing leadership opportunities in the community, including that for peer leaders in breastfeeding and community kitchen peer facilitators. This experience illuminated tensions between peer and paraprofessional, volunteer and paid models. In Canada, there was found to be limited academic literature around the LHA (specifically in relation to food), and limited awareness of the existence of these programmes through initial

contact with key academics in the field of food and health. However, there were a few key people who had knowledge of these programmes through their personal work experience who helped inform the direction of research in Canada.

Canada has received international attention in health promotion ever since the 1974 Lalonde Report and the 1986 Ottawa Charter for Health Promotion, for its community food programmes and an emerging national community food centre model (Lalonde, 1974; WHO, 1986; Saul and Curtis, 2013). Specifically, LCFA programme models have been established for many years in Canada but the academic literature on them remains limited. Food and its impact on health continues to be a salient and complex issue. Canada has seen different models of the LHA and LCFA growing; alongside, the growth of civil society and opportunities for community engagement on issues such as food, health and social justice. The aforementioned experiences, including working within the first and original Community Food Centre Canada, have shaped my views and interpretations in this research.

Although some comparisons are being made between the UK and Canada, as initial research was inspired by the situation in the UK, this is for the main purpose of looking at examples of practice, different LHA/LCFA model approaches and to enable valuable learning of programmes that does not just focus on local issues. A true comparison is not being made as it is recognised that there are differences historically, geographically and politically. Though, drawing on parallels is useful for similarities in the two countries which share many of the same public health issues. The predominant focus remains on the Canadian context, drawing on international references.

1.2 The History of the Lay Community Food Advisor

Due to the limitations of peer-reviewed literature on the LCFA and in Canada, the wider, international LHA literature is drawn upon. The most dominant literature comes from the UK and the US and is most limited in Canada, in particular, with a food focus.¹

A number of systematic reviews have been conducted on LHAs, not all of which have been deemed adequately relevant for the purpose of this research mainly because of their focus on low and middle income countries (LMICs) and/or lack of focus on health promotion, however, have been useful to capture the wider issues (Gibbons and Tyus, 2007; Lewin et al, 2006 and 2010; Lehmann and Saunders, 2007; Viswanathan et al, 2009; Bhutta et al, 2010; Ginneken et al, 2013; Glenton et al, 2013; Daniels et al, 2014; McCollum et al, 2016). What follows is a

¹ Details of how the literature review was approached are included in Section 3.3.

review of the vast literature found to be informative for the basis of the thesis, including drawing on the wider LHA literature. This includes rationale, description, typology of programmes and LHA characteristics. To be clear, while there is a vast literature, there is little to draw upon in this specific area of research.

It is important to note that a wide range of titles have been used in the literature and in practice across countries, regions and localities including: Community/Village Health Worker, Health Aide, Peer Educator/Advisor and Lay Public Health Worker. This diversity in titles has been acknowledged in the literature (Witmer et al, 1995; NRHA, 2000; Perez and Martinez, 2008; Bhutta et al, 2010; Simoni et al, 2011; Yoeli and Cattan, 2017). Bhutta et al (2010) for example, have listed 59 different titles for these positions working across different countries; Taylor (2015) has identified 131 titles in the literature. Even so, this may leave out many other LHA terms used around the world. As well, these titles and roles have been defined and interpreted differently; even within the literature, there is a general lack of clarity of terms making it challenging to advance a common evidence-base (Simoni et al, 2011; South et al, 2013a). One of the most predominant terms used is Community Health Worker (CHW), which has been adapted as a formal title recently in the US, but still, this is an umbrella term with many others being used in practice (CDC, 1994; Balcazar et al, 2011; CDC, 2014). Despite CHW being a dominate title, Lay Health Advisor and Community Health Advisor are also recent terms found in the literature.

Historically, LHAs, originating from 'Health for All', have been initiatives 'built from the ground up' working to tackle national, regional and local health priorities (WHO, 1978). Meeting Health for All goals requires reducing inequality gaps in part through improving access to resources for those most in need. In practice, this has often proved difficult to achieve (Ramprasad, 1988; WHO, 2002). Community-based health initiatives have long been recognised as a significant contribution towards achieving good health, and recognising that the individual and community possesses the answers to their own good health (Jay, 1983; Puska et al, 1985; Scheuermann et al, 2000; Hancock, 2009; WHO, 2010b). Communities are not homogenous in the issues they are faced with and different problems exist for different people (Boutilier et al, 2000). Thus, having community members who can better represent and understand the community and are able to deliver initiatives on a wide range of health issues has been considered effective at improving health outcomes and at reducing disparities in health particularly within LMICs. LHA strategies have in many countries been a response to the health workforce crisis in order to strengthen health systems and reduce the burden of disease. LHAs have been heralded as a more sustainable, cost-effective strategy to re-orient

health services and reach under-served communities (Thomas et al, 1998; FAO, 2003; Magnussen et al, 2004). In HICs they have been increasingly gaining attention as a strategy to fill health gaps (Kahssay et al, 1998; Rosenthal et al, 2010; Torres et al, 2013; Najafizada et al, 2015).

'As long as there are communities under-served by health services, CHWs/LHAs will continue to have an important role in developing countries and, increasingly, in countries of the industrialised west.' (Kahssay et al, 1998)

LHA programmes have existed for decades in low, medium and high- income countries mainly as a capacity-building strategy aiming to fill gaps in the community by increasing equitable access and utilisation for health, within countries and regions, and respond to population shifts (Karwalajtys et al, 2009; Cook and Wills, 2011; Torres et al, 2014; Najafizada et al, 2015; McCollum et al, 2016). There is even a website dedicated to being a 'global resource for and about' CHWs (CHW Central, 2017). Though the role has been reported by some to lack clarity, their overarching role is widely reported to include: bridging service gaps between the community and service provider; bridging knowledge, understanding, and relationship gaps between the professional and lay person; and bridging the health gap between those better and worse off (Bender and Pitkin, 1987; Witmer et al, 1995; FAO, 2003; Perez and Martinez, 2008; APHA, 2009; Dugdill et al, 2009; Bhutta et al, 2010; Cherrington et al, 2010; Carr et al, 2011; Nkonki et al, 2011; Najafizada et al, 2015). LHAs have also been reported to fulfill a broader, more transformative role in community development (Nittoli and Golith, 1998; Lehmann and Saunders, 2007; Standing et al, 2008). The World Health Organization (WHO) provides a definition of LHAs:

'members of communities where they work, selected by and answerable to the communities for their activities, supported by the health system but not necessarily a part of its organisation, and have shorter training than professional workers' (WHO, 1989; Lehmann and Sanders, 2007)

The American Public Health Association (2009) has provided an expanded description of LHAs, to reflect the modern reality of these roles in a HIC working in public health. LHAs are described as:

'frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served...this trusting relationship enables LHAs/CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to service delivery...LHA/CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counselling, social support and advocacy' (APHA, 2009)

LHA strategies fall into two broad categories: public health (health promotion such as health education and chronic disease prevention) and health care (clinical care or support for

patients). LHA models generally fall into promotive/prevention or curative/treatment models. The traditional and more commonly used approach in LMICs is that of disease management or treatment whereas HICs may more commonly include that of health promotion and disease prevention (Bhutta et al, 2010; Cherrington et al, 2010; Lewin et al, 2010). This latter approach is the main focus within this thesis. There is a breadth of recent literature on the LHA (CHW) in the US and in the UK (primarily Health Trainers). The main distinctions here are that the US LHA roles span curative/clinical and preventive/promotive work across a variety of settings, whereas the UK LHA is mostly lifestyle focused, predominantly in community settings.

LHAs have mostly been described as community-based who are ideally recruited by the community or are representative of the community with whom they are working, as this has been found to be most effective (WHO, 1989; Nemcek and Sabatier, 2003; Lehmann and Saunders, 2007; Bhutta et al, 2010). This approach is based on the traditional model of utilising those who are 'natural helpers' providing outreach to the community and are considered to be better placed to provide or facilitate social support, act as advocates or change agents, resulting in more positive health outcomes as they can align with social and cultural norms. They not only can play a role in improving the health of communities through improved knowledge, attitudes and behaviour, but can also help to improve the understanding of service providers with community needs (Richter et al, 1974; Werner, 1981; Bender and Pitkin, 1987; Watkins et al, 1994; Altpeter et al, 1999; Lehmann and Saunders, 2007; Kennedy et al, 2008; Carr et al, 2011; Ahmad et al, 2017; Simonsen et al, 2017).

LHA roles may be broad and generalist in nature or specialised. LHAs may work with individuals or groups, helping them to access health and social services, and may provide education or advocacy on a number of health issues. LHAs may provide a range of activities as part of screening, prevention, health promotion, management and treatment programmes ie. compliance (for both communicable and NCD). LHA interventions have shown promise at achieving positive outcomes in areas of: maternal health, birth and newborn care, breastfeeding promotion, childhood health and immunisation, primary care, HIV/AIDS, mental health and substance-abuse. They have shown effectiveness in increasing health care utilisation and health education but have been limited in showing sustained behavioural change (Hoff, 1969; Swider, 2002; Gibbons and Tyus, 2007; Lehmann and Saunders, 2007; Viswanathan et al, 2009; Lewin et al, 2006 and 2010; Bhutta et al, 2010; Nkonki et al, 2011; Ginneken et al, 2013; Glenton et al, 2013). More success has been reported through interventions that are quite specific (Fisher et al, 2017). Broad or generalist roles can present both challenges for clarity and boundaries, as well as opportunities. This may particularly be

the case with health promotion activities (Swider, 2002; Williams et al, 2016).

Support for LHA strategies has gone through waves over several decades, often during social or political change. It has often come down to a lack of resources and whether there is enough broader support for LHA programmes (Vaughan, 1980; Werner, 1981; Giblin, 1989; McGlone et al, 1999; Wolff et al, 2004; Lehmann and Saunders, 2007). Being supported by the health system in some way has been favoured (WHO, 1989). As Kok et al (2015) found, the health system policy context influenced CHW performance (though in LMIC context). The general consensus in the literature promotes LHA programmes to be integrated as LHA programmes are considered to be more vulnerable if not part of the formal health system.

'where this is not the case, they exist on the geographical and organisational periphery of the formal health system, exposed to the moods of policy swings with the wherewithal to lobby and advocate their cause, and thus are often fragile and unsustainable' (Lehmann and Saunders, 2007)

However, there may not be consensus on how this looks and its implications. Programmes are also found to be more effective if grounded in the community and with community participation, with some concerns raised over LHAs increasingly becoming agents of the state. Community outreach and engagement are advantages to LHA programmes, however, programmes may be limited in their ability to do so as the implication of limited resources can mean a limited number of LHAs trained or a limited number actually working in the community (Baker et al, 1997 and 2001; South et al, 2011). For LHAs to be successful, government and political support is deemed necessary, but so too is for LHAs to be connected with communities (Haines et al, 2007; Kok et al, 2015 and 2017). The more effective engagement with marginalised communities has been reported to be best achieved with LHAs being based in community or voluntary groups rather than the formal health system (Cook and Wills, 2011; South et al, 2011).

The utilisation of LHAs has been increasingly recognised as filling human service gaps in health (Nittoli and Giloth, 1998; Torres et al, 2013; Torres et al, 2014; Najafizada et al, 2015). Their role has been described as potentially being broader than this (WHO, 2004b; APHA, 2009).

CHWs/LHAs 'should not be viewed simply as local helpers who can temporarily take on tasks the formal health care delivery system lacks the resources to perform. They are not primarily a cheap way to deal with human resource constraints. Rather, programmes can and should be seen as part of a broader strategy to empower communities, enable them to achieve greater control over their health and improve the health of their members.' (WHO, 2004b)

However, the scope of practice of LHA and LCFA roles has been reported to be limited with tensions between narrow and broad approaches (Eng et al, 1997; Kennedy et al, 2008; Minore

et al, 2009). Though, a way to address this scope of practice has been shown to be effective with the formation of coalitions that include different actors (Simonsen et al, 2017).

Community coalitions can open up potential for health improvement and play a role in reducing disparities in health if they are more inclusive of issues and participatory (Meister and Guernsey de Zapien, 2005; Anderson et al, 2015). Coalitions can enable a broader scope of health promotion work (Hill et al, 2007).

There are reported tensions between promotive/preventive and treatment/curative models with LHA strategies, the latter approach often being most common (Vaughan 1980; Standing et al, 2008; Coufopoulos et al, 2010; Nkonki, 2011). Some of the literature reports LHAs at doing best at fulfilling specific tasks rather than a broad range of tasks (Lewin et al, 2006 and 2010) but this is mostly framed within a narrow, curative model. Many LHA programmes have been quite specific, for example, focused on compliance of medication or immunisation, or prevention of diabetes or cardiovascular disease and the promotion of healthy foods such as fruits and vegetables. For example, Fisher et al (2017) focus their review of peer support strategies on complex health behaviours in prevention and disease management specific to diabetes; DeHeer et al (2015) studied health behaviours specific to reducing risk of cardiovascular disease through LHA promotion of community resources and Balcazar et al (2012) focus on the use of LHAs in the prevention of cardiovascular disease, however, do advocate for an ecological approach that 'embraces' the LHA model.

Studies recognise the limitations of LHA roles, particularly if focused on individual behaviour change and that these roles can be faced with other issues they may be unprepared for such as the wider factors influencing behaviour. The common view is that LHAs can solve problems in the community, when they are only one aspect of the wider role an agency or the state plays in improving the health of the community. Indeed, LHAs may, due to their status and relationships within the community, identify more issues than may have been anticipated. This may be challenging to address or ensure LHAs are equipped to handle but can also be considered an added value of these roles, and an opportunity for them to work on wider issues (D'Onofrio, 1970; Dugdill et al, 2009; Ball and Nasr, 2010). This wider role may include advocacy and though they are reported by some to have a role here, it is not clear how this looks, whether it be systemic advocacy work or individual advocacy for example, and how transformative it is; advocacy can mean many things (Carlisle, 2000; Maurana and Rodney, 2000; Wolff et al, 2004; Cherrington et al, 2010).

Advocacy in public health is not a new concept², and can be representational or facilitational (Altman et al, 1994; Carlisle, 2000). This has been argued to be 'deeply contrasting', with representational advocacy being the most dominant (Smith and Stewart, 2017). There is a history of LHA roles acting as social justice and policy advocates (Richter et al, 1974). LHAs are in a 'unique position to represent communities and advocate on a community level by pressuring lawmakers to pursue structural changes that will address health inequities' (Ingram et al, 2008). Importantly, LHAs are in a position to more closely understand the complexity and reality of people's situations and through their connections can communicate this through to decision-makers (Ingram et al, 2008; Perez and Martinez, 2008).

'The community leads its own development and community leaders are themselves capable of opening doors to the wider citizenry. Local leaders are therefore defined by the relationships they have with the community, by their social, rather than political or financial capital.' (IACD, 2009)

LHA roles have shown some success in identifying problems and solutions in the community (Nemcek and Sabatier, 2003). There is some tension here that by the community being responsible for its own health and solutions, it can take away attention from government responses that are needed. However, LHAs/LCFAs can be valuable as a necessary conduit of issues that are policy-related.

Typology of LHA Programme Models

South et al (2013a) suggest grouping features of LHA programmes into four dimensions: intervention, role, professional support/service and the community. These dimensions are explored throughout Chapters One and Two.

In Canada, LHA models fall along an informal to formal spectrum in relation to their connection with the public health system: independent, connected to, integrated within (or co-opted) (Torres, 2013). Informal models may operate out of volunteer or community agencies/ NGOs; these models are independent of formal health organisations. They may exist with larger social service agencies or associations such as that of lay community facilitators with the Canadian Diabetes Association. In the middle of the spectrum, models have a formal connection to the health system ie. Public Health unit, community health centre, clinic or hospital. At the formal end of the spectrum, models are integrated into the health system, in that they are incorporated as part of programming within the organisation such as through Public Health units, community health centres, clinics or hospitals such as with the Ottawa Public Health

² Advocacy in public health can be described as 'efforts to change community conditions related to health' (Altman et al, 1994).

unit's Multicultural Health Team. At this formal end, a co-operative model can also exist whereby a formal relationship exists with the health system and resources are accessed through the local Public Health unit or community health centre, for example, but a community agency takes responsibility for the programme delivery. All the aforementioned models are dependent on funding, however, the sources of funding and the ability to secure funding in the short to long-term may vary. Professionalised involvement and control invariably comes into play depending on these connections (South et al, 2013a). Access to pay, benefits, training and organisational support may differ and be connected with how the relationship with the health system works (Torres, 2013). Regardless of how programmes sit within the public health system, effective partnerships are a key feature of successful programmes (Lehmann and Saunders, 2007; South et al, 2011; Torres et al, 2014).

The most common feature of programmes across LMICs and HICs is that work is often targeted at and with communities and populations experiencing disadvantage and are at risk of poor health outcomes. This includes lower socio-economic groups and/or geographical areas most commonly (but not exclusive to) mothers, children, the elderly, socially excluded, minority ethnic groups and new immigrants (NRHA, 2000; Nemcek and Sabatier, 2003; Dugdill et al, 2009; Najafizada et al, 2015; Yoeli and Cattan, 2017). Key life stages and transitions have been a focus area of some LHA programmes. For example, on pregnancy and early motherhood as this is often where programmes may be able to create change and have the most impact due to motivation and people being more receptive to change (Besharov and Germanis 1999; Johnson et al, 2008; NICE, 2008). However, some concerns have been raised about LHAs successfully reaching their target populations and that those most hard to reach communities remain most hard to reach (Attree et al, 2012; Price and Lester, 2012; Goodall et al, 2014).

Programmes either focus on individuals or groups, but are most commonly group-oriented rather than working with individuals when in a health promotion capacity (the focus of this thesis). Of note, there is literature that focuses on certain communities and specific populations, including maternal and child health. While this literature is referred to, the thesis focus is not on one specific community or population group.

Typology and Challenges for LHA Roles

South et al (2013a) categorises roles by: peer education, peer support, popular opinion leaders, bridging roles and community organising. Many roles can be combined to be a 'hybrid' but are seen as bridging/connector models more widely (in LMICs and HICs) and peer education/support models (more so in HICs). However, much of the literature points to confusing or lacking distinctions.

Roles have been classified as functioning as: informing, enabling, educating, outreach, awareness raising and supporting (Kennedy et al, 2008). Attributes for LHA/LCFA roles have been determined to be: credibility, approachability, local knowledge, respect, empathy, understanding, having a shared background or something in common, social skills and good communication, the ability to develop trust and relationships (Nittoli and Golith, 1998; Kennedy et al, 2008; Rosenthal et al, 2010; Glenton et al, 2013; South et al, 2013b). Multicultural competence has also been found to be valued (Eng et al, 1997; Torres et al, 2014).

LHAs in Canada have been reported to be diverse, reflecting the diversity of their roles and those with whom they are working (Ahmad et al, 2017). LHAs have most commonly been described as 'peers' acting in a non-professional capacity: possessing natural helper qualities and being non-judgemental and responsive to community needs (Simoni et al, 2011; South et al, 2013b). What they lack in professional qualifications they are considered to make up for in life experience or a shared commonality, such as being a mother or being from the same culture or community (Johnson et al, 2000; Dugdill et al, 2009; Coufopoulos et al, 2010). Social relationships, including trust, are important in the LHA role, as a key function has been to provide support. However, this element of support and trust may differ depending on how formal and professionalised the role is (to be explored in Chapter Two) (South et al, 2011; South et al, 2013b; Najafizada et al, 2015; McCollum et al, 2016; Ahmad et al, 2017).

Interventions by LHAs to improve lifestyle factors have shown some effectiveness for lifestyle behaviours, health outcomes and reducing disparities in health. These have often been for specific groups, of immigrant populations and/or specific at decreasing chronic disease risk (Scheuermann et al, 2000; Kim et al, 2004; Will et al, 2001; Staten et al, 2004; Rhodes et al, 2007; Fleury et al, 2009; Gardner et al, 2012; DeHeer et al, 2015). The benefits of programmes have been reported to be at an individual and community level. LHA empowerment has been reported through key areas of social connectedness, self-awareness, self-esteem, increased confidence and control over their own lives; at the community level, an increase in community capacity, engagement and altruism (Glenton et al, 2013; Ahmad et al, 2017). This increase in community capacity not only contributing to the health and welfare of communities but cascading out to wider social networks. The effectiveness of LHAs has been attributed to their ability to develop relationships and 'having the time' to spend with people (Ball and Nasr, 2010). Though their community engagement aspect and ability to provide social support has widely been reported (Dennis, 2003; McElmurry et al, 2003; Cook and Wills, 2011; South et al, 2011; Harris and Haines, 2012; South et al, 2012; Taylor, 2015), there remains limited evidence

showing community empowerment in relation to SDH (McCollum et al, 2016). However, effectiveness in general is difficult to show due to the complex nature of programmes and other factors that can influence outcomes, and it is often more feasible to focus on outputs rather than outcomes (Vaughan 1980; Standing et al, 2008; Coufopoulos et al, 2010; Nkonki et al, 2011).

Some common issues have been raised about the LHAs. While less so questioned is the need for these roles, more questions have been raised around what they should look like: their function, utilisation and design of such programmes – whether it be in health care or health promotion (Vaughan, 1980; Standing et al, 2008). And though there is substantial support for the LHA model, there has been some disagreement on whether they are more effective than professionals or other approaches (Attree, 2012; O'Mara-Eves et al, 2013 and 2015). Though they are traditionally intended to work within their own communities, in practice this may not always be the case, particularly in HICs (Cook and Wills, 2011; Yoeli and Cattan, 2017), though Torres (2013) makes a statement describing LHAs in Canada this way with no question. There is some critique on these programmes for their focus on being health agents rather than change agents, concerns that programmes are too downstream and focus on personal responsibility rather than working within a SDH frame (Torres et al, 2014). LHAs 'play a paramount role in connecting people to vital services and helping to address the economic, social, environmental, and political rights of individuals and communities' (Perez and Martinez, 2008). Are LHA roles merely filling a human resource gap or acting as change agents (Plescia et al, 2008)? Are they individual change agents or system change agents? Do they support the system or challenge the system or can they do both?

The dominant model that has emerged from studies is that of providing an extension of existing professional health services and roles (Kennedy et al, 2008). And this would coincide with efforts to reduce costs. Programmes have been considered to be cost-effective in that the labour of the LHA is cheaper to that of the professional, and in their potential to reduce the cost of more expensive health services (Baker et al, 1997; Whaley and True, 2000; DeBell, 2003; Najafizada et al, 2015; Rush, 2017). Some cost-effectiveness reported is more of a clinical/curative model of providing direct health services rather through a preventive/promotive model. Despite reported cost-effectiveness for some initiatives, economic evaluation tends not to capture institutional features and complexities of programmes (Berman et al, 1987; Walker and Jan, 2005). Although programmes may seem desirable, particularly to governments, for being inexpensive to run in the short-term, they will have limited effectiveness without tackling the SDH which can be onerous and expensive (Attree et

al, 2012). And interventions that focus on behaviour change can be difficult to prove long-term results (Capacci et al, 2012). The difficulty with connecting outcomes in isolation with programmes also makes it difficult to establish true cost-effectiveness (Besharov and Germanis, 1999). It must also be considered that prevention of disease and health promotion is a far more cost-effective approach in the long-term than tackling treatment of illness and disease (Wanless, 2004). Having more people on the ground to do this via the LHA model may turn out to prove cost-effective in the long run at the prevention and early intervention stage, by increasing capacity.

'You don't just measure the risk of doing something; you measure the risk of not doing it...and to get politicians thinking – 'what is the cost of not doing this?' The anti-smoking campaign years ago was successful because it was attached to economic cost.' (Roberts, pc, 2010)

There are several examples of well established LHA models across the globe. These include the Mexico's Promotore/as, Chinese bare-foot doctors and Cuba's Community Health Providers in LMICs, which are more traditional examples of LHA models utilising community members as natural helpers. In HICs, examples include the Dublin Community Mothers programme and UK Health Trainers utilised in more of a public health capacity, both with some food and nutrition focus. Community Mothers, a model providing one to one supports to other parents, has resulted in improvements in child development, self-esteem and parenting skills (Johnson et al, 1993). Benefits including improved and sustained mother and child diets have been reported (Johnson et al, 2000). The Expanded Food and Nutrition Education Program (EFNEP) and Women and Children (WIC) Program in the US are large-scale examples, targeting low-income populations. The EFNEP is the largest nutrition education programme in North America operating in all 50 states under the USDA (US Department of Agriculture), part of its success is due to matching 'paraprofessionals' and volunteers with their target groups according to background, ethnicity, income and education and incorporating practical learning - a model which has been piloted and recommended to be emulated in the UK by Kennedy et al (1998). Changes in healthy eating behaviour have been found to be more positive for those participants who received individualised education. Reported additional benefits beyond food and nutrition have been education, employment, health and community involvement. Sustained changes in attitudes, knowledge and behaviour for participants have been reported, highly linked to motivation (Chipman and Kendall , 1989; Dickin et al, 2005; Devine et al, 2006; Koszewski et al, 2011; Wardlaw and Baker, 2012). Cost-effectiveness has been demonstrated in relation to participants reporting spending less on their monthly food while at the same time eating more key nutrients, although it is not clear whether this has been sustained (Burney and Haughton, 2002). Another study found a \$10 benefit for every \$1 spent, positive

cost-benefit in relation to the prevention of chronic disease (Rajgopal et al, 2002). WIC's more targeted approach and provision of food packages including nutrient-dense foods such as fruits and vegetables alongside nutrition education has resulted in increased intakes of healthy foods for this population (Herman et al, 2008). However, it must be considered that eligibility and participation on programmes can be short-term.

Some systematic reviews on LHAs have found LHAs to contribute to the prevention and management of communicable and NCDs, and improved maternal and child health but insufficient evidence for policy and practice. Most have not focused on interventions related to food policy (Lewin et al, 2006; Lewin et al, 2010; Ginneken et al, 2013; Glenton et al, 2013). Interventions focused on diet alone or diet and exercise have been found to be more effective than interventions that deliver a broad range of health-related advice and activities (BNF, 2004). But in general, there remains questions as to what makes a programme effective, more effective than another and how transferable they are (Lewin et al, 2006 and 2010). As well, how programmes work set within a wider community and societal level context.

The Lay Community Food Advisor

There are many food and nutrition community-based programmes that aim to improve food security and nutritional well-being for which LHAs play an integral role (FAO, 2003). The focus of policies and programmes has often been on food insecurity, under-nutrition and micronutrient deficiencies in LMICs (Beaudry and Delisle, 2005). Nutrition interventions may also focus on growth monitoring, promotion of breastfeeding, complementary feeding and communications for behavioural change (nutrition information, education) (Lehmann and Saunders, 2007). In HICs, the LCFA role may work within a curative or promotive model, in health care or public health, however, the focus of the thesis is on the latter, the role LCFA programmes play in Public Health.³

The term Lay Community Food Advisor (LCFA) is used in this thesis rather than the suggestion by Kennedy et al (2008) of using the umbrella term 'Lay Community Food Worker' (for consistency), in recognition of these roles not always being paid positions, whereby the use of 'worker' may assume all positions are paid. Although they both involve labour, the LCFA title includes non-paid labour. The choice of 'advisor' was settled upon as this was a descriptor used by some roles but also recognises this may be contentious due to the possibility that advisor could indicate a position of hierarchical nature (in relation to community participants). Indeed, the term 'lay' could be contentious (Taylor, 2015), but is used in this thesis to

³ When referring to the organisation or institution, Public Health (capitalised) is used, when referring to public health more broadly, public health (lowercase) is used.

distinguish from a professional role (that requires professional qualifications specific to that discipline and sits under a professional title). Taylor (2015) has illustrated the overlapping contention between 'community', 'lay' and 'peer' with different meanings and interpretations. In hindsight, a different term could have been used and many were considered, but the reality is that there is no universally accepted term. At the beginning of the thesis, there was no clear term being used to describe LHA or LCFA roles, however, the CHW has become a more common term in Canada and the US in addition to countries having CHWs for many years. Peer Nutrition Educator has been used, but this in practice may be inaccurate. And Community Food Worker (CFW) is perhaps the most common food-related LHA term, but in preliminary research it was found that some models utilising this term had changed to other titles as a result of LCFAs voicing their dissatisfaction with the term, in particular, with 'worker'. For example, one respondent noted that LCFAs associated the title with being a worker at McDonalds. Community Nutrition Assistant has been used over the years, but seems to be less popular a term now as 'assistant' may mean assisting people to eat healthier (Richards and Caraher, 2007), but may also imply a subordinate position. Organisations were choosing titles that were felt to better reflect LCFAs' role and function. Utilising the term 'lay' was intentional as it was also found in searching the internet that some CFW positions were more formalised. For example, job advertisements as seen recently in Canada, requiring tertiary-level education related to the position such as a food and nutrition degree (this was also found to be the case with CHW). Indeed, this can vary but it was felt these titles too could be misleading.

The Lay Community Food Advisor (LCFA) is based on the premise of community members, recruited from the local community trained to deliver consistent messages on healthy eating in various practical ways. They are often programmes targeted at working within communities of lower socio-economic status. The rationale for the development of LCFA parallels that of LHA roles: filling the gap in the nutrition and dietetic workforce, the need for skill mix and cost savings, and addressing the complexity of diet-related issues (Kennedy et al, 2008). Perceived benefits identified by LCFAs and professionals have included the ability to reach the hard to reach, cost-efficiency, increased service coverage, personal development for LCFAs and improved social support (Kennedy, 2010). Though the benefits of EFNEP and WIC for example, are well documented, in general, there remains uncertainty as to whether benefits of programmes translate into long-term behaviour change and value for money (D'Souza et al, 2006; Coufopoulos et al, 2010; Black et al, 2012). Though the general rationale for the existence of LCFAs has not so much been disputed, the role and function of the LCFA has lacked clarity, particularly in relation to the professional roles (primarily dietitians and nutritionists) and institutions (Kennedy et al, 2008; Coufopoulos et al, 2010).

1.3 How LCFAs sit in Institutional Structures and in the Community

This section focuses on the debates mainly in HICs and where available, the LCFA and Canada specifics, through looking at more detail of programmes: their location and role differentiation, recruitment, training, retention, supervision and support structures; and employment and volunteer models.

The location for LHA/LCFA programmes falls into two categories: where they are situated within institutional structures and where they operate. LHA/LCFAs work across a broad range of settings and may be situated within clinical and community environments that have a health focus; ranging from hospitals, Public Health units, community health centres, not-for-profit, charitable and social service agencies, churches, workplaces and schools. Some roles may even extend to home visiting -often in a clinical capacity (Beam and Tessaro, 1994; Wolff et al, 2004; Richmond and Ross, 2009). Different models of the LCFA exist, whereby they may be classified under clinical or public health/community roles. Dietetic assistants/aides, the most common LCFA title found within a clinical model, operate within hospitals and are focused more on individual care, are task oriented such as serving meals to patients, and operate under dietitians as their supervisors (BDA, 1999). This differs from the role under study in this research, which is the LCFA working within or connected to Public Health, specifically Public Health units, as public health work is structured in Canada. These roles may mean working across a variety of the above settings, broadly within community as a setting. Supervision and support is normally provided by the institution ie. hospital or Public Health unit. Most LCFA positions are situated within nutrition and dietetic departments within hospitals or Public Health units and supervised under dietitians or nutritionists in these departments.

Community-based roles may be broader, such as that of the CFW, carrying out practical food activities in the community or focused on nutrition and health education and may be in more informal institutional structures such as community agencies whereby their supervisors could be by anyone in the agency.

Recruitment and retention of LHAs/LCFAs have long been reported challenges with programmes across the globe (Vaughan, 1980; Standing et al, 2008; Coufopoulos et al, 2010; Nkonki et al, 2011; South et al, 2011; Koszewski et al, 2011; Wardlaw and Baker, 2012; Daniels et al, 2014). Traditionally, programmes have recruited from the communities with whom they would be working but recruitment can be from a broader catchment of recruitees (Bhutta et al, 2010; Najafizada et al, 2017). These positions traditionally have not required formal qualifications, and as such, have been a way to open doors for people with little or no formal

education (Nittoli and Golith, 1998; South et al, 2011; HTE, 2013). Many programmes focus on recruitment and training of LHAs but do not consider retention of LHAs. Attrition rates can be high and may be higher for those recruited from low-income communities (Leaman et al, 1997; Nkonki et al, 2011). This may be related to institutional support for LHA/LCFAs and whether positions are paid or unpaid. In Canada, as with other HICs, LHAs are most often recruited from the organisation (not through the community themselves) but are expected to possess qualities that make them representative of the community with whom they work (Najafizada et al, 2015). These roles may also be going to more highly qualified and skilled people available to do the jobs, due to cuts in Western world health spending and migrants with high human capital (Nittoli and Giloth, 1998; Vang et al, 2015; Ahmad et al, 2017).

LHA/LCFA programmes can lack long-term vision and commitment to resources, and may not have clear pathways of training and support, including employment and further development opportunities (Leaman et al, 1997; McGlone et al, 1999; Coufopoulos et al, 2010; South et al, 2011). Funding is provided through the health system for the most part and is often connected with the hospital and or local Public Health unit unless roles are independent of the health system, for which funding could be more varied (Torres et al, 2014).

Roles can range from volunteer to paid positions, hourly or full-time, or receiving stipends for the work. The effects of different remuneration models have been explored for LHA programmes in LMICs and HICs. Issues raised for the LHA have been whether they should be in volunteer or paid roles, as well as how much they should be paid - and there is no agreement (Lehmann and Saunders, 2007; Glenton et al, 2013; South et al, 2014; Singh et al, 2015).

LHA/LCFA positions if paid, can mean more accessible opportunities for those on low-income, social assistance or who are new immigrants (Nittoli and Golith, 1998; South et al, 2011) but may not be a guarantee that those positions will be filled that way (Goodall et al, 2014). Paid positions include that of the UK Health Trainers. Examples of volunteer positions include that of Community Mothers and that of the WIC programme in the US. The EFNEP has both volunteer and paid positions. There are some views that by LHAs being in paid positions, this can further distance them from the community relationships (LHAs themselves concerned over social status) or that it alters people's motives ie. that they are driven by earning money rather than other reasons (South et al, 2011; Glenton et al, 2013). This can be highly dependent on how they are viewed and classified (natural helpers/ peers or paraprofessionals) and by whom. It is also a question of the value placed on their roles and the compensation attached, which may not necessarily be monetary if there are other benefits such as expenses paid, training or childcare provided. Incentive strategies, which are highly context specific, influence

motivation of LHAs which is linked to recruitment, retention and performance of LHAs (Daniels et al, 2014).

The gaining of new knowledge of skills has been found to stimulate desire and drive to move on to further learning (Molloy, 2007). Payment of these roles must also consider not interfering with other benefits the LHA may be receiving such as social assistance (Adebayo, 1995; Leaman et al, 1997). This issue is contentious amongst the LHA/LCFAs themselves, and between the professionals and management (South et al, 2014). Often there is a mismatch between expectations and pay (Coufopoulos et al, 2010). Pay, or lack of sufficient pay, can be a significant barrier to the retention of LHA/LCFAs (Leaman et al, 1997). The career and family-supporting job potential of these roles has been questioned for some time; many positions being temporary, not providing adequate hours of work and/or being paid low wages (Nittoli and Giloth, 1998). This may have shifted due to further institutionalising of LHA positions, however, there has also been a rise in volunteerism. But the demographics of volunteers in Canada show those of higher socio-economic status to be more likely, and the immigrant population less likely than their Canadian counterparts, to volunteer (Vezina and Crompton, 2012; Sinha, 2015). Statistics Canada reports a key motivation to contribute to their community and those more likely to volunteer to be highly educated with a higher level of household income, and are more likely to be employed (and volunteer in addition to their work) (Vezina and Crompton, 2012; Sinha, 2015).

Being employees of institutions may affect relationships with the community and to whom allegiance lies - the community or the employer (Cherrington et al, 2010). Cherrington et al (2010) suggests there is a place for a combined model of paid and unpaid LHAs within HICs, as is the case with EFNEP. Similarly, Singh et al (2015) recommend a combination of paid and volunteer LHAs, working in different capacities and differing scopes of practice, in LMICs. The volunteer and paid aspect of these roles in itself is confusing. Ahmad et al (2017) distinguish lay workers from volunteers, categorising volunteers as often 'older individuals from high-income groups who have spare time.' While this may have truth, some LHA roles do fall into volunteer categories, and this adds to the confusion about whether or how peer, lay or natural helper roles are different (to be explored further in Chapter Two). And there may be a hierarchal nature to roles in institutions dependent on whether they are full-time, part-time, sessional paid or volunteer positions; this can relate to the level and type of supervision and support for LHAs/LCFAs.

Adequate training has been considered essential for years but the literature supports ongoing questions over whether training has been sufficient for LHA programmes, how best to provide

training and its characteristics (Hoff, 1969; Cauffman et al, 1970; Werner, 1981; Turner and Shepherd, 1999; Lewin et al, 2006; Viswanathan et al, 2009; Glenton et al, 2013; Torres et al, 2014; Ahmad et al, 2017). Training has also been questioned for LCFA roles (Leaman et al, 1997; Kennedy et al, 2008). LCFA roles have been reported to receive training once recruited by the institutions. This may include training on nutrition knowledge, food skills and group facilitation (Leaman et al, 1997). Training for LHAs may come by way of organisational, institutional/educational programmes and on-the-job training. This may include some level of accreditation or certification. LHAs are traditionally not intended to have pre-requisite educational requirements with training most commonly being provided by the organisation once recruited, often designed in response to the needs of the target population (Najafizada et al, 2015). Training should be supportive and flexible if backgrounds of LHAs are taken into account (Nittoli and Golith, 1998; South et al, 2011). This has been the traditional model, which still may be the case in LMICs (Bhutta et al, 2010). In HICs, this may only be partially true. These positions may be filled by individuals with any level of education and thus may impact on the training. Training could be focused on the service delivery aspect (most common) or personal development and empowerment aspect of LHAs (South et al, 2013a). LHAs may be trained up with the skills to work on one specific project or on a wide range of skills in order to provide a variety of services. Indeed, there are mixed views on the need for standardisation of training based on good practice. This would however enable those working within the field to understand their roles and abilities, and provide consistency and clarity among programmes (Dower et al, 2006). The US and UK have adapted more formalised models. In the UK, the Health Trainer role has a national framework which includes job descriptions, competencies and accreditation (Cook and Wills, 2011; Harris and Haines, 2012). In the US there are competencies to be achieved in which an LHA can gain certification as LHAs are mostly related to health care access and utilisation, but this too can be mixed and varied (Kash et al, 2007; Barbero et al, 2016; Wilkinson et al, 2016). The established EFNEP and WIC programmes in the US provide training and competency based certification (Whaley and True, 2000). This is also the case with some LCFA models including accreditation options through the National Open College Network within the UK, whereby local training can be provided in line with learning objectives, however, there is no national framework. This has raised tensions about the formalisation of these roles and the impact.⁴

The nature of varied roles and functions of LHAs makes it difficult to standardise training. This also leaves out the qualities required in an LHA in order to be effective, which are pre-existing

⁴ See Section 2.1 on LCFAs and Professionalisation

as a natural helper and that training can't provide; training should be complementary to LHAs 'experiential and embodied knowledge' (South et al, 2011). One of the problems of lack of resources is that there may not be sufficient staff or expertise to plan, deliver and evaluate the training of LHAs. This then may result in ad hoc training of inadequate quality. Yoeli and Cattan (2017) suggest the training work both ways: that LHAs play a role in training the professional in areas they may have expertise, such as engaging and communicating with hard to reach communities. As Kennedy et al (1998) reports, it is important for health professionals to have a better understanding of the complexities of behavioural change among people in different socio-cultural groups. This not only deems the LHA as a valuable educator in the community, but also for professionals and institutions.

Ongoing organisational supervision and support must be connected to training for programmes to be successful as inadequate management, supervision and support once in practice can often be issues (Chaulagai, 1993; Lehmann and Saunders, 2007; Nkonki et al, 2011; South et al, 2011). There have been reported issues of boundaries of the role as well as more support for these roles if clear boundaries are in place (Dugdill et al, 2009; Dworatzek and Stier, 2016; Williams et al, 2016). Personal and professional knowledge – science, factual or experiential can merge with these positions (Ahmad et al, 2017). These issues would be important aspects of training and supervision, and indicates some tension between professional and lay roles in institutions (to be explored further in Chapter Two).

1.4 History of Canadian LCFAs (and LHAs)

Here is where the Canadian particularities come into focus. In Canada, there has been some recognition of the LHA model but there is a general scarcity of peer-reviewed literature available on both the LHA and LCFA. A review of the grey literature has allowed for some insight into the extent of programmes operating across the country and across different organisations. The LHA role exists across Canada but it is not clear whether they are considered lay or peer or paraprofessional roles, and in some cases require some specific tertiary level education. The main purpose of these roles has been reported to offer an extension of health services in the community for those of under-served or disadvantaged communities (Torres, 2013; Torres et al, 2013; Torres et al, 2014; Najafizada et al, 2015, Ahmad, 2017). There has also been some recent attention to the LCFA role (Blay-Palmer and Knezvic, 2015, p.446; Dworatzek and Stier, 2016).

Most of LHA roles working in the community have been reported to target Indigenous, immigrant and low-income groups (Torres et al, 2013; Torres et al, 2014; Najafizada et al, 2015). Formal literature in Canada includes that of Community Health Representatives and

Multicultural Health Brokers, both of which are specific to populations and regions. The only defined role of LHAs found is that of Community Health Representatives described as:

'front-line community workers who perform a broad range of health-related functions ranging from environmental health to health care delivery, medical administration, counselling and home visits, education and community development, and mental health' (Richmond and Ross, 2009)

Community Health Representatives are an example of those individuals who are recruited from and representative of the community with whom they work; these positions are for individuals of Indigenous heritage and only work with those communities (Adebayo, 1995; Nativet, 2017).

The research on Multicultural Health Brokers (including that of doctoral theses) has looked at the role of programmes in addressing health equity for immigrant and refugee women in Alberta (Ortiz, 2003; Torres, 2013; Torres et al, 2014). This research found programmes increased access to health and social services and capacity building in support of immigrant adaptation, settlement and integration into Canada. The Canadian research has found the roles of the LHAs to be largely unregulated and unrecognised for filling health resource gaps and under-utilised in public health (Torres, 2013; Najafizadeh et al, 2015). This may coincide with the lack of a national coordinated framework that includes role terminology, definition, competencies and training curriculum (Torres et al, 2013; Torres et al, 2014). Minore et al (2009) have highlighted a restricted direct care role of LHAs due to concerns over liability and accountability. This aspect has transferred to their limitation in health promotion and prevention activities. As such, they have made recommendations for established scope of practice and competencies for training, standards, accreditation and regulation in Canada on a federal level for Community Health Representatives (working with Indigenous populations). Karwalajtys et al (2009) promotes broadening a volunteer model of peer-led health promotion to respond to Canada's diversity and also highlights a limited scope of activity. This latter model has grown as an effective and feasible collaborative, community-based strategy in Canada (Chambers et al, 2005; Kaczorowski et al, 2011).

Despite various LCFA programmes existing across Canada for some 20 years, there is little formal literature drawn from Canada specific to LCFA programmes. Dewolfe and Greaves (2003) for example, conducted evaluation into a food security initiative in Ontario for which LCFAs had some involvement with facilitating groups, but this was not an evaluation on LCFAs and LCFAs were not isolated out in the intervention. Blay-Palmer and Knezvic (2015) refer to them but only provide a summary of what one programme model does in Ontario. An LCFA

programme model in Ontario has also been identified as a promising practice by Health Canada (HC, 2010) as a way to improve food skills in the population.

Most LCFA roles in studies are referred to as 'peer educators'; peer education in many areas including nutrition being valued for some time (Leaman et al, 1997; Hopp et al, 1998; Perez-Escamilla et al, 2008; Dworatzek and Stier, 2016). On an individual or household level, LCFAs have been reported as having a role in supporting people on low-income to eat healthy with improved ability to work within their personal resources, in improving knowledge and food skills (Lehman et al, 1997; Hopp et al, 1998; Dewolfe and Greaves, 2003; HC, 2010). Leaman et al (1997) describe an LCFA project focused on delivery of basic nutrition information and food skills targeting low-income communities. This programme focused on those of low-income but highlighted high attrition rates and cited the challenge of limited number of hours paid for the work. LCFAs have also been referred to as a way to help strengthen communities' food systems through community gardening for example (Blay-Palmer and Knezvic, 2015). But this localised approach has also been recognised as limited. Dworatzek and Stier (2016) identified benefits of social support for participants and experience and employment benefits for LCFAs. Dietitians were found to prefer LCFAs working within a narrow rather than broad role, specifically within a community setting with specific population groups. Both Leaman et al (1997) and Dworatzek and Stier (2016) identify financial constraints related to level of commitment to programmes and payment of workers. There are examples of LCFA models within the Canadian Diabetes Association, operating in British Columbia. This is an example of a programme that specifically focuses on diabetes prevention through the promotion of nutrition education and food skills, operating independent to the health system. Though not all programme models are connected with Public Health, the focus of this research is programmes which are, as such are important for Canadian public health, and may play a unique role in addressing public health.

1.5 Summary

There is broad use of LHAs in LMICs and HICs across a range of activities but specific components of the interventions, including contextual factors such as those related to community, economy, environment and health system which all influence programmes, are not well known (Lewin et al, 2010; Kok et al, 2015; Ahmad et al, 2017). Much of which has been studied in LMICs has been that related to health care service delivery, and in HICs has often either looked at specific populations, specific chronic disease focus or programmes linked to health services in a certain country. Programmes targeting and working with one specific culture and/or community may be different than a programme which aims to work

across different cultures and communities; programmes can work differently depending on country or regional context. Difficulties with terminology and the great range of settings within which programmes operate make it difficult to connect outcomes with effectiveness and informing policy (Kennedy et al, 2008; Simoni et al, 2011; South et al, 2013a). Recent works have reinforced research gaps: primarily mechanisms for which LHA programmes bring about health improvement (Torres, 2013; Torres et al, 2013; Torres et al, 2014; Najafizada et al, 2015; Taylor, 2015). There is opportunity to better understand the details of programmes, particularly in the under-researched area of LCFAs as they relate to food policy in Canada. Unclear areas include a lack of strategies that incorporate SDH; questions of access and utilisation of programmes, remuneration, demographics of LCFAs and sustainability. There is limited research on the perspectives on LHAs/LCFAs themselves, and that which exists uncovers the need for more exploration (Kennedy et al, 2008; Coufopoulos et al, 2010; Ahmad et al, 2017). Chapter Two continues with an exploration of issues, situating the LCFA in the wider literature.

Chapter Two. Situating the LCFA in a wider literature

This chapter explores how the LCFA sits in the wider literature; some of which is more sociological and some is more policy-oriented, and some is focused on the role of lay workers in public health and health promotion.

2.1 LCFAs and Professionalisation

This section introduces the wider literature about professionalisation and its relevance to LHA/LCFA roles. There is a long history about professionalisation and questions of its rationalisation and implications. Long have been argued the motives behind it, including self-interest and power conflicts (Marshall, 1939; Wilensky, 1964; Hoyle, 1982; Friedson, 1988; Evetts, 2003; Currie et al, 2012).

Professionalisation may be by way of education, training, licencing, accreditation, standardisation and/or regulation. It may be favoured to increase credibility and recognition and the winning of approval from other professions. Many roles have experienced increased professionalisation over the years- doctors, teachers, social workers and nurses to name a few, but even these positions, such as that of the social worker, have had some resistance, 'profession-building being favoured at the expense of social change' (Jennissen and Lundy, 2011, p. 291) or at the expense of the profession itself (Hoyle, 1982).

Professional and Lay Helping

As there has been a general trend towards professionalising roles, there has also been an increase in different types and levels of roles. The professionalisation of China's barefoot doctors is one such example (Rosenthal and Greiner, 1982). The creation of new roles can either threaten or enhance power and status of existing professionals (Currie et al, 2012). Some roles have been created to shift the tasks of the higher professional ie. from doctor to nurse practitioner, and some exist to supplement higher professional duties ie. dental hygienist supporting the work of the dentist. Some roles may be considered more or less professional depending on the country or region, and aspects of professionalisation ie. midwifery. Due to the confusing nature of the titles of the LHA/LCFA, they may be utilised in a misunderstood capacity and/or under-utilised in important areas for which they may make a difference.

LHA models have been recommended to be integrated into the health and social system in both the UK and US (Rosenthal et al, 2010; Martinez et al, 2011; Harris and Haines, 2012; Wilkinson et al, 2016). There has been some push for LHA roles to be standardised and

regulated by a professional body in the US. Ingram et al (2012) suggest that the field would benefit from being considered a 'health profession rather than an intervention' in relation to the US health care delivery system. The US adapted this formal model in 2010, with CHW being recognised as a job classification by the Department of Labor, with a number of states providing certification and accreditation (Rosenthal et al, 2011). Accreditation exists for some roles such as that of the Health Trainer in the UK. The UK Voluntary Register of Nutritionists provides professional registration for nutritionists and has been working to establish a quality assurance framework for roles such as LCFAs (Cade et al, 2012). There is no such comparable professional body in Canada for those working in public health and the community in Ontario. There is the Ontario Dietetics Association and the Ontario Home Economics Association, both providing designations of Registered Dietitian and Professional Registered Home Economist/Human Ecologist. Indeed, home economics has been professionalised - domestic living expanded to become 'scientific and professional' (Begley and Gallegos, 2010), coinciding with food skills no longer being taught at home, and the dietitian often being clinically focused, information and advice-driven with limited food skills training.

Is the LCFA another layer of worker to support the professional? Does that make them a paraprofessional (as is the worker in EFNEP in the US)? Professional status refers to a set of relationships with others: the 'professional' is expected to behave in a certain way and possess a certain amount of formally acquired knowledge and/or skills. A 'paraprofessional' is one whose work has some of the characteristics of a profession or professional (Eng et al, 1997). As Eraut (1994, p. 33) describes, there are different modes of knowledge: replicative, applicatory, interpretative and associative that all may fit with roles across a natural helper to professional spectrum. Many professional groups utilise people in assistant roles and those providing an extension of services in health and other fields. These groups are most commonly classified as paraprofessionals. Qualifications can vary greatly and some roles may place more value on formal over informal qualifications. In many public service roles for example, where safety and public trust is of concern such as police officers, firefighters and doctors, rigid standards are necessary. But what does this mean for the worker in the community, especially when working with under-served and disadvantaged populations?⁵ Tensions have been raised specifically about the professionalisation of these roles and the implications. Professionalisation may be seen as desirable but 'over-professionalisation could be counterproductive when seeking to engage under-served or marginalised populations' (South

⁵ Disadvantage or marginalisation is characterised by: low-income, social exclusion, having limited access to resources and/or living in deprived areas (Laverack and Labonte, 2000; O'Neill et al, 2004).

et al, 2011). Professionalisation, as well as increased organisational control has been cautioned as resulting in the LHA becoming less responsible to the community and a loss of natural helper function, the very qualities so valued of the LHA in working with these communities (Whelan, 1990; Dennis, 2003; Cherrington et al, 2010; Fitzsimons, 2010; Gilkey et al, 2011; South et al, 2011; Mathers et al, 2014).

Professional development for workers, including LHAs, is often desirable (but providing development pathways doesn't necessarily translate to professionalisation). Too much professionalisation of roles can also result in a loss of low-income community access to jobs, representation and community development (Nittoli and Giloth, 1998; South et al, 2011). Fitzsimons (2010) expresses the tension between community development and professionalisation:

'the professionalisation of community work is detrimental to radical practice because of its encouragement of individual vertical progression for learners and a favouring of professional practitioner benefits over collective community gain' (Fitzsimons, 2010)

Furthermore, community work can reveal other tensions, among them between the workers themselves - some who are considered representative of the community ('locals' or 'insiders') and others who come from outside the community ('outsiders' or 'incomers'). Who are LHAs/LCFAs? The insiders may have the community relationships and/or lived experiences, and the incomers may have certain other credentials. For the most part, LHAs are valued for being insiders and thus having better connections with the potential to lead to more effective outcomes. But LHAs can be either, and though this may raise some tension, both insider and incomer assets should be valued (Cook and Wills, 2011; Yoeli and Cattan, 2017).

Professionalism is another quality that may be desirable for workers across the spectrum, including LHAs (as background work revealed). Indeed, providing training on professionalism has been recommended in some LHA roles, but in a way that enables working across different professions and in the community, and recognises that this expectation should be different from that of other roles (Bhutta et al, 2010; CDC, 2014). The 'balance between the normative and ideological elements of professionalism is played out differently' across occupational classifications and settings (Evetts, 2003).

Classification

But how are LHAs/LCFAs classified? Are they lay/natural helpers, peers, paraprofessionals or professionals? LHAs may see themselves as 'some kind of professional', but have reported not knowing how they are seen: 'as professionals or not professionals' (Cook and Wills, 2011). This is echoed by some LCFA views (Kennedy et al, 2008; Coufopoulos et al, 2010). Indeed,

they may be classified differently across institutions, the community and even amongst themselves.

Natural helper, paraprofessional and peer are often used interchangeably in both practice and the literature, with varying interpretations (Dennis, 2003; Kennedy, 2006; Kennedy et al, 2008; South et al, 2013a; Taylor, 2015). Terms do get categorised together, for example, peer and lay (Simoni et al, 2011; O'Mara-Eves et al, 2013; Ahmad et al, 2017) and separately (Anderson et al, 2015) and often without clear explanations. Interventions are described sometimes as peer-led and sometimes as lay-led. The paraprofessional is set apart from the LHA in some cases, and in others is not. Minore et al (2009) for example, classify LHAs as paraprofessionals. Lindsey (1997) refers to 'peer paraprofessionals.' Ingram et al (2012) classifies them as 'ideally' a health profession. And Torres et al (2014) as unlicensed 'professionals.'

Cochrane systematic reviews have utilised the following definition for LHAs:

'a member of the community who has received some training to promote health or to carry out some health care services but is not a health care professional...any worker carrying out functions related to health care delivery, trained in some way in the context of the intervention, and having no formal professional or paraprofessional certificate or tertiary education degree' (Lewin et al, 2006 and 2010; Glenton et al, 2013)

This definition, as does WHO (1989) and Lehmann and Saunders (2007), describes the LHA as being from the community which may be more related to LMICs (as discussed earlier). It makes it clear LHA's are not professional and distinguishes LHAs from having any formal or paraprofessional qualifications. In HICs, this may be much less clear in the literature or in programmes that operate. Drawing from experience and the literature, LHAs are referred to as peers, lay or natural helpers, paraprofessionals and even professional.⁶ The literature is quite mixed in this regard, and in some cases there are more nuanced differences or lack of clear distinctions made. There is often a blur or merge between peer, lay and natural helper and it can depend on how terms are referred to, whether it be role or function. For example, a peer worker could be described as a natural helper. Key overarching distinctions are commonality with community ie. lived experience, shared identity, training, remuneration and formality of role. For this thesis, lay is being used as the main overarching term. These descriptors may matter due to implications of the role of the LHA/LCFA in practice. In this regard, it is useful to consider some conceptual models that show the complexity. These models highlight that the LHA may be perceived differently amongst themselves, the community and with professionals in their social interactions.

⁶ See Appendix A for a summary of distinctions between terminology.

The literature highlights the role of the LHA to fit anywhere along an informal to formal (lay to professional) continuum as Figure 2.1 shows.



Figure 2.1 Natural Helper - Paraprofessional Continuum (Eng et al, 1997)

Eng et al (1997) classify the lay helper as being informal, by way of being a natural helper who is not recruited by any agency and does not receive payment – someone community members naturally turn to; the paraprofessional as a more formal lay helper, being recruited from outside the community and receiving special training (and payment) to carry out the role and function, some of which are tasks downloaded from the professional role; training and other opportunities for development playing the largest role in moving the LHA along the continuum. A model of informal helping is characterised by utilising existing social networks and facilitating change as identified by the community whereby a model of formal helping is characterised by lay workers going into communities to create change as defined by their organisation's goals.

Dennis's (2003) model around peer support within a health care concept illustrates social relationship classifications across as either embedded or created social networks, depending on where the LHA sits along the lay-professional continuum. This relates to how they are insiders or incomers and how the relationships form. McCollum et al (2016) have found 'pre-existing' social relationships to be of value in increasing equitable access in the community.

Cherrington et al (2010) reinforces that the informal helper on one end is more likely to be aligned with the community, underscoring the unpaid (volunteer) position as being more community-driven, whereas the paid position means greater allegiance to the organisation for whom the LHA works. On one end of the informal spectrum, natural helpers are often considered more peer-like and more likely to be in volunteer positions. On the other end, they are more formal and paid positions.

Kennedy et al (2008) show a conceptual model of the LCFA to be not linear (as Eng's) but three dimensional as related to the NHS, noting the influence of the health professional and how the role of the LCFA is perceived (Figure 2.2). This may be interpreted as a way of recognising the complexity of the lay model, as a way of controlling it or containing it ie. the professional controlling what they do and autonomy and empowerment of the LCFA may be limited. This

may look different outside of the NHS or another health organisation structure. What is clear is the hierarchal nature of the professional, and the power dynamics that may occur with the model. But the extent of professional control could vary and depend on how informal or formal the model (Eng et al, 1997; South et al, 2013a).

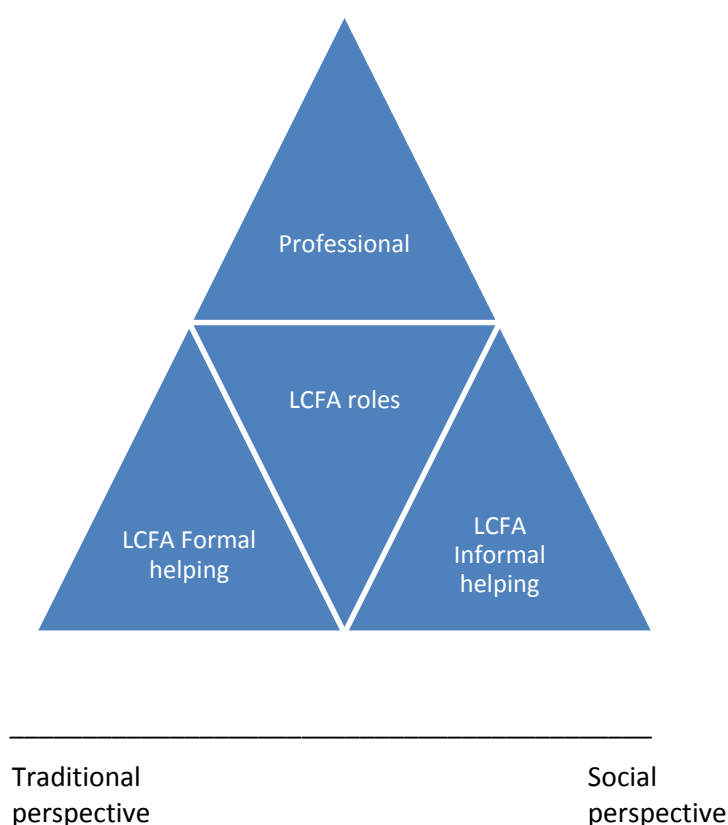


Figure 2.2 Conceptual Model of the LCFA (Kennedy et al, 2008)

The utilisation of peer as a descriptor for roles is common. Dennis (2003) simplifies the concept of peer support as 'the giving of assistance and encouragement by an individual considered equal.' Fisher et al (2017) have defined peer support as 'emotional, motivational and practical assistance provided by non-professionals.' Peer support strategies are popular in a variety of areas and have been growing because of the ability for peers to connect and give voice to communities over issues, and are deemed to be more cost-effective.⁷

⁷ Local examples include the Ontario Peer Development Initiative, a collective of agencies advocating for mental health policies (OPDI, 2017) and St Stephen's Community House Peer Centre in Toronto that has peers across all its organisational services (SSCHTO, 2017).

But how are these roles socially defined? There may be some differences that distinguish these titles with training, structure, supervision and support. For example, paraprofessionals may often fit within the hierarchy of a more formal organisation with professional oversight and may have more recognised training. This can gain credibility with professionals, but a key challenge with these roles is their acceptance among both professionals and the community (Fisher et al, 2017). WHO (1989) characterises LHAs as having shorter training as professionals, but this could be a paraprofessional too. A lay/natural helper could have less training, be a volunteer or paid differently and may be more community-based. Lay/natural helpers could develop and evolve, as was the case with China's Barefoot Doctors, into a paraprofessional role (as Village Health Aides) through further training and/or gaining a qualification (Rosenthal and Greiner, 1982). The experience in the US has found that over the years the paraprofessional has become institutionalised and through development (moving along the continuum), has become 'absorbed' by the human-service paradigm rather than serving as change agents (Riessman, 1984; Nittoli and Giloth, 1998; Plescia et al, 2008; Ingram et al, 2012).

2.2 Lay Professionals in Health

Changes to the health care system have increased the need for more community-based, multi-skilled, multi-disciplinary workers (Nittoli and Giloth, 1998; Whitehead and Davis, 2001; Potera, 2016; Fisher et al, 2017). LHAs have most commonly been utilised to fill the health care gap rather than carry out health promotion activities. LHAs have received attention more recently due to health care workforce capacity issues. 'Task-shifting', a strategy to address shortages of professional health workers, delegates tasks to the lowest category of worker who can carry out that task successfully (WHO, 2006a). This is seen in LMICs and HICs, considered a cost-effective strategy at filling the gaps where more skilled workers are not available, not necessary or unaffordable for health systems. They may be considered replacements of or complementary to professional health services (Simoni et al, 2011). Lay professionals in health have emerged largely due to uneven and inequitable distribution of health resources, resulting in under-served communities. This is the main problem being cited in Canada and LHAs being one solution for which to address the problem (CFHCI, 2007; Torres et al, 2013; Najafizada et al, 2015). Utilising lay professionals such as LHAs can enable increased quality, appropriateness and capacity of services that are more supportive (CFHCI, 2007; Bourgeault et al, 2009; Ginneken et al, 2013; Potera, 2016).

There are a number of advantages as well as challenges to the utilisation of lay workers in health. The use of lay workers can often be for clinical compliance and adherence that

requires specific training, role and function, and can be controlled with clear boundaries. There is less clarity on how the role and function of lay workers fits within a health promotion context (Swider, 2002; Williams et al, 2016). Key advantages include the strengthening of the public health workforce, increasing its capacity and diversity when competing with personal health services (Thomas et al, 1998; Karwalajtys et al, 2009). Lay positions in health may cultivate better relationships and increase social networks and social support, and help to reinforce healthy behaviours (Israel, 1985; Dennis, 2003; Simoni et al, 2011; Taylor, 2015). These relationships are especially important for people who experience disadvantage. Payne et al (2001, p.145) point out that the relationship aspect is more important than lived experience for people to be supported, and relationships can be developed regardless of sharing a common background, as long as people have the necessary skills to do so. LHA/LCFAs may be seen as a trusted source of information, through informal and relevant information delivery. If they share a commonality such as culture or language, messages around health may carry more meaning as opposed to professional delivery of information that can feel detached or not relevant (Hall and Elliman, 2003; Martin et al, 2005). Often professionals have difficulty in accessing local communities and community members and the 'negotiated style' in which community work ideally should be done (McGlone et al, 1999). LHAs/LCFAs can be a liaison between the professional or organisation and the community and help to see health as achievable (Giblin, 1989; Simoni et al, 2011; McCollum et al, 2016). They may thus be preferred to over health professionals (Kennedy, 1999). Workers not being health professionals (if perceived in this way) can be more accessible to the community (Ball and Nasr, 2010). However, Attree et al (2012) challenge the assumption that the LHA is better placed than the health professional to improve health behaviours and highlights the inconsistency in studies showing this strategy as effective. And Goodall et al (2014) found no evidence that LHAs made a significant difference in supporting healthy eating.

Modern LHA roles continue to reveal lay/professional tensions. There are questions of whether their roles, knowledge and experience are valued by the professional in a work environment (Cook and Wills, 2011; Ahmad et al, 2017; Yoeli and Cattam, 2017). How are they viewed by professionals? How are they viewed by the community? Lay workers can be stuck in the middle and this can create different tensions depending on power dynamics.

Professional Hegemony

Health systems, whether in health care or public health, are led by health experts. This includes a dominance of a medical model with hierarchal positions. The medical doctor has long been at the top of the ladder; indeed, this high regard has become entrenched in society

and health systems. The doctor - nurse relationship has long been a navigated one for which doctors can exert their power (Gair and Hartery, 2001; Whitehead and Davis, 2001; Bourgeault and Mulvale, 2006). Both doctors and nurses have enjoyed increased professionalisation of their roles over the years. Lay professionals add another layer to this (health system) hierarchy; being at the bottom may place them closer to the community but further away from professionals, creating more power differentials that could bump the status up of professionals even more.

LHAs are not considered professional health experts but may be considered 'experience-based experts' with local, personal or cultural knowledge and community belonging (Gilkey et al, 2011; Ahmad et al, 2017). Being seen at the same level as community members seems to offer less of a 'talking to' from high above and more of a 'talking with', due to a shared understanding, taking into account participants' existing knowledge and life experiences that is shared and valued without constraints of traditional expert/client relationships. This 'experiential' and 'embodied' knowledge rather than textbook/professional training and knowledge is of value (Illich, 1970; Coufopoulos et al, 2010; South et al, 2011; Gilkey et al, 2011); but LHAs often report their knowledge being undervalued (Yoeli and Cattan, 2017). South et al (2013b) challenge assumptions that 'lay' skills are of 'lower order' than professional skills.

LHAs are appreciated by health professionals but issues have been raised by professionals about increased workload and loss of authority (Coufopoulos, 2010; Glenton et al, 2013). They are often more accepted by professionals when there are clear boundaries placed on the role (Dworatzek and Stier, 2016). If the role and function of positions are not clear, there can be issues of trust between professionals and lay workers (Haines et al, 2007). This may also be deemed a threat if lay positions take away roles and functions from professionals. However, this should also include the valuing of other abilities to enable working with a broader spectrum of people and having a better understanding of the barriers and drivers of good health.

There have been challenges and questions of integration of these positions, both LHA and LCFA, into public health/ professional health services (Coufopoulos et al, 2010; Mathers et al, 2014; Williams et al, 2016). From a health promotion perspective, this can be quite different dependent on how informal or formal these positions are. The more formal position may decrease the ability of LHAs to be seen at the same level with those they are working, which may reduce comfort and trust. This may eliminate one of the very reasons for having lay workers in health: to get away from being judged or talked down to from the health

professional, particularly when personal lifestyle is at play. Community engagement can be challenging for LHAs if working in a health institution. On the flip side, if the lay professional is not respected and valued in the professional environment, this can be disempowering. For integration to work, the value of the lay professional must be accepted in health structures, this needs to consider different sets of non-traditional acquired knowledge and skills (Cook and Wills; 2011; South et al, 2011; Yoeli and Cattan, 2017).

LHAs have been found to be motivated by career development and knowledge gain, as well as social recognition and altruism (Wolff et al, 2004; Glenton et al, 2013; Ahmad et al, 2017). Though there may be some overlap here with professionals, altruism may be only true for the caring professions and is common for volunteers. Fostering deeper trust and closer relationships with people in the community is a key function of lay workers (as compared with professionals who maintain distance). This closeness can mean better understanding of people's situations but this also reveals other issues directly or indirectly related to health that may be difficult (particularly by nature of working with disadvantaged populations). This may mean more effectively being able to address barriers and drivers to health but also necessitates mechanisms to support LHAs as they can be put into intense or triggering situations. Self-care is important for any worker particularly in the field of helping others, but this aspect may be missing from programmes with lay workers. The promotion of self-care should be built into programmes through supportive relationships and teams, training, supervision and reflective practice that nurtures and protects the LHA (Kubiak and Sandberg, 2011; Jackson, 2014).

The LCFA in Health

LCFA models may be a key strategy to reach disadvantaged and those most hard to reach populations. Based on the principles of the LHA, LCFAs are intended to have a better understanding of the social, cultural, economic and environmental barriers to healthy eating. LCFA programmes aim to tackle issues around food of awareness, attitude, access, availability and affordability and may be gatekeepers between the community and health and other services. LCFAs may have links to community members and may be more able to access more marginalised communities through their own social networks, better so than professionals. The capacity and appropriateness of the professional dietitian/nutritionist/home economist may be limited; LCFAs may be better able to bring together groups of people with common backgrounds and issues, and to increase coverage in the community.

'You can have a lot of people who are semi-skilled doing good enough and reaching more people; as long as they (LCFAs) are trained on basic messages and know boundaries - they know what they don't know...nutrition is not rocket science. The details don't matter but the basic messages do... they may be less knowledgeable about the details of nutrition but more knowledgeable about the needs of the group, cultural aspects, language skills, acceptance, and so on... ' (Roberts, pc, 2010)

There tends to be a gap between people's perceived knowledge and actual knowledge about what is healthy, often being socially and culturally influenced. An LCFA may be better placed to work through this and raise that awareness about healthy foods, and showing healthy methods of preparing food in more meaningful ways (Kennedy et al, 1999; Kennedy, 2010). LCFAs can help contextualise messages enabling more practical and relevant communication that can cascade out beyond the formal structures of the group. Learning how to put information into practice that fits into people's lives increases the likelihood of change (Contento et al, 1995; Kennedy et al, 1999; DH, 2004; Beaudry and Delisle, 2005; Contento 2008).

2.3 Canadian Public Health and the Context it provides for LCFAs

This section discusses public health issues in Canada and how they relate to LCFA programmes with concepts of health equity, poverty, power, diversity and community.

'Public Health, along with other organisations and groups, can work to create greater fairness in the distribution of good health' (NCCDH, 2014). Health for all means that people have the right to good health through a comprehensive approach of primary health care and addressing underlying social, economic and political causes of poor health. This is underpinned by equity in health (focusing on the most vulnerable of society as well as the health of all of society), health promotion and disease prevention, community participation and inter-sectoral collaboration (WHO 1978, 1997 and 1998).

No one person or role can perform all the activities required to achieve health for all and no single approach can achieve all desirable population health outcomes (Lehmann and Saunders, 2007; Frohlich and Potvin, 2008). LHA models can contribute to helping regions and countries achieve health for all status (WHO, 1988 and 2010a). The introduction of China's Barefoot Doctors in the 1940s resulted in China making significant improvements in the health of its population and decreasing the gap in health status between its rural and urban areas (De Geyndt et al, 1992; Liu et al, 1999; Bloom et al, 2001). Community Health Providers have been used in Cuba as part of their primary healthcare model for decades— a model focused on social welfare, primary and preventive care; Cuba has some of the best health indicators in all of Latin America and the developing world (Campion and Morrissey, 2013). Successfully

emulated elsewhere, even countries like Canada can learn from Cuba's system that has adapted a SDH approach (Stone and Cressman, 2014). Similarly, Mexico's Promotoras/es model has spread across Latin America and to the US through Great Society's New Careers movement as part of the government's goal of ending poverty and promoting equality (Perez and Martinez, 2008).

Poorer health is more prevalent in more disadvantaged groups and it disproportionately affects those of lower socio-economic status (DH, 2010; Marmot, 2010; Phelan et al, 2010). Evidence shows a gradient in health (social health gradient) moving up and down the socio-economic ladder: the lower the socio-economic position, the worse a person's health (WHO, 2013b). Everyone is affected by the social health gradient, with the most unequal of societies experiencing poorer health outcomes (Wilkinson, 1996; Wilkinson and Pickett, 2009). Canada continues to lag behind in health equity strategies that require action on SDH (Raphael, 2009; Raphael and Sayani, 2017); this action being highly dependent on institutional ideologies and structures (Raphael et al, 2014). Public Health is necessary for reducing health disparities and plays a role at policy, organisational and societal level by way of setting priorities, allocating resources, participating in policy development, orienting interventions and collaborating with other sectors (internal and external strategies) (Kouri, 2012; NCCDH, 2013a).

Power imbalances must be addressed to promote health equity with Public Health playing a key role in addressing these imbalances with inside and outside strategies. Power: social, economic and political, is a critical factor shaping social hierarchies and health differences between population groups. Core interpretations of power can be expressed as power 'to' (actors intervening in order to alter events), power 'over' (actors influencing behaviour of others), power 'with' (collective action) and power 'within' (power from individual consciousness). The latter modes involve a change of traditional structures to power sharing. Power is often covert, in that advantaged groups are able to shape decision making and policies with the exclusion of disadvantaged groups (WHO, 2010b).

Socio-economic factors account for the biggest impact on health (not health care), followed by health behaviours (Marmot, 2010). Socio-economic positions shape the environment, and this undermines the ability to be personally responsible. Interventions must go beyond efforts to address intermediate (environmental) SDH and address structural SDH for long-term health outcomes, and take into account factors working against positive outcomes (Winne, 2008; Jepson et al, 2010; Rayner and Lang, 2012; Gore and Kothari, 2013; Roberto, 2015). Focusing beyond health care and addressing the underlying SDH is seen as complex, expensive and long-term, and not congruent with political timelines (Kirk et al, 2014; Abban, 2015; UN, 2015).

There is a gap in the evidence showing the effectiveness of interventions targeting specific socio-economic, cultural and vulnerable groups and limited evidence to show what works to reduce health inequalities (O'Mara-Eves et al, 2015). As well, there is a gap in how best to address inequalities with behavioural interventions such as promoting healthy eating (Jepson et al, 2010).

Health inequalities are the result of social inequalities: social conditions such as knowledge, money, power, privilege and social connections are all causes of health (Wilkinson, 1996; Marmot, 2010; Phelan et al, 2010).⁸ Nutritional inequalities are the consequence of cost (and income), access (and where people live), knowledge and skills around healthy food. Thus far, little success has been achieved in improving these inequalities (McGill et al, 2015). Canada experiences considerable health inequalities; the gap in income and wealth inequality has steadily been worsening (Ontario faring the worst) - women, people of colour, immigrants, Indigenous people and children are disproportionately affected (Mikkonen and Raphael, 2010; Block, 2017).

'Canada compares unfavourably to other wealthy developed nations in its support of citizens as they navigate the life span...(Canada's) income inequality and poverty rates are growing and are among the highest of wealthy developed nations' (Mikkonen and Raphael, 2010).

Modern health systems are faced with more challenges due to chronic illness and disease, co-morbidities and people living longer. The principle of universality is embedded in Canada's Health Act but despite having a universal health care system and that many Canadians enjoy a relatively high standard of living and health, this has been unevenly and inequitably distributed (O'Neill et al, 2000). Canada has an expensive health system but still does not fare well in terms of health outcomes. The federal government has an important role in leading on public health issues, not only to ease the financial burden on health systems but to increase the quality of people's lives (Malik, 2013). Canadians of lower socio-economic position along with unhealthy behaviours cost the health system the most (Manuel et al, 2016). Resource allocation continues to be heavily focused on curative aspects of health; health care continues to be prioritised, and funding constraints often mean limited commitment to health promotion (O'Neill et al, 2000; alPHa, 2003; Malik, 2013; Schrecker, 2013; Kirk et al, 2014).

Canada has a reputation for being a leader in public health. The Lalonde Report 'A New Perspective on the Health of Canadians' was significant in health promotion in Canada

⁸ Health inequalities are determined through measures of life expectancy and infant mortality and exist across regions and different countries but also within countries, both rich and poor, pronounced across class, gender and race. Inequities result from avoidable, unjust and unfair inequalities and a lack of action to address them (WHO, 2007).

(Lalonde, 1974). It is credited with being the first acknowledgement that biomedical interventions were not as responsible for health and wellbeing. Four 'health fields' were identified that were interdependent of one another: environment, human biology, lifestyle and health care organisation. Many of the same issues identified in the report are still relevant today. However, despite it being ground breaking and holistic, it was criticised for its focus on individual responsibility. Since the 1970s, health promotion has been a re-branding of public health and that of a health education model and social marketing, coinciding with the concept of health being the result of individual choice (Kirk et al, 2014). In the 1980s, when food insecurity became an issue, charitable models emerged alongside. Many have critiqued the dominant discourse informing public health practice continues to be lifestyle focused, despite in theory recognising the SDH (Labonte, 1993; Raphael, 2000; Hancock, 2011; Schrecker, 2013; Kirk et al, 2014). Canada has been heavily criticised for its backwards progress in health promotion towards 'neoliberal individualisation of responsibility for health' (Schrecker, 2013). For years, health promotion has gone 'largely unnoticed' and 'not been positioned as a serious strategy within the health system' (Jackson and Riley, 2007). Adding to this issue is Canada's complex political structure, complicating responsibilities for policies and action. Successful health promotion practice requires multi-level, high level political commitment and a supportive structure, but all levels of Canadian government (federal, provincial, regional and local) have been criticised for failing to recognise the potential of health promotion at improving the health of the population (Nathanson, 2007, p.206; Hancock, 2011).

Strategies to address social inequalities that go beyond specific health policy have been lacking (Riches, 2002; Rideout et al, 2007; Loopstra and Tarasuk, 2013). However, the current government in Canada has recently announced its first national housing strategy with a focus on supporting vulnerable populations. As well, Ontario has shown some promise in making changes to income policies including increasing its minimum wage to a living wage (and may be partly due to coordinated campaigning by organisations working on poverty issues) and has recently announced the launch of a basic income pilot project in a few cities. Though a positive step at reducing income gaps, the basic income amount is limited and needs to connect with other policy areas. However, the raising of minimum wage may benefit those who need it most such as marginalised workers (Macdonald, 2017). It is too early to know at the point of writing what impact this may have, but policy changes may have some effect on areas such as household food security.

It is difficult to adapt to the complex, multi-needs of a diverse population without the use of a diverse workforce at all levels (Hoff, 1969). Population shifts, patterns of immigration and

migration over several years have made it more of a challenge to reach the health for all goal. There can be many groups that carry different cultural, social, religious beliefs and habits that affect their lifestyle and the food they eat for which it is important to have an understanding (Freudenburg, 1997). Furthermore, certain ethnic groups are more predisposed to disease and obesity differs, both in prevalence and in how it is experienced, across societies. Some groups are more likely to experience inequalities in health due to poor access to services, lack of knowledge and understanding, race or ethnicity, gender, social status, language and/or cultural barriers. Champions within communities can play a role in reducing barriers to health (Kim et al, 2004; Staten et al, 2004; Simonsen et al, 2017). Though the optimal number and mix of LHA functions and tasks are unknown, the consensus is that LHA/LCFA programmes play a key role in reaching and improving the health of under-served and disadvantaged communities (Lehmann and Saunders, 2007; Cherrington et al, 2010; Simonsen et al, 2017). There has been some recognition in Canada of the role LHAs play in health care improvement (CFHCI, 2007) and in immigrant and Indigenous populations taking on these roles (Bourgeault et al, 2009). Roles have mostly included focus on health care rather than public health and health promotion (Najafizada et al, 2015; Ahmad et al, 2017).

Canada celebrates multiculturalism and preserving culture, tying it in with the importance of diversity, equality, inclusivity and integration (Dewing, 2013; CIC, 2015). Always a country with high levels of immigration, it has seen increases in recent years, in part due to political shifts favouring Canada over other countries such as the UK and US (Statistics Canada, 2017). Immigration policy favours highly qualified immigrants due to its points system but this also includes high numbers of refugees. The selective nature of migration at both individual and policy levels generally being responsible for a healthy migrant population; immigrants often arrive to a new country healthy and healthier than their host country counterparts. Known as the 'healthy immigrant effect', foreign-born advantage offers a protective effect against certain chronic diseases, mental health, risk behaviours and mortality. However, this effect varies across life stage and wears off after some years living in the new country, and it is not clear why this may be (Vang et al, 2015). There has been some recognition of the role of LHAs/CHWs in general of their contribution to health promotion and community development in Canada with this population (Torres et al, 2013; 2014). This presents opportunities for LCFA roles to be diverse (and welcome skills of immigrants) as well as to support diverse communities. Helping communities to preserve their cultures healthily in a new country while also enabling social connections with both similar and different community members can also provide further benefits such as improving language skills (Richards and Wilkins, 2005). Culture also includes more broadly 'people's habits, social processes and everyday rules for life

(norms) and provides reference points for which people act and think.' Changes in culture lead to changes in thought patterns and behaviour; 'public health is about culture change' (Rayner and Lang, 2012, p.276).

Ontario as a Setting and Relevance to LCFA Programmes

Ontario as a province sees the most number of new immigrants and is one of the top provinces for settling (Statistics Canada, 2017). Most responsibilities for health fall to individual provinces; LCFA programmes explored in this study are connected with local Public Health authorities in Ontario.

Local authorities have become recognised as having an important role to play as policy levers. Canada's power is both centralised and decentralised when it comes to areas of social and health policy; the specifics of the health system and its delivery, with the goal of reducing poverty and health inequalities trickling down to provincial and local government (Nathanson, 2007, p.206).

As a consequence, there has been considerable policy fragmentation; the recognition of the complex nature of health-determining factors has led to a 'whole of government' approach intended to integrate the work of different ministries towards a common goal of health of the population. There are concerns that the current system will not be sustainable. Challenges of Ontario's Public Health system include (alPHA, 2003): shortages of professionals; eroded funding - a lack of funding for public health versus health care; societal changes - demographic shifts include an aging population, diversity, technology, and growing public interest in health. Optimising human resources capacity, meaning that the full spectrum of workers needs to be utilised - from physicians to nurses and so on - in order to be more cost-effective and efficient, has been recommended to make the system more sustainable (OMF, 2012).

The health care system is only responsible for about one quarter of the population's health, as a result, a preventive model needs to be embraced; public health at the forefront operating through a population health lens, but also a health equity lens (OMHLTC, 2010). Action should be universal but proportionate to the level of disadvantage (Marmot, 2010).⁹ Targeting services, programmes and access for those worst-off is necessary for health equity (CIHI, 2015; McCollum et al, 2016). Inequalities in nutritional choice have justified the need for programmes targeted in poorer areas that aim to improve diet by increasing information, awareness, skills and access (James et al, 1997; Satter, 2007; Saul and Curtis, 2013). LCFA roles are relevant due to patterns of immigration - both for how LHA roles in various capacities are

⁹ 'Proportionate universalism' stresses that only focusing on disadvantaged members of society is not enough to improve health and reduce health inequalities (Marmot, 2010).

often filled by immigrants (Torres et al, 2014; Ahmad et al, 2017), and for the cultural context of programme delivery in the community: two key beneficiary groups that are culturally and socially defined.

It has been recognised for some time that local initiatives are an effective way to help those in lower socio-economic groups and local food initiatives may help improve community food security (McGlone et al, 1999; McCullum et al, 2003 and 2005; Moron, 2006). Though, their ability to effectively improve household food security in the long-term has been questioned by some as it distracts from policy responses (Tarasuk, 2001; Loopstra and Tarasuk, 2013; Huisken et al, 2017). As well, programmes often focus their efforts on disadvantaged populations or marginalised groups (Laverack and Labonte, 2000; O'Neill et al, 2004; Attree, 2006) but are not necessarily located in areas most in need (Kirkpatrick and Tarasuk, 2010) and often do not focus efforts on addressing the SDH (Raphael, 2000).

In Ontario, local health units are responsible for delivering Public Health programmes and services focused on prevention and must provide a minimum of standards, tailored to local circumstances for the population (alPHA, 2003). The Ontario Public Health Standards (OPHS) are guidelines and minimum requirements for mandated programmes and services that all boards of health (governing bodies) local health units must provide. An overarching theme for these standards is addressing SDH and reducing health inequities with work that 'shows understanding of local community context...and innovation to address emerging needs or gaps in services.' Provincial health promotion priorities for disadvantaged populations include healthy eating (OPHS, 2008). Under the chronic disease standards, two key requirements are related to LCFA programmes:

'increase capacity of community partners to coordinate and develop regional/local programs and services related to healthy eating, including community based food activities' and 'provide opportunities for skill development in the area of food skills and healthy practices for priority populations' (OPHS, 2008)

The standards also recognise the benefits of 'peer' programming, including the ability for peers to influence health-related behaviour. This focus is on individual behaviour and downstream activities but there is recognition of the importance and necessity of upstream efforts (OPC, 2006). The OPHS were revised in 2017. This has attracted criticism as the standards instead place emphasis on individualised approaches to healthy eating without recognising wider influences, food systems and environments (OSNPPH, 2017). Despite healthy environments and food safety being standards, little attention is paid to healthy eating beyond being listed as one of many topics to cover within healthy lifestyles and behaviours. The revision to the

standards have not been operationalised and it is not clear what impact these changes may have with public health programmes (OPHS, 2017). The 2008 standards have also been critiqued for not being clear enough on action required with priority populations in addressing health inequities (Hassen et al, 2017); population health and health equity remains important in revisions.

Local Health Integration Networks, as regional health authorities, are the funding sources for Public Health units and aim to better integrate health care, public health services and engage with communities (OMHLTC, 2010). However, they may be more effective at joining-up certain services than others. As with commitment to healthy eating, general attention to health promotion in Ontario has been diminishing.

Though public health has begun to be seen through a broader lens, health care continues to dominate the public policy debate in Canada. The practice of public health policy remains disjointed, in part due to the multiple layers of government, as well as lack of recognition of the interconnections across policy areas (Fafard and Tarasuk, 2017). Public health policy and practice is wrought with tensions. Tension between market justice values (individual responsibility, limited government intervention, voluntary behaviour) and social justice values (basic income and benefits, collective good, government involvement) creates public health 'policy conflicts' (NCCDH, 2015). As well, there are tensions between evidence-based policy and practice and local community empowerment, top-down and bottom-up approaches. Top-down approaches do not always go over well, governments often receiving considerable scrutiny for public health efforts and 'nannying' its citizens, for which many rebel or resist (Rayner and Lang, 2012, p.36). People may not want government intervention, but what if something more damaging is at play, such as big food? Can there be a balance between freedom to eat what one wants and the nanny state; do people just need a nudge? Where does responsibility lie, to whom, at what level and how?

2.4 Roles and Principles of Health Promotion

This section introduces a wider debate about what the purpose and significance of the LCFA is. Are they more 'sticking plaster' or are they an example of a worker who is about prevention? This section situates the LCFA within health promotion and key tensions around prevention versus cure, upstream versus downstream approaches and community engagement, with theories and concepts relevant to this thesis.

Health is defined as 'a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity' (WHO, 1978). This definition is absolute and can classify a

large proportion of the general population as unhealthy, but it is aspirational. It may however be a challenge for people to think about health in this multi-faceted way. Health is viewed and felt differently by different people, changes over time, and is influenced by social and cultural norms. Factors affecting health can be: political, economic, social, cultural, environmental, behavioural and biological (WHO, 1986). Moreover, not everyone engages or wants to engage in health-seeking behaviour (Wardle and Steptoe, 2003; Guthman, 2011). Health promotion needs to consider that there are different interpretations to health (Seedhouse, 2004, p.5).

Health promotion is defined by the World Health Organization as:

‘the process of enabling people to increase control over and to improve their health to reach a state of complete physical, mental and social wellbeing...an individual or group must be able to identify and realise aspirations, to satisfy needs and to change or cope with the environment’ (WHO, 1986)

There are three main models of health: biomedical, behavioural and socio-ecological. In Public Health, biomedical models still dominate with health promotion traditionally being viewed as disease prevention. Behavioural models often focus on health education. Biomedical and behavioural models focus on the individual modifying behaviour and can narrow the scope of initiatives. A socio-ecological model considers the broader environmental, socio-economic influences beyond the individual. Much of health promotion work remains on individualised rather than socio-ecological approaches and thus does not address the wider influences on health and health decision making (Dalgren and Whitehead, 1991; Seedhouse, 2004; Bourgeault and Mulvale, 2006; Marmot, 2010; Golden and Earp, 2012).

Lomas (1998) argues that Public Health has been 'colonised' by the individualist ethics of medicine and economics. And focusing on lifestyle and modifying risk factors ie. screening, immunisation stands in the way of making more 'radical' approaches to change the social system. Carlisle (2000) has argued that this approach jeopardises the ability for Public Health practitioners to tackle health inequalities. This has been echoed by others, with questions remaining as to whether a mostly biomedical approach is still embedded in Public Health and as related to LHA/LCFA programmes (Kennedy et al, 2010; Kirk et al, 2014; Mathers et al, 2014). LCFA programmes in this thesis are of interest to explore whether they play a wider role in health promotion.

Over some years, there has been a general shift in discourse in health towards population

health (Kindig and Stoddart, 2003; HC, 2017b).¹⁰ Population health recognises that whole of populations need to be healthy, and there is a spectrum of risk-factors for poor health (IOM, 2002). A population health approach focuses upstream but has been criticised for not effectively incorporating health promotion and addressing systemic factors (Labonte, 1997; Robertson, 1998; Richmond and Ross, 2009; Hancock, 2011; Kirk et al, 2014). There has been recognition of some of the criticism (PHAC, 2001), as with the Public Health Agency of Canada's (PHAC) Population Health Promotion model (PHAC, 2014). This is a useful framing model for population health and health promotion in Canada because it considers important health promotion concepts.

PHAC's (2014) three-dimensional model in Figure 2.3 integrates the principles of The Ottawa Charter with the SDH (WHO, 1986). This approach includes policies and programmes in and outside the health sector. The model recognises that action can be taken at various levels for population health: individual, family, community, system and societal. Action is guided by focus on the a.What: should action be taken on?; the b.How: should action be taken?; and c.Who: should take action? (PHAC, 2014). It is not clear how and to what extent the population health promotion model is implemented in practice.

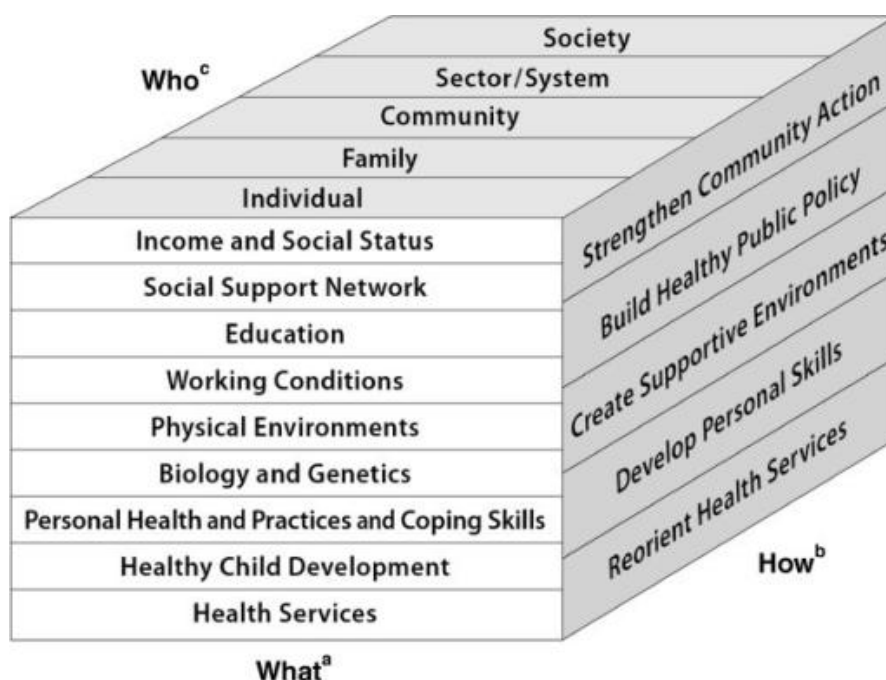


Figure 2.3 Population Health Promotion Model (PHAC, 2014)

¹⁰ Population health is a widely used term in Canada. Interpretations differ from simply meaning the 'health of populations' to 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group' (Kindig and Stoddart, 2003).

Public health, meaning 'health of the public' requires understanding and recognition of its complexity in order to protect and promote it (Rayner and Lang, 2012). Public Health can employ a combination of strategies to be effective: advocate for healthy public policies and supportive environments; mediate between different interests in society to benefit health; and enable individuals and communities to achieve their full potential (WHO, 1986; Kickbusch et al, 1990; Hancock, 1993; Kickbusch, 1995; WHO, 1998). Improving health necessitates addressing the SDH, which can be both individual (biological, behavioural) and collective (social, cultural, physical, economic, environmental and political) (Raine, 2005). Action on SDH¹¹ is needed to achieve social and health equity (WHO, 2006b) and 'helps to redress the imbalance between curative and preventive action and individualised and population-based interventions' (WHO, 2007b).

'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition' (WHO, 2011)

LHA interventions play a key role in addressing SDH (Freeman, 2016). With an ecological model of public health, important are the relationships among multiple SDH with emphasis on societal level factors, and that problems are seen as bigger than the individual (Rayner and Lang, 2012); not only that 'multiple levels of influence exist but also that these levels are interactive and reinforcing' (Golden and Earp, 2012). The potential of an ecological LHA model has been identified (Balcazar et al, 2012).

Responses to tackle public health problems are necessary across many levels and action can be **downstream, midstream or upstream**. Downstream activities are normally at service-level and can address immediate health needs. Midstream changes address intermediary determinants or material circumstances such as food security, housing and employment at regional, local, community or organisational level. Upstream changes address structural determinants such as social status, income, exclusion or racism, and often need to be at macro-level: state, national and beyond (NCCDH, 2014). Public Health may work across different levels. Downstream strategies are often aimed at the individual ie. food skills education and easier to develop and implement underpinned by behavioural and biomedical models. Midstream strategies factor in physical, socio-cultural and community environments.

¹¹ Social class, race/ethnicity, gender, economics and environment are predominant SDH: community networks, social support, living and working conditions, income, education; employment, housing, food security (household and community); quality of health and social services are all SDH (Dalgren and Whitehead, 1991; Acheson, 1998; Wanless, 2004).

Upstream health determinants not only include policies, but societal norms (IOM, 2002).

Though upstream level strategies are necessary, they are much more challenging to address; and those strategies that work best are not well understood (Raine, 2005; Cullerton et al, 2015).

There remains questions as to whether health promotion programmes, activities and messages are creating an even wider inequalities gap considering the 'differential take-up across different social class groups' (Jepson et al, 2010). Though a healthy diet may be able to buffer some socio-economic differences, healthy dietary behaviour seems to afford those of higher socio-economic status greater protection to health and prevention of disease (Bonaccio et al, 2017). Many interventions have not specifically evaluated the take-up across socio-economic groups, and upstream healthy eating interventions such as taxation have been found to be more effective than downstream interventions such as education, at reducing inequalities (Dorfman and Wallack, 2007; McGill et al, 2015).

Public Health may work at local level to drive action, which can be more relevant and efficient ie. rather than waiting for national policy change but must be supported; learnings and best practice as well as barriers to progress across local environments can be shared and driven forward. LHA initiatives (state-wide supported programmes in the US) have been shown to play an effective role in tackling policy initiatives (as part of a coalition) such as obesity at local and state levels (Simonsen et al, 2017).

'A supportive policy environment facilitates the scale up of health interventions' (Hardee et al, 2012). The North Karelia project in Finland can be cited as an example of a community-wide approach evolving from a local project to becoming a national programme, targeting the lower socio-economic population resulting in improved health of the population through multi-level, multi-stakeholder effort (Puska et al, 1985; Nissinen et al, 1988; Pekka et al, 2002). An example of a Canadian scaled-up programme is the Canada Prenatal Nutrition Program (CPNP), which evolved from a local programme into a national, federally funded programme operating across low-income communities in Canada. CPNPs have endured sustained financial support from the federal government since the 1990s and have resulted in improved healthy birth weights and breastfeeding rates connected with the greater the intensity of services (PHAC, 2010b; Muhajarine et al, 2012). This latter example has relied on resource inputs and commitment from multiple partners (including local Public Health units) at local level to be sustained. Though community-based and a good example of partnership programmes, CPNPs have a heavy emphasis on one-to-one support and education activities facilitated by professionals.

Though there is recognition for action on upstream interventions, as Whitehead and Popay (2010) warn, there can be a tendency to move away from policy action and shift downstream by emphasising on 'individual lifestyle factors and neglect of the conditions that structure and constrain individual choices.' Public Health has been criticised for focusing too much on 'downstream' initiatives without sufficient attention to the upstream aspect (Dorfman and Wallack, 2007). Modern health promotion is not just about giving information but empowering communities. Community involvement is key to successful health promotion, with a relationship existing between increased community control and greater health impact (WHO 1986; NICE, 2008). A model that incorporates community participation is more likely to lead to better health outcomes (Lawn et al, 2008) but still seems to prove difficult to do in practice. This can be more effective if community strengths are utilised and people, who are ideally local, are recruited as agents of change (NICE, 2008). Community engagement¹² means moving from 'participation to empowerment to control to improvement in health' (Popay, 2006). Community participation at all levels of programme development ensures appropriate health issues and messages reflect the needs and wishes of the community. In doing so, the community is empowered and likely to make sustained changes in response to health programmes (Rifkin et al, 1988; Garcia and Henry, 2000; NICE, 2008).

Interventions at social level can lead to changed attitudes and behaviour at individual level, and changes at individual level can lead to collective change and contribute to participation in social change (Gutierrez, 1995; Scheuermann et al, 2000). Community engagement for organisations must be understood as a 'process that evolves over time' and involves trust, communication and collaboration (Fraser Health, 2009; NCCDH, 2013b; Rifkin, 2014). Health promotion has typically been government-led, a professional initiative rather than social movement with ownership and power that can still lie with Public Health (Pederson et al, 1994). There is a distinction between community-based strategies and community development strategies; this is the difference between the issue being identified by the agency who also may have decision making power and the issue being identified by the community (Baum, 1998; Stead et al, 2012). Community members should not just be playing a passive role as recipients of programmes (Terris, 1992; Boutilier et al, 2000; Scheuermann et al, 2000). In practice, community development may be something decided by health professionals, and 'working with communities may mean working on communities' (Wallerstein, 1993).

¹² The umbrella term of community engagement describes approaches used to encourage involvement of communities in a range of activities; this overlaps with community development and community participation (NICE, 2008).

Core to health promotion is the concept of empowerment.¹³ The LHA model has been reported to be based on community empowerment (Cherrington et al, 2010; Simoni et al, 2011). It is often difficult to attribute a change in behaviour or health gain directly to an intervention in the community, as there are often multi-faceted approaches (Brug et al, 2005). Pedagogy approaches should be guided by people's own knowledge and experiences, environment and personal circumstances (Freire, 1972). Increased knowledge and skills may be empowering but approaches must go beyond education (Tones and Tilford, 1994). It has been argued that sustained community changes can only be made with empowerment education (Wallerstein 1993 and 1994; WHO, 2007). Mexico's promotora/es model, for example, utilises this approach (Perez and Martinez, 2008). The difficulty with this approach is that changes are difficult to attribute to the intervention and it is difficult to measure empowerment (WHO, 1986; Wallerstein, 1992).

Tensions exist within the framework of health promotion, between 'bottom-up' and 'top-down' approaches and personal responsibility versus the SDH. The top-down approach is still more often used, despite claims of a bottom-up approach; focusing on disease prevention (top-down) versus community empowerment, which requires a shift in power (bottom-up). This may be the case due to little clarity of how to operationalise empowerment (Laverack and Labonte, 2000). Practitioners may often feel that community empowerment is implicit in their practice, yet the reality may be that there has not been a power shift - that organisations can struggle with a true community participation approach (Carey and Braunack-Mayer, 2009). Furthermore, there are concerns over whether community development has become professionalised: from less of a bottom-up approach to a top-down one (or outsider-in). This being in part due to ties with government funds and increased professional involvement in community development work (Geoghegan and Powell, 2005). Of course, outsider involvement and resources is often necessary, given the interdependent relationship (Kretzmann and McKnight, 1996). As well, it is more common for government resources and public funding to support service provision (that supports policies) rather than activism (working against policies); community development on two ends of the spectrum (Lee, 2006).

'Peer' interventions have demonstrated patchy effectiveness in part due to their lack of clarity on underpinning approach (Turner and Shepherd, 1999; Simoni et al, 2011; Southgate and Aggleton, 2016). In this regard, it is useful to explore relevant theories. Common successful

¹³ Empowerment can be viewed as multi-dimensional: material (to satisfy basic material needs), psychosocial (having control over their lives) and political (participating in decision making processes and having a political voice) (WHO, 2007).

models for food and nutrition interventions have been reported to be the Stages of Change/Transtheoretical Model and Social Cognitive Theory (Prochaska and DiClemente, 1983; Bandura, 1986; Sahay et al, 2006; Krummel et al, 2017). Behaviour is shaped by social and environmental factors (Bronfenbrenner, 1977). Individuals are partly influenced by each other's behaviour and shaped by social and cultural contexts (Bandura, 1977 and 1997). Bandura's (1997) model points to self-efficacy as a key variable to change behaviour, a popular approach in LHA interventions (Simoni et al, 2011). Self-efficacy for food literacy skills has been reported in hands-on community-based initiatives targeted to mothers and families (Hanula et al, 2010; Krummel et al, 2017).

Nudge Theory has become popular as it allows for influence over behaviour to occur more gently while people may still feel they have a choice rather than that they are in a nanny state; steering people in the right direction rather than imposing limitations. Nudge is more about a default choice rather than people consciously choosing through information or education. Governments have favoured this approach, as it simplifies choice. However, if government favours this gentler approach, how can it compete with the powerful promotion of big food marketing of unhealthy foods (Rayner and Lang, 2012, p.274)? From a public health perspective, interest and interpretation of this approach by government has often been via the individualist route, rather than opting for policies that place less onus on the individual such as regulation, legislation and other upstream solutions (system-change). Nudge theory may allow for complementary approaches in public health interventions (Thaler and Sunstein, 2008; Menard, 2010; Bonell et al, 2011). 'Nutritional nudges' (such as food labelling) however can create dependence on expert and scientific input and create or maintain greater power divides across the food system (Scrinis and Parker, 2017). Nevertheless, the LHA/LCFA model may be a supportive one that nudges people towards a healthier lifestyle but in a less expert-imposed way (Williams et al, 2016).

Social Network Theory means interactions and relationships amongst people and/or groups of people can influence the social capital of individuals (Putnam, 1995). Social systems in health have long been recognised as important; and yet society as a whole has deteriorated in this area, with diminished opportunity to build social networks and cohesion. Community-focused rather than individual-focused strategies may be more effective to improve health (Putnam, 1995; Lomas, 1998). Furthermore, peer or lay helper programmes, may be more influential in facilitating or changing social norms (Simoni et al, 2011). However, there are different kinds of social capital, of which may generate different results. For example, relationships can be merely surface-level and others of higher and deeper level quality, they can be bridging or

bonding and groups can be exclusive or non-exclusive. Some form of exclusivity inevitably exists with social capital, as in communities (Rayner and Lang, 2012, p.247-252). 'Community' is not synonymous with social cohesion (Boutilier et al, 2000). Community as a setting for health promotion can thus be problematic. The term 'community' is used widely, often with no real boundaries, and referred to as favourable to address health issues but can be too 'idealised', assuming communities are homogenous and free of conflict within (Boutilier et al, 2000). Boutilier et al (2000) caution that health issues such as poverty, that are only dealt with on a local community or individual level and thus deemed 'local responsibility' neglects a much wider social context. Participation can be idealised too, implying inclusivity when issues of access, power and privilege can mean different groups and sub-groups may participate differently (Rifkin, 2014).

The lower down the social scale the less power people may feel they have over their health (Marmot, 2004). There is a relationship between powerlessness and disease, and between empowerment and health, and people are able to participate more fully in society if they have good health (Wallerstein and Bernstein, 1988; Wallerstein, 1993, 1994; WHO, 2007). Focusing empowerment on an individual level can be misleading, as the focus on personal responsibility leaves out underlying structures and contexts for which inequalities occur (Ledwith, 2011, p. 32). Community empowerment cannot be separated from the responsibility of government to ensure human rights and fair distribution of social and material goods. Community development is strongly associated with LHA programmes, does it mean empowerment of workers and autonomy? Or is this position another layer of worker to be controlled?

Nathanson (2007, p.3) emphasises public health is about community action to prevent ill health of individuals and communities, and that this action can take on many forms. But, perhaps too much emphasis has been placed on community and social capital. Indeed, the Community Food Centre model that has emerged across Canada in recent years is a brand that first and foremost argues for community and its power in creating change in food and health at the community level (Saul and Curtis, 2013). Yet, focusing on community alone can promote 'depoliticised' approaches to public health and SDH and be less effective than approaches which join-up citizens with institutions and government (WHO, 2010b).

2.5 Theories of Policy Analysis

'Policy is a powerful means of mediating multiple environments' (Raine, 2005). Public policy analysis recognises that decisions about policy are complex and consider more than just evidence, including politics, competing priorities and ideologies. The process of policy change

can also be a lengthy one (Lomas, 2000; Black, 2001; Cullerton et al, 2016). In this light, common frameworks used in policy analysis as the most promising models are explored.

Policy development is complex and partisan politics often comes into play, giving preference for certain issues (Kouri, 2012). Power, overt and covert, is at play in the policy making process. The government role in taking action can be influenced by other more powerful interests, and can depend on public views and acceptance, and thus may tread lightly with issues on the policy agenda. A key example is healthy food policies, which are not in the best interest of big food (Cullerton et al, 2015).

'One of the biggest challenges for policy-makers is to create and foster a positive environment that allows numerous players from multiple levels to play a role in the interpretation and application of evidence.' (NCCMT, 2015)

Policy decision makers are often not Public Health actors; Public Health being only one voice in the process, but an important one (Milio, 2001). Other key players are the public (whose opinions affect adoption of policy) and the media (influence policy makers and public understanding and opinions). Although Public Health status may not be high in some realms and can have little power: competing with other, more powerful actors and interests, Public Health is of most benefit to 'citizens who themselves have few resources and little power.' Furthermore, Public Health has been thought to traditionally not being radical and being apolitical, but Public Health is 'inherently political' (Nathanson, 2007, p.4). It is useful to look at the policy making process to understand how policy change happens which can be lacking when looking at food and health policy. There is limited use of policy or system change theories in areas of healthy food; most of the theories around healthy eating focus on individual behaviour change (Cullerton et al, 2015).

The Stages Heuristic model helps to understand policy making process as a series of stages from agenda setting, policy formation, decision making/policy adoption, implementation, and evaluation. A key advantage is being able to identify opportunities in the process to create action strategies to influence and enact change. Criticisms of this model have included it being too linear, and can over-simplify the process, as it does not factor in the complexities and determinants of policy (Fafard, 2008; Breton and De Leeuw, 2010; NCCHPP, 2015). This model is rejected here because it lacks focus on the underpinning drivers of policy and the multiple levels of influence.

Development of healthy public policy needs to include policies to protect and promote health, incorporating social, economic and environmental factors outside of individual control.

Frameworks need to consider the complexity of the process and the relevance to Public Health

programmes in providing supportive environments and understanding wider conditions shaping behaviour and health; the social climate (social, economic and political context) often carrying the most weight (Milio, 1987; Milio, 2001; Exworthy, 2008).

The Advocacy Coalition Framework is useful to use as a lens to understand and highlight different beliefs in policy change. This framework requires two strong coalitions with shared belief systems influencing changes in policies (policy makers may be inside or outside coalitions). Coalitions may be individual, interest groups or institutional actors coming together on a particular issue. This framework may over-emphasise external shocks and under-emphasise the conditions leading to policy change. Policy change generally can take many years although external shocks such as socio-economic change or change in government can create instability and opportunity for policy change to occur more quickly (Sabatier and Jenkins-Smith, 1993; Cairney, 2013). This framework has been applied to drug and tobacco policy with economic as well as health crises and impacts driving the change (Kubler, 2001; Breton et al, 2008). It has also been applied to menu labelling policy with opposing coalitions of Public Health and industry (for and against government regulation); local success was achieved at enacting policy change (Johnson et al, 2012). When considering LCFA programmes, this framework may be useful to apply as programmes contributing to the building up of a coalition for Public Health but it may be difficult at this stage to do so without two clear coalitions.

Punctuated Equilibrium Theory characterises policy making as long periods of small changes and brief periods of major change. This framework identifies factors that encourage and resist policy change on a large scale. Much like the Advocacy Coalition Framework, shocks such as socio-economic change, change in government, and mobilisation of interest groups or coalitions encourage policy change. Policy entrepreneurs, policy monopolies, laws, lack of belief in policy ideas and fragmented layers of government are all factors that can resist policy change (Givel, 2010). In Public Health, examples include applying this framework to tobacco policies and disease control (Givel, 2006; Shiffman et al, 2002; Moloughney, 2012). It may be premature to apply this framework effectively to LCFA programmes, although there are early signs that government changes can make this relevant.

The Health Policy Triangle (Walt and Gilson, 1994) is particularly useful as an organising framework (Collins, 2005). It enables learning of the interconnecting relationships between actors, context, content and processes involved. The framework can help explain interactions between institutions, interests and ideas and to frame programmes within a policy environment: to understand their history, process of development and their future direction as

shaped by different sectors and their involvement (Walt et al, 2008). The Health Policy Triangle helps to explore systematically and organise the place of policy but may be lacking in explaining or predicting behaviour and outcomes (Cullerton et al, 2015). This framework is useful to outline the problem and contributors (actors, policies, behaviours) as it relates to strategies such as LCFA programmes.

The Multiple Streams Framework highlights different streams needing to come together at the same time: the problem, the policy (solution) and politics (political will) to open a 'policy window.' Within organisations and communities, key stakeholders fall into two specific groups: policy holders or keepers (who have a mandate for specific policy) and policy influencers or entrepreneurs (who have an interest in the issue). When a policy window opens up, an opportunity arises for policy entrepreneurs, who may be inside or outside government, to push their issue forward and tackle important policy problems (Kingdon, 2010). This framework has been applied to the development of a food policy body and at the use of public health professionals as policy entrepreneurs (Craig et al, 2010; Caraher et al, 2013). Kingdon's model is particularly useful to apply 'when looking at how issues move into the policy making agenda and how alternative solutions are translated into policy' (Kingdon, 1995; Exworthy, 2008). The framework is not without criticism, in particular not giving enough attention to the influences of the media which can shape the problem, increasingly relevant and dominating in modern society (Scheufele, 2000; Stout and Stevens, 2000; Chow, 2014). As well, though streams are useful to categorise, they are not necessarily independent (Sabatier, 2007; Robinson and Eller, 2010). Considering the streams to be interdependent, it may still be a timely opportunity to apply this framework considering LCFA programmes as policy levers and entrepreneurs, as some evidence has shown (Simonsen et al, 2017). This model has been successful in applying to 'ambiguous' problems that are competing for attention with other issues and where solutions are not clear ie. government response to obesity and health inequalities (Moloughney, 2012). Thus, it is worthwhile to use due to heightened attention to diet-related ill health but there is lack of agreement on how to deal with the problem. Is it a matter of personal lifestyle choice or are systemic issues at play? Should people be told what to do or be left alone? Should focus be on prevention or treatment of disease?

Key determinants to be considered in influencing policy development are: social, economic and political context (social climate), timing and relevance of issues, parties with the greatest influence, recognition of interests, capacity of those wishing to influence and different players working together (Milio, 1987; Buse et al, 2012, p.83). Understanding barriers and enablers of policy change is useful in developing strategies. Barriers to policy change include neoliberal

ideology, industry press, lack of knowledge, skills and resources from health advocates, and government silos. Enablers are having a clear solution to the problem, stakeholder relationships, drawing attention to the issue with emotions and values, and engaging policy entrepreneurs or advocacy (Cullerton et al, 2016).

The utilisation of more than one framework applied to a problem may provide complementary perspectives and may enable both descriptive (to understand the status, history of its development, actors and policy context) and analytical frames to be applied (Moloughney, 2012). This consideration may be useful to apply to LCFA programmes as a policy option to understand how they can play a role in supporting and challenging policy.

2.6 Why this is interesting for Food Policy

There is growing evidence that although food has been on the public health agenda for some time, insufficient attention has been paid to it, relative to the associated impact of poor food (Roberts, pc, 2010). The challenge of public health in food policy is that food policy is dominated and often controlled by food industry and agriculture, with concerns over areas such as health lagging behind (Caraher et al, 2013). Though increasingly being recognised the need to apply a health lens to food policy, there has been a long-term impasse about how to tackle food and health. Food is a unique issue for public health. It cannot merely be tackled in the same way as other issues such as smoking for example, though this is complicated too. People need to eat, but what they eat, how it is produced and distributed, and how it is accessed, is hugely complex and can have significant implications for their health, society and the environment. Structural and political responses are necessary but which best responses are unclear (Cullerton et al, 2015).

Food policy and health policy is interconnected. Food policy has evolved over the years, from policies aimed at increasing production – agricultural and technological outputs, market-driven responses to issues of social justice, the environment and climate-change, and sustainability – but this has not yet gone far enough (Entz, 2015). Food policy, traditionally focused on productionism, must too focus on the problem of consumption. The development of modern food policy analysis must recognise the importance of government intervention but go beyond looking at food and health simply as what the state tells people to do (Lang, pc, 2017). The challenges of food policy range from the food system to society, are not just about health directly but social inequalities, environmental crises, globalisation and localisation, big food, alternative and mainstream systems (Hawkes, 2004; Pettoello-Mantovani, 2005; Clapp and Scrinis, 2016). Food policy interconnects with many policy environments and thus must be comprehensive (Rock, 2006; Roberts, 2009). It 'shapes the who, what, when, how and

whether people eat... and the consequences' (Lang et al, 2009, p.21). The enormous problems with the food system - both in the production and consumption phases interconnect with the problems of poverty experienced across the globe, demand the need to 'reform' systems and connect policies - health, social, economic, environment, food and agriculture. A paradigm focused on well-being, resilience¹⁴ and sustainability is necessary and one which includes food systems, national strategies and shaping enabling environments (local, national, international) (FAO, 2004 and 2014; UN, 2014). Policy action is needed from production, distribution to consumption phases, individual to systemic responses that are local, regional, national and global.

Most recent attention has been around the promotion of healthy eating, preventing obesity and DR-NCDs. Food policy actions are necessary across three domains: behaviour change, food environment and food systems (WCRF, 2015). Though this is recognised, it is often the case that policy approaches focus on downstream rather than upstream activities, however, joined-up policy approaches are needed to address the complex nature of food (Caraher and Coveney, 2003; Caraher and Dowler, 2007; Capacci et al, 2012; Cullerton et al, 2015).

The perspective taken in this thesis has been informed by the analysis developed by the Centre for Food Policy and others (Lang and Heasman, 2015; Lang and Rayner, 2012; Mason and Lang, 2017). This proposes that many problems and challenges have emerged in public life and public policy across many areas – health, environment, society, and economy – due to the massive changes in the food system. Some of these are well documented and acknowledged in the public health and nutrition worlds, such as the rapid spread of diet-related ill health (Popkin, 2002; Popkin and Gordon-Larsen, 2004), environmental damage (Nellemann et al, 2009; Mason and Lang, 2017), and social dislocation (Wilkinson, 1996; Wilkinson and Pickett, 2009; Devlin et al, 2014). There has been an explosion of output of 'ultra-processed' foods, high in fat, salt and sugar, and made from mass commodities (Monteiro et al, 2010; Monteiro and Cannon, 2012; Monteiro et al, 2017). These are branded and high value-added foods, but alter the nature of diets and what people aspire to eat. As this literature and thinking has developed – during the time of the present research work – the question arose as to whether the existence and roles of LCFAs are shaped by this food system transformation set within a public health context. The present enquiry thus set out to explore LCFAs with this 'big picture'

¹⁴ Harrop et al (2009) describes resiliency as 'the successful adaptation to life tasks in the face of social, disadvantage or highly adverse conditions.' It can be seen through the lens of food literacy (dietary resilience) and healthy communities (resilient communities). Resiliency is also one of the four pillars of food security (FAO, 2009).

in mind. What is the role of the LCFAs: are they indirectly confronting the economic forces shaping bad diet? Are they soaking up dissent which otherwise might be more overt? What is their role as actors in the food system? How significantly could they really change behaviour (Lang, pc, 2017)?

Food behaviour is complex and policies are often aimed at personal food choice. Though there is clearly a need for behaviour change, the complexities of food behaviour must be understood and acted upon within a broader framework, particularly with diverse and disadvantaged populations (Peterson et al, 2002; Brug et al, 2008; Raine, 2010). Healthy food choice is 'highly open to interpretation' and not the only determinant of health (Cullerton et al, 2015). Furthermore, determinants of food choice are individual and collective (EUFIC, 2005; Raine, 2005; Contento, 2008). Individual determinants include physiological influences, nutrition knowledge, skills, access, perceptions of healthy eating and psychological factors. Collective determinants of food choice include: interpersonal influences, physical, economic and social environments (EUFIC, 2005; Raine, 2005; Contento, 2008). Gender, ethnicity, class, income, social and cultural norms all influence food choice (Dowler and Dobson, 1997; Raine, 2005; Contento, 2008). Food carries social, historical, cultural, religious, financial and emotional meaning; it acts as a connector - to culture, to community, and is central to identity (Caraher and Coveney, 2003; ODI, 2003; Weller and Turkon, 2015). Food has a convening power and can 'be the most tangible and direct way to help individuals and communities gain a measure of control over their lives' (Winne, 2008, p.173). As Guthman (2011) questions, 'who has the choice to have choices'? Healthy choices can be much more of a challenge when people feel less control over their lives (their environment or circumstances) and thus are less likely to be able to think long-term or prioritise the same about the consequences of choices such as diet.

Policy approaches to increase uptake of healthy foods can be broad or narrow, aimed at the individual or at the population (from communities, sub-populations or whole nations). Examples of these approaches include: mass educational/social marketing campaigns (population-wide), restrictions on advertising unhealthy foods, price strategies to promote purchasing healthy foods (including taxation on unhealthy foods), nutrition counselling or education, universal programmes such as providing fruits and vegetables in schools (such as the national 5 A DAY programme in the UK) or more targeted programmes such as prescribing fruits and vegetables (Kearney et al, 2005) or food subsidy packages (Herman et al, 2008; Black et al, 2012). Legislation such as food regulation, labelling or food safety, can be addressed at individual and system level ie. how to safely prepare food versus tackling the complexities of

the food system (Raine, 2005). Specific examples in Canada include CPNP providing grocery vouchers (and sometimes food hampers) to pregnant low-income mothers (Muhajarine et al, 2012); the Food Miles programme subsidising the transportation cost of perishable foods (Hill, 1998; Galloway, 2017); and local food box programmes that often provide subsidised access for those on low-incomes (Miewald et al, 2012).

Population-based strategies seek to change social norms by encouraging healthy behaviours and reducing health risks, and show government taking some responsibility for people's health (WHO, 2009). While some population-wide strategies such as public education campaigns can be well resourced, and macro level strategies are important, this strategy in itself may not be enough without being matched with policy action such as legislation (Segal and Opie, 2015). This often does not happen in food and nutrition due to influences of big food. They may also not bring into account local differences of communities and sub-populations that make messaging more relevant and more effective. At micro level, nutritionists and dietitians are promoted to be the best source of 'professional' advice for what to eat, this should be complementary to population approaches (Segal and Opie, 2015). This strategy can include other positions (such as LCFAs) as reliable sources of information to enable people to eat healthier, beyond merely delivering information and advice that support informed 'choice' (Capaccio et al, 2012).

Policy interventions targeted at increased healthy eating consumption are often at the consumption end of the food stage, with approaches to nudge people in the right direction. Approaches such as menu labelling have not been found to be effective at changing behaviours. Despite this, in 2017 Ontario's government implemented the Healthy Menu Choices Act (GoO, 2015). Healthy-food symbols and traffic light labelling have shown the most promise but this can depend on environments for which people are making food choices (Fernandes et al, 2016). Modern approaches such as text message interventions and social networking sites have shown some promise in changing health behaviours, but this may only be with certain groups in the population such as those who are better positioned socio-economically to make healthier choices, as is the case with mass educational campaigns or adolescents and young adults (Armanasco et al, 2017; Mosdol et al, 2017; Wickham and Carbone, 2017; Yang, 2017). Health Canada (HC, 2018a) is in the consultation phase of new 'front of package labelling'; while this might be helpful to make 'choices', the healthiest of foods do not need nutrition labels, so this really is applied to processed foods.

Emphasis on information and personal food choice behaviour is not an effective approach without understanding and addressing the wider contexts of the behaviour and the

environment, and having supportive policies (Caraher and Coveney, 2003; Contento, 2008; Cullerton et al, 2015). Nutrition policy may be aimed at nutrition needs and health, whereas this may not be true for food policy.

The **food environment** has many layers: the personal, the social, the physical and macro-level environment (Story et al, 2008). Macro considerations include climate change, food's environmental footprint and the consequences to health, for which sufficient action has been lacking (Hancock, 2009; Lang and Heasman, 2015). People's health can be influenced by the environment due to different dimensions: availability, accessibility, acceptability, affordability and accommodation of healthy foods (Penchansky and Thomas, 1981; Contento et al, 1995 and 2008; Stokols, 1996; Caspi et al, 2012). The local food environment can translate to food deserts, fast food outlets or healthy food outlets close to schools, homes and workplaces (Story et al, 2008; HC, 2017b). Community-level initiatives can be effective at engaging communities and changing the local food environment to increase access to and quality of food such as through gardening and good food markets (Moron et al, 2006), however, this is small-scale; communities need to be understood as part of larger social and economic structures (Pickett and Pearl, 2001; Golden and Earp, 2012). Even within communities, due to their heterogeneity, people can experience the food environment differently (Jablonski et al, 2016).

Unhealthy diets can be cheaper when considering direct cost and poorer areas tend to have fewer healthier choices, with the existence of 'food deserts' or 'retail deserts' (Davey, 2001; Caraher and Coveney, 2003; Larson et al, 2009). Though the extent to which these food deserts exist and how they are defined may be disputed (Cummins and Macintyre, 2002), it is clear they do exist (Slater et al, 2017). Though it may not always be the case that those on low-incomes do their food purchasing in their neighbourhood (Hillier et al, 2011), economic and geographical variations in countries, regions and cities lead to differences that can affect health (Pickett and Pearl, 2001; Thornton et al, 2010; Walker et al, 2010). Healthy food access (recognising there are different dimensions to access) can be the bigger problem than knowledge and awareness (Vaandrager et al, 1992; Attree, 2006; Caspi et al, 2012). However, improving access to healthy foods doesn't necessarily translate to improved uptake of healthy foods depending on a number of factors including cost, knowledge, other foods available, influences and preferences (Ruel and Alderman, 2013; Durao, 2015; Jablonski et al, 2016).

The availability of cheap, unhealthy food is a 'deeply structural problem' (Guthman, 2011, p.196) and the drive for local and organic food plays a role in widening the food gap when

considering issues of access (Winne, 2008, p. 186). A paradox exists - healthy foods are cheaper in more affluent areas with lower income areas having access to a disproportionate amount of unhealthy foods (James et al, 1997; Acheson, 1998; Power, 2005; Winne, 2008, p.111; Allen, 2010). Lower socio-economic groups face greater challenges when it comes to making healthy food choices and often have to be more resourceful in how they shop and eat (Morris et al, 2000; O'Neill et al, 2004; Dachner et al, 2010). This can translate to a reduction in quality and/or quantity of food (Attree, 2006; Saul and Curtis, 2013). If healthy eating is to be the default choice and sustainable, strategies to address behaviour change must be accompanied with environments that are conducive to healthy eating; not only working within these environments, but challenging them and the systems which influence food behaviours (Story et al, 2008; Scrinis and Parker, 2016; HC, 2017b).

Increasingly, **food systems** have gained attention of governments at all levels around the world. The Milan Urban Policy Pact (2015) has engaged global cities committing to take action on the challenges of contemporary food systems such as nutrition and sustainability; major Canadian cities are signatories to this pact. A better food system includes realising food as a human right and bringing different voices to the table (Dowler et al, 2001; FSC, 2017). Food systems and health systems are interdependent: diet is affected by the food system and improving diet leads to improved health (Appavoo, 2014).

Increased attention in Canada has been paid to food literacy, food security (being framed more at household and community level), food systems and environments. The Report on the State of Public Health in Canada in 2017 highlights these areas of concern (HC, 2017b). But this level of commitment and attention has been confusing. For example, some provinces (including Ontario) and territories have recently decided to stop monitoring household food insecurity through Statistics Canada, as this is only an optional measurement (PROOF, 2017). The Nutritious Food Basket (GoO, 2010) is a tool used to calculate the cost (by local Public Health units) of a healthy diet in regions across Canada. This cost increases every year with most people on low-incomes falling short of affording what's considered the basics of a healthy diet; this tool continues to be used and serves as evidence of the unaffordability of a healthy diet (DoC, 2011). The Ontario government has recently announced a Food Security strategy and been engaged in endorsing sustainable local food systems strategies, though so far this has been limited (OMHLTC, 2016). Canada's (including Ontario's) agricultural policies focus heavily on industrial agriculture and exports, this contrasts with local food promotion (GoO, 2013; Entz, 2015). However, Canada has most recently been engaging with the public on 'A Food Policy for Canada' in the development stages of a national food policy with a summit and call

for input through public surveys, inviting the contribution of multiple stakeholders. This food policy aims to have long-term health, environment, social and environment goals (GoC, 2017).

Joined-up food policy: across health, agriculture, environment and social policy, can mean more sustainable, equitable and effective policy (Rideout et al, 2007; Roberts, 2009; Bronson, 2014). A preliminary report on Canada's new Food Policy recognises the right to food as a guiding principle, which is a breakthrough. Over recent years, food strategies have emerged in Canada but have not been adapted into policy nor have they necessarily been 'joined-up' in their approach. Canada's most recent Healthy Eating Strategy aims to improve information, nutrition quality of foods as well as consideration for vulnerable populations (children), access and availability. This has thus far included work to revise Canada's Food Guide, food labelling, restriction on marketing of unhealthy foods to children, and sodium reduction targets (HC, 2018a and 2018b). Ontario's Food and Nutrition Strategy was created with the purpose of providing a coordinated, cross-government, multi-stakeholder approach to the development of food policy (Sustain, 2013b). As well, on a provincial level there is advocacy for a 'comprehensive province-wide healthy eating approach' which includes taxation of unhealthy foods, food literacy in schools and strengthening the food system (ALPHA, 2016). In 2013, the Ontario government unveiled a 'Local Food Act', focusing on strengthening the food system with links to food and agriculture and food production. Though this has politicised local food somewhat, it is criticised for not going far enough and lacking attention to areas such as food literacy and food access (Sustain, 2013a; GoO, 2013; Sustain, 2014). Food access and local food year round are not so easy to achieve in a country so vast with extreme seasons (Simmons, 2011). Provincial policy strategies to promote healthy eating include Foodland Ontario, a campaign focused on seasonal food (Foodland, 2015) and EatRight Ontario, a provincial website promoting healthy eating through information from dietitians (EatRight, 2016). However, most recently (March 2018), the OMHLTC announced the funding for EatRight Ontario will be cut, which means the service will no longer be available (EatRight, 2018). Foodland Ontario continues to be funded by OMAFRA, which continues to support local food (OMAFRA, 2017). Figure 2.4 illustrates how food and health policy is organised at macro, meso and micro levels in Canada as related to LCFA programmes.



Figure 2.4 Food and Health Policy in Canada (Source: Author)

Local level initiatives working to promote food systems include Food Policy Councils, which have emerged in recent years, are models for influencing the physical and economic determinants of healthy eating (Raine, 2005). To date, many regional and municipal food policy councils are in place to engage local stakeholders and coordinate different players in identifying needs and issues, and set priorities as they relate to food security and the food system. Toronto's Food Policy council is an example of a long established one, which joins up citizen groups and government (TFPC, 2017).

With this localised approach in mind, community development has a role in the food system, 'the need for more integrated, bottom-up, participatory initiatives as a way to scale out and up adaptive capacity' (Blay-Palmer and Knezvic, 2015). Inclusive food policy means valuing diversity and community voices: programmes situated within and between Public Health and community can be a powerful means to address issues of the food system through advocacy (Allen, 2010; Appavoo, 2014; FSC, 2017).

Attention has been growing in the connection between social justice, food and health (Allen, 2010; Weiler et al, 2015). Health social movements have been growing in recent years as they can focus on the SDH, which have been 'largely ignored' by the Canadian government (Hancock, 2011), through leveraging community and shifting the balance of power.

Movements require shared goals and understanding of a problem and have seen gains in health care, health and safety, housing and tobacco regulation (Diani, 1992; Brown and Zavestoski, 2004). Borne out of the principles of social justice and social movements; the local food movement has been at the forefront of attention to promote more equitable, healthy and sustainable food in recent years. Local food movements can include efforts to transform nutrition labelling, food safety, urban agriculture, charitable food assistance and food security, and health professionals driven by reducing the burden of disease. There a political platform for Public Health involvement and leadership in the local food movement (Freudenberg et al, 2011).

Everyone should be able to participate in the food system, and typically those who are able to participate with a voice are not those who are living on a low-income (Winne, 2008; Allen, 2010; Guthman, 2011). Movements can evolve to include more 'diverse segments' of the population or even be driven by those on the lower socio-economic scale (Robinson, 2010). Movements have a role to play in drawing public and policy attention and shifting away from personal responsibility to that of collective responsibility and towards a more socially inclusive and equitable society; key to fit within healthy public policy framework (Wallack and Lawrence, 2005; Allen, 2010; Werkheiser and Noll, 2014). As well, linking up of health, social and environmental issues (such as obesity, food security and the food system) at all levels, with shared overall goals (such as reducing diet-related ill health and inequalities), brings shared resources. Robinson (2010) suggests 'piggybacking' on shared goals (existing social and ideological movements) to create change at different levels. Local movements need to be joined-up and connect with the wider policy context and so too must local food programmes to the wider food system, to ensure greater equity in food and health opportunities and outcomes, of which LCFA programmes may be able to engage in.

Food Literacy

An increasingly utilised but still emergent term, food literacy, evolved through the concept of 'health literacy',¹⁵ has gained attention in many HICs, including Canada in recent years. Though a fluid concept (Velardo, 2015), it can be defined as:

'the scaffolding that empowers individuals, households, communities or nations to protect diet quality through change and strengthen dietary resilience over time, it is composed of a collection of inter-related knowledge, skills and behaviour required to plan, manage, select, prepare and eat food to meet needs and determine intake'
(Vidgen and Gallegos, 2014)

Food literacy is often viewed as having knowledge. There is often a KAB (knowledge, attitude and behaviour) or KAP (knowledge, attitude and practices) gap between one having the knowledge about what is good for them and putting it into practice. Being informed means one may be more likely to make healthier choices, which depends on how this information is received and by whom. A KAB or KAP model is simplistic, that changes in knowledge lead to changes in attitude, which then lead to changes in behaviour (Contento, 2008). There can be significant differences in knowledge across the socio-economic scale, with higher levels of knowledge, as well as healthy behavioural take-up, the higher up the scale (Parmenter, 2000, McGill et al, 2015; Bonaccio et al, 2017). However, having knowledge and skills can enable dietary resilience, an important personal resource (Harrop et al, 2009; Smith et al, 2010; Vesnaver et al, 2012).

Learning about what to eat and learning how to eat are different, and both are needed; food skills are vital in enabling people to eat healthy but aren't enough if not accompanied by knowledge and awareness of healthy food. Not only has there been a global nutrition transition, but also a 'culinary transition' brought on by a combination of technological advances, food system changes and changes in the wider environment (social, economic, physical and cultural). Society over recent decades has become 'deskilled' in terms of cooking and food preparation; many arguing food skills are life skills yet there are fewer opportunities for people to learn these skills due to shifts in home and education environments: a de-prioritising and de-valuing of food skills, which were once a necessity (Lang and Caraher, 2001). But who should have those skills and be responsible for transferring those skills to the population? Questions have arisen when this should be to dietitians/nutritionists who commonly don't have that training and who should be teaching them (Begley and Gallegos,

¹⁵ Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to be able to make appropriate health decisions (Carbone and Zoellner, 2012). Health literacy is considered a public health goal and essential to empowerment (Nutbeam, 2000).

2010; Slater, 2013). With increased emphasis on food skills, combined models such as that of dietitian/nutritionist and chef have been incorporated into initiatives for skill mix (Thomas and Irwin, 2011). Desjardins (pc, 2009) points to this culinary transition and tension with food skills:

'Cooking skills are so important but have been un-cool, cooking is not popular...partly due to feminism, getting women out of the kitchen because it was seen as oppressive...schools doing away with home economics as seen as unimportant...processed and ready foods and the requirement therefore to have very few skills, yet celebrity chefs and their food programmes are cool. It's not in the food industry's favour to teach cooking skills so still very little support here.' (Desjardins, pc, 2009)

From a feminist perspective, getting out of the kitchen has been liberating for women, enabling them to take on other roles. Big food has made it possible to get away with having little or no food skills. Though women continue to dominate in participation of food literacy (from a profession perspective - dietitians, nutritionists, home economists with the exception of chefs, to participation of cooking). Knowledge and food skills does not necessarily translate to people preparing and eating home cooked meals from scratch, nor should it be assumed that cooking translates to good health outcomes. Furthermore, time at home cooking meals from scratch displaces time spent doing other things like working and earning money. In addition, cooking at home can be inefficient and ecologically unsustainable. It can thus be expensive for households to achieve, with those on lower incomes most affected and finding ways to make their skills work for them, healthy or not (Caraher, 2016, pp.121-127).

Nutrition education is about 'any set of learning experiences designed to facilitate the voluntary adoption of eating and other nutrition-related behaviours, conducive to health and well-being' (Contento et al, 1995). Focusing on behaviour in nutrition education involves tying in national nutrition guidelines such as Canada's Food Guide to Healthy Eating with participant needs, perceptions, beliefs and motivation. Strategies that are tailored to the needs of the population, group or individual, are practical and participatory in their approach are more effective (Contento, 1995 and 2008; Kobetz et al, 2005; Sahay et al, 2006; Eyles and Mhurchu, 2009).

National food guides are recognised and widely used tools for the delivery of nutrition messages. Many countries have been undergoing changes to their food guides in light of emerging evidence and the need to build in sustainability. The UK's Eatwell Guide has been recently revised to include environmental concerns. Brazil's new food guide has been celebrated as practical, focused on whole foods rather than nutrients; taking into account the social environment and takes away industry influences (Nestle, 2014; Fullan, 2015). Similarly,

the US food pyramid has been reinvented into a Healthy Eating Plate taking into account the ways that people actually think about how they eat (a sense of general proportions versus counting servings in counter-intuitive sizes) and challenges the lobbying influence of big food (HSPH, 2015). Food guides and messaging are somewhat getting away from focus on nutritionism, which gives power to big food, and focusing more on whole foods (Clapp and Scrinis, 2016). Though Canada's Food Guide (HC, 2007a) is generally supported, it has been criticised for being obesogenic, focusing on nutrients and serving sizes rather than whole foods, benefitting big food (particularly the dairy and grain industry) over public health, being complicated and not reflective of how Canadians really eat. Recent recommendations of a senate report on obesity have been to make it more meal-based rather than nutrient-based, and focus on whole foods while explicitly discouraging processed foods, and that revision takes place without input from the food and agriculture industries (SOC-AFF-SOC, 2016). After a decade, Canada's Food Guide is being reviewed and revised for unveiling in 2018; with a revision process engaging multiple stakeholders including the public and industry and claims to be making efforts to ensure the process is transparent and 'free of conflict' (HC, 2017a).

Helping people to eat healthier can go a long way in improving health (WHO, 1986). But what constitutes a healthy diet? That in itself has been up for debate and has continuously changed over the years due to new and different nutrition science emerging. A 'healthy diet' can be characterised as a diet high in fruit and vegetable consumption, high in fibre and low in sugar, salt and processed foods. The definition of a healthy diet has evolved beyond that of a biological perspective, to one with environmental considerations. The modern diet or ideal diet may be framed as a 'sustainable diet', interpreted as plant-based, eating seasonally, locally and organically; still, a sustainable diet has been difficult to clearly define (Lang et al, 2009, p.121; Mason and Lang, 2017). What is clear is that the nutritional quality of diets has deteriorated overall, thanks in large part to the global explosion of ultra-processed foods (the worst foods nutritionally) displacing consumption of unprocessed or minimally processed foods (Monteiro et al, 2017; Steele et al, 2017). Of course, this aforementioned 'healthy diet' is often more accessible for those higher up the socio-economic scale (Barosh et al, 2014).

Motivation is a key driver and barrier for healthy eating (Dibsdall et al, 2002). People are motivated by needs, and as basic needs are met (food, shelter), they are motivated to fulfil higher order needs (Maslow, 1943). A person with little money may only be motivated however to fill the hunger gap rather than nutrient gap. And modern motivation is complicated by the food deskilling of society (Slater, 2013). But in order to eat well, and eat healthily, they do. Though poor food literacy is a broad issue in the population, it has been

found to disproportionately affect those of lower socio-economic status when considering all attributes required to plan, manage, select and consume food (Palumbo et al, 2017). Being food literate means considering the impact of food selection on personal health but also on society (Krause et al, 2016). This goes beyond how it is often viewed.

Though food literacy has been gaining increasing attention often in being embedded as education and skills through the school system, it is still unclear how it is being understood and interpreted in its relation to the social context, food system and environment (Slater, 2013; Cullen et al, 2015; LDCP, 2017). Food systems literacy has emerged: food literacy as a set of skills required to navigate the food system (Widener and Karides, 2014; Palumbo et al, 2017). Importantly, food literacy needs to be understood as bigger than the individual but often is not, and considered within a narrow personal skills framework. A food skills focus fails to address the underlying issues and structural changes to the wider food system intertwined with how and what people eat (Caraher, 2016, pp.119-122). However, bringing people together over food ie. through focus on food skills and preparing food together can help contribute to behaviour change. But this may be dependent on both internal and collective factors (Raine, 2005; Vesnaver et al, 2012).

There must be an understanding of factors influencing diet in order to plan and implement strategies around healthy eating. Food literacy must now, more than ever, be considered within a broader lens (Slater, 2013; Sumner, 2015). In Canada, it continues to be framed at individual and household level (Brichta and Howard, 2013). Strategies that include partnerships, are multidisciplinary and incorporate (structural, economic and material) barriers to dietary change through community collaboration and participation will make food literacy more comprehensive (Vaandrager et al, 1992; Turrell et al, 2002). There are current challenges with identifying and measuring food literacy and its outcomes, but this is an emerging area of interest (Azevedo Perry et al, 2017; LDCP, 2017; Palumbo et al, 2017). Comprehensive food literacy can align with policy priorities and move beyond personal responsibility (Vidgen and Caraher, 2016, pp.238-240).

Food Security

Food security¹⁶ is a SDH, for which system change strategies are needed (OPHA, 2002; Caraher and Coveney, 2003). A key challenge with addressing food insecurity is the complexity of its causes and for policy makers being able to distinguish between causes ie. poverty/ low-income, inequalities and symptoms ie. hunger/ food insecurity, which translates to being the difference between transformative or ameliorative solutions (Freudenburg et al, 2011; Ledwith, 2011, p.11). Household food security can become affected long-term primarily due to ongoing insufficiencies in income (through unemployment, under-employment, and inadequate social security), increasing debt, food and living costs, and lack of access to healthy foods. Households have coping strategies to deal with this; food aid being one but often is a last resort (Lambie-Mumford et al, 2014). Community-based programmes generally have limited effectiveness in improving household food security due to their inability to address the underlying causes of poverty (Tarasuk, 2013). The success and reported benefits to participants of the EFNEP and WIC programmes, for example, could be related to programmes not being stand alone, and connected with people receiving benefits as in the US where there is a system of government food aid (Besharov and Germanis, 1999; Whaley and True, 2000). When this is systematic and provided by the government (as opposed to non-government food aid such as that provided by charities, as is the case in Canada) there is more likelihood of improved household food security (Lambie-Mumford et al, 2014). However, the US remains a country of enormous inequalities and large-scale poverty, recent years seeing scaling back of social programmes; thus, there are bigger problems in the system.

There has been a shift from the concept of household food security to community food security, taking into account the importance of economic, environmental and social aspects of the food system (NCCDH, 2008).

'A situation in which all community residents obtain a safe, culturally acceptable, nutritionally adequate diet through a sustainable food system that maximizes self-reliance and social justice.' (Hamm and Bellows, 2003)

Strategies to improve community food security in Ontario have been categorised as (FSP, 2005):

1. *Emergency Strategies (eg. food banks, drop-in meals)*
2. *Capacity Building Strategies (eg. collective kitchens/community kitchens, community gardens, good food box schemes, farmers' markets)*

¹⁶ Food security exists when 'all people, at all times, have physical, social and economic access to sufficient, safe, nutritious and culturally acceptable food for an active and healthy life'. It has four pillars/dimensions: food access, availability, stability/resilience and utilisation (FAO, 2009).

3. *System Change Strategies (eg. healthy public policy development, advocacy, social marketing, campaigns).*

This draws parallels with the community 'food security continuum' comprising of three stages: efficiency, participation/transition/substitution, and redesign (MacRae, 1994). This continuum describes working from a food insecure to food secure stage and ranges from short-term to long-term food security strategies: from charitable responses to hunger to a stage of addressing underlying causes of the problem and thus reaching a stage of food security. The reality in Canada has been efforts mainly with high charitable investment on short-term strategies and some limited mid-term strategies; less effort has been placed on system change strategies. These different strategies may engage with different populations, that is, the most food insecure are most likely to be participating in the first strategy (Roncarolo et al, 2015). Emergency strategies can 'offer short-term reprise from the effects of food insecurity' (Roncarolo et al, 2016) and capacity-building strategies may be able to go beyond immediate hunger (FSC, 2011; Miewald et al, 2012). However, addressing food security effectively has continued to be low priority in Public Health in Canada (Seed et al, 2014). Nevertheless, household food insecurity in Canada has consistently been growing, affecting upwards of four million Canadians (Tarasuk et al, 2013; FBC, 2017), with Canadians experiencing nutrition inequities due to their 'social position' (Tarasuk et al, 2010; Fafard and Tarasuk, 2017).

Action on food insecurity has often been relieved by charitable responses. This entrenched charitable model has been a threat to systemic policy strategies (Riches, 2002; Rideout et al, 2007; Riches, 2011; Riches and Silvasti, 2014, p.42-56). Although some food assistance responses have been assuming larger roles such as skill building and advocacy, this has often been limited. Some charities work to provide healthy food, but this distracts from the deeper problem. Responses are short-term at best and often are aimed at using charities to address a food waste problem and engage with big food - not considering the best interests of public health (Dachner and Tarasuk, 2017; FEED, 2017). There are limitations as to what can be achieved if the focus remains on local food assistance and community food programmes (Tarasuk, 2001; Loopstra and Tarasuk, 2013).

Some report 'a socio-cultural shift toward a preference for managing one's poverty privately', whereby people internalise problems such as hunger and are least likely to utilise services and programmes with so-called 'poverty programming being enjoyed by the non-poor' (McIntyre, 2011). Food rather than food security or income being the focus can create a broader access point for interventions. Health promotion programming can often be universal in its approach and those most resourceful and connected are most likely to seek out and take advantage of

programming; this can then contribute to widening inequalities (Frohlich and Potvin, 2008; Goodall et al, 2014). Food insecurity is often seen as a problem of individuals' resource management skills rather than a problem of access to resources, with gaps in understanding of issues between those working to address food insecurity and for those living with it (Hamelin et al, 2010).

There can be difficulties in winning a 'public interest' approach to the food system. LCFA programmes may be a good opportunity to attack changes and be utilised more broadly with a public interest approach to the food system (local, regional and global) through engaging the public more broadly and equitably. LCFA programmes may be able to join-up the approach of Public Health when recognised that giving information on healthy eating cannot tackle, on its own, the social challenges of food and deal with nutrition and health inequities. Canada's emerging National Food Policy and Healthy Eating Strategy, though has challenges due to a broad mandate with a number of stakeholders to please, presents opportunities for programmes to engage.

2.7 Summary

This research began with a conceptual model as a guide with an overarching objective of exploring how LCFA programmes contribute to addressing public health. The literature review has reinforced the areas being most scarce to be LCFA programmes and implications of their role in food policy- how they integrate with Public Health, how they are situated more broadly, and the tensions arising with behavioural, lifestyle focused interventions and wider approaches. The global, national and local food and health challenges are significant and cannot be addressed without tackling the micro, meso and macro context. How does the LCFA role fit as a strategy? What are they able to achieve, what are their opportunities and where are the gaps?

PART TWO - METHODOLOGY

Chapter Three. Research Design and Methodology

3.1 Overview

The aim of the thesis was to explore Lay Community Food Advisor (LCFA) programme models and their role and contribution to public health through a food policy lens. The research was qualitative in design. Research strategies used to understand the role and implications of LCFA programmes in health and food policy were: a single, nested case study incorporating face-to-face interviews, overt participant observation and document review, with a cross-comparison and focus on the similarities and differences between cases.

Background work in the UK and Canada informed the development of the thesis and the formation of the areas of interest and research questions (RQs). Set out in the following sections are the development of RQs, theoretical propositions, application of conceptual framework and criteria for interpreting findings within a case study approach.¹⁷ Figure 3.1 provides a summary of the research process.

¹⁷ See Section 3.5 on Case Study Approach and Section 3.6 on details of background work and scoping exercises.

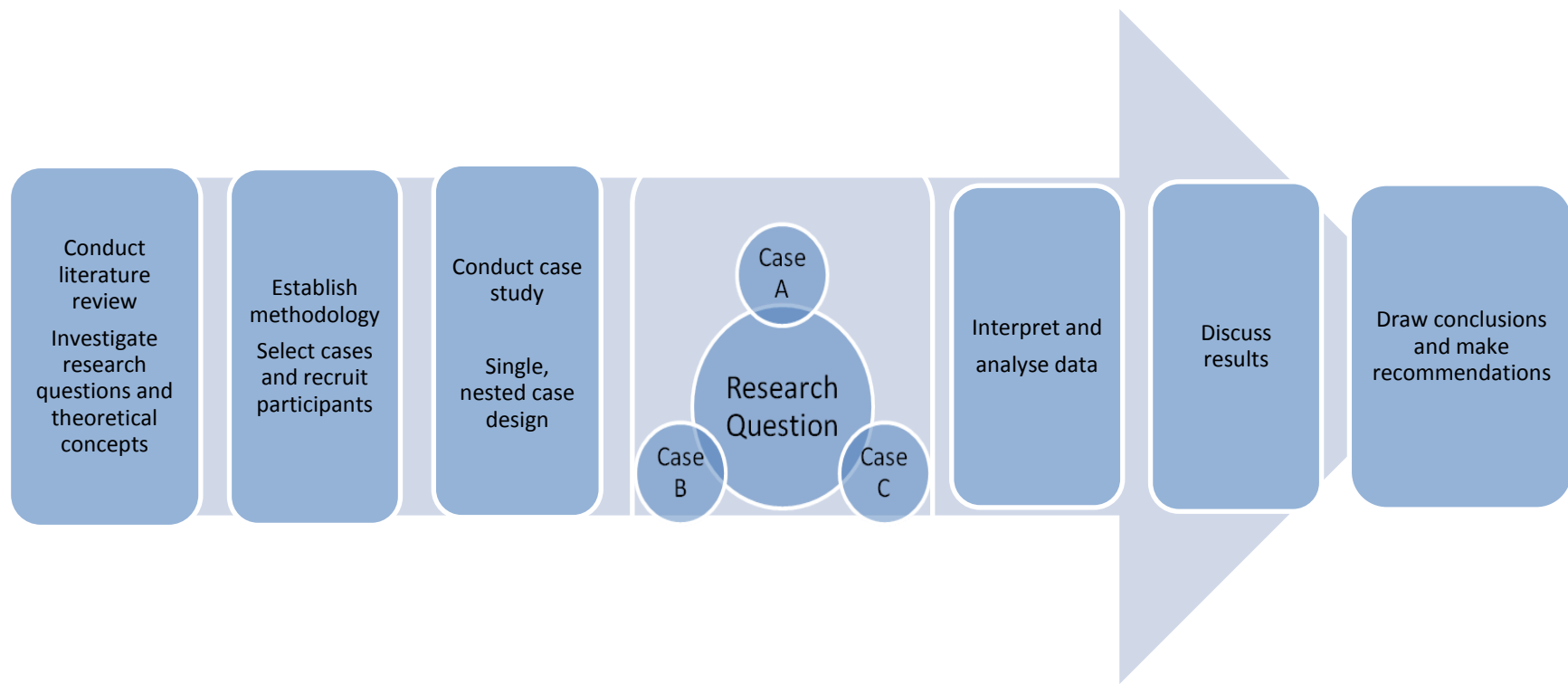


Figure 3.1 Summary of Research Process (Source: Author)

3.2 The Research Objectives and Questions

As discussed in the first two chapters, there are a plethora of LHA programmes around the world with broad and specific areas of work and varying degrees of success addressing challenges of access to health care, promoting health and reducing disparities in health. The literature review is able to draw a picture of LHA/LCFA programmes. The challenge is extracting details, their context and mechanism for how they work, clear roles as well as opportunities particularly for how LCFA programmes can best tackle healthy eating in order to prevent diet-related ill health and address nutritional inequalities, given the complexities of food and health issues. LCFA programmes are of interest in how they can promote health within a broader frame. Providing a cross-comparison of programmes can help illuminate findings that are not just applicable to one specific situation. None of the programmes featured have been researched in this light. Hence, the overarching research objective is to study the role LCFA programmes play in public health with three main objectives:

- To describe the context, drivers and (identify) strategic components of different programme models
- To determine the role of programmes in addressing healthy eating behaviour (across the socio-economic spectrum)
- To determine the wider role and impact of programmes in food and public health

The overarching question or aim of this study was - What is the role and contribution of LCFA programmes to public health through a food policy analysis lens? The RQs were derived from the overall aim and designed to address the research objectives, established through a combination of scoping exercises, researcher experience and informed by the literature review. The RQs were formed based on knowledge gaps around: strategic, operational and outcome aspects of programmes considering context (social, cultural, economic), mechanism (programme delivery) and outcomes.

RQ1. What contributes to programme function at strategic level; why and how are they sustained and what are their challenges?

RQ2. How does programme delivery occur; how do programmes work to address healthy eating across the socio-economic spectrum and is there a differential take-up?

RQ3. What are the programme outcomes (intended and unintended) at different levels: individual (for the LCFAs and beneficiaries), organisational, community and policy level?

3.3 Methodology for the Literature Review

Theoretical propositions are helpful to place limits on the scope of the study and make it more manageable. These propositions or issues can arise through the literature, personal and/or professional experience, theories or generalisations and help to guide the research process (Stake, 1995; Yin, 2003; Baxter and Jack, 2008). Propositions may be more connected with hypotheses but it is important to consider that a level of knowledge and experience informs the process – this includes 'political, social, historical and personal contexts' (Stake, 1995). Here, they are considered more as a framework for understanding the issues surrounding the RQs. Key to informing this stage has been professional experience and background work in public health and community environments, including LCFA programmes. Table 3.1 outlines propositions as they relate to the RQs.

Table 3.1 Theoretical Propositions as they relate to Research Questions

Research Question	Theoretical Proposition
1. What contributes to programme function at strategic level? a. why and how are they sustained? b. what are their challenges?	How public health structures (national and local) recognise food as impacting on health and the value added of programmes affects commitment to them. There are multiple forces in Public Health that impact level and type of implementation and sustainability of programmes.
2. How does programmes delivery occur? a. how do programmes work to address healthy eating across the socio-economic spectrum? b. is there a differential take-up?	Resources dedicated to these programmes and support structures affects how they are able to operate and within what scope of practice for the LCFA. Programmes are able to address healthy eating more broadly due to their (linguistic/cultural or other shared commonality), non-professional/natural helper qualities and more appropriate and tailored delivery. The influences on behaviour are much wider: social, cultural, financial, historical, political.
3. What are the programme outcomes (intended and unintended) at different levels (as applied to food and health policy priorities): individual (for the LCFAs and beneficiaries), organisational, community and policy level? a. what are their limitations? b. where are the opportunity gaps?	Programme outcomes are achieved at multiple levels which all interrelate, but are not recognised for wider outcomes that include those unintended outcomes which are often not defined in policy and thus unlikely to be identified (due to narrowly defined programmes). Attention may be focused on downstream activity; outcomes may be focused at individual behaviour level but there is a wider benefit to programmes.

The literature review was carried out at points in time mainly between 2004 (at the initiation of the research idea) and after a family move to Canada, a few years after which, in 2013, the present Canada-based research was initiated. This involved different stages; first a review of the literature informed by initial working knowledge of the LCFA roles to grasp the key issues, concepts and identify gaps. This included a wider scoping of the literature to broaden personal knowledge base to inform the direction of the research. The next stage was more focused with specific research objectives and questions in a systematic way (systematic review). In 2017, the literature was re-engaged with to further focus the thesis. More weight was given to HICs, Canadian and LCFA literature where available, as well as to LHA programmes specifically in health promotion. Publication dates were considered, with more weight given to the most recent literature with some older literature included for historical relevance. LHA literature was drawn on internationally due to limited literature available in Canada and with LCFAs specifically.

Primary data included:

- Academic literature - peer reviewed journal papers (formal)
- Field work - Interviews with key informants, programme observations, documents
- Personal communication (in-person, verbal) with academics and practitioners in the field (included: Kennedy, 2004; Desjardins, 2009; Roberts, 2010; Lang, 2017)

Secondary data included:

- Grey literature – policy documents, unpublished material, reports or evaluations
- Text books; Books - academic and some relevant non-academic (experiential and activist authors), recommended by academic advisors (Winne, 2008; Guthman, 2011; Ledwith, 2011; Saul and Curtis, 2013; Vidgen, 2016)

The literature review process involved searching for key words and terms across relevant sites, search engines and databases: PUBMed, Zetoc, HILO, PubMed/Medline, Embase, CINAHL, OVID, SAGE, Cochrane, Health Evidence registry, CHW Central, Google scholar and Google. As well, literature was generated through references of articles of interest.

The plethora of terms used to describe LHA/LCFAs in the literature (and in practice) made this process challenging. Due to the limitations of the food specific LHA, the wider literature was drawn upon as well as key concepts. Key search terms utilised in the process are listed in Table 3.2. Information was also collected via community nutrition Listservs during scoping exercises. A synthesis matrix was used to help (re)organise and synthesise main ideas around LHA/LCFA programmes applied to literature given the most weight, including: more recent dates, systematic reviews, Canada, health promotion and food-policy focused.

Table 3.2 Search Terms and Key Words in the Literature Review Process

Generic Terms and key words	Food-specific terms and key combinations
<i>lay health educator</i> <i>lay health advisor</i> <i>lay health advocate</i> <i>peer worker</i> <i>peer advisor</i> <i>peer educator</i> <i>training lay people/workers/educator</i> <i>paraprofessional</i> <i>natural helper</i> <i>community health worker</i> <i>community health provider</i> <i>community mothers programme</i> <i>community participation</i> <i>community engagement</i> <i>community empowerment</i> <i>advocacy</i> <i>advocacy and health</i> <i>social determinants of health</i> <i>health inequalities</i> <i>inequities in health</i>	<i>nutrition assistant</i> <i>community food/nutrition assistant</i> <i>community food worker</i> <i>community food advisor</i> <i>community lay food worker</i> <i>community food advisor</i> <i>lay food advisor</i> <i>lay food and health worker</i> <i>lay food worker</i> <i>peer nutrition educator</i> <i>community development + nutrition</i> <i>lay health/food advisor + community</i> <i>community nutrition</i> <i>food + community</i> <i>community nutrition assistant</i> <i>community nutrition worker</i> <i>community nutrition educator</i> <i>food security/insecurity + health</i>

Table 3.3 shows the flow of rationale from overall research objective to questions to devising and collecting data: interview questions, observation and documentation.

Table 3.3 The Methodological Flow

Research Objectives →	Research Questions →	Interview Questions →	↔ Observation ↔	↔ Documentation
To describe the context, drivers and (identify) strategic components of different programme models	1. What contributes to programme function at strategic level? a. why and how are they sustained? b. what are their challenges?	What is the rationale/ theoretical basis for the programme? How has the programme evolved? What is the overall problem the programme aims to address? What are the contributors to the problem? Has this changed? What policy supports/works against the programme? What keeps programmes going? Key components?	(programme meetings and/or programme delivery) Focus Aim and objectives Participant interaction Topic discussion General sharing of information	Interview notes and transcripts Observation notes Field notes Programme reports Programme supplementary materials
To determine the role of programmes in addressing healthy eating behaviour (across the socio-economic spectrum)	2. How does programme delivery occur? a. how do programmes work to address healthy eating across the socio-economic spectrum? b. is there a differential take-up?	What is the focus and approach of the programme? Who is the target population? Who are you reaching and how? Who is not being reached? What are key components that make programmes work? How does the programmes differ from others? What programmes/initiatives complement it? What are the challenges and tensions at	Focus Demographics of LCFAs, and participants, recruitment Type of activity Type of group Approach of LCFA How learning takes place How messages are	Interview notes and transcripts Observation notes Field notes Programme reports Programme supplementary materials

		operational level? What are the programme gaps - what can they do? What can't they do? Anything missing? Emerging needs?	transferred	
To determine the wider role and impact of programmes in food and public health	3. What are the programme outcomes at different levels: individual (for the LCFAs and beneficiaries), organisational, community and policy level. a. What are their limitations? b. where are the opportunity gaps?	What can/does programme achieve at individual, community, organisational and policy level? How does programme address public health? How does it do so within food literacy, determinants of health and community engagement? What are their limitations and opportunities?	Participant interaction Participant sharing of learnings and outcomes	Interview notes and transcripts Observation notes Field notes Programme reports Programme supplementary materials

3.4 Conceptual Framework

Underpinning research with theory helps to deepen understanding and explain findings more broadly (Crowe et al, 2011; Thomas, 2011). An initial conceptual framework serves as a guide, helps with focus and scope, showing relationships and allows for general constructs to be put into 'intellectual bins' (Miles and Huberman, 1994, p.18). This framework can grow and develop as the findings emerge.

A qualitative research approach was established as the best means for which to answer the RQs. It is recognised that concerns have been raised about qualitative research, in particular internal and external validity, sufficiency and reliability of sources of information, selection and interpretation of data (Diefenbach, 2009). As well, usefulness of information and results generated from qualitative data have not been traditionally considered highly credible (Baxter and Jack, 2008). However, with quantitative data, thoughts, feelings and perspectives are hard to capture. Qualitative research enables more depth of information and understanding of social contexts in an ever-changing world (Flick, 2002, p.2). Gathering the views of actors and their reality enables a deeper meaning of findings, and though the author may not agree with these interpretations, the author must understand them.

A general inductive approach was used for the research process: gathering data based on specific level of focus; establishing links between RQs; looking for patterns (analysis); developing theory as related to policy at theoretical, strategic and practical level (Flick, 2002, p.46; Thomas, 2011). This was done through beginning with a focus of LCFA programmes and their contribution to public health, there was some intended broad direction with concepts of food literacy, community engagement and SDH as can be seen with interview questions in order to keep a level of focus (to be able to answer the RQs) in the enormous field of public health, but allowing opportunity for new findings to emerge. Inductive reasoning allows for a more open-ended and exploratory approach, for relationships and theories to emerge rather than testing a specific hypothesis that would be deductive in approach (Gray, 2014). Figure 3.2 shows the elements of the research process and choices as guided by Gray (2014, p.35), each stage being guided by the next.

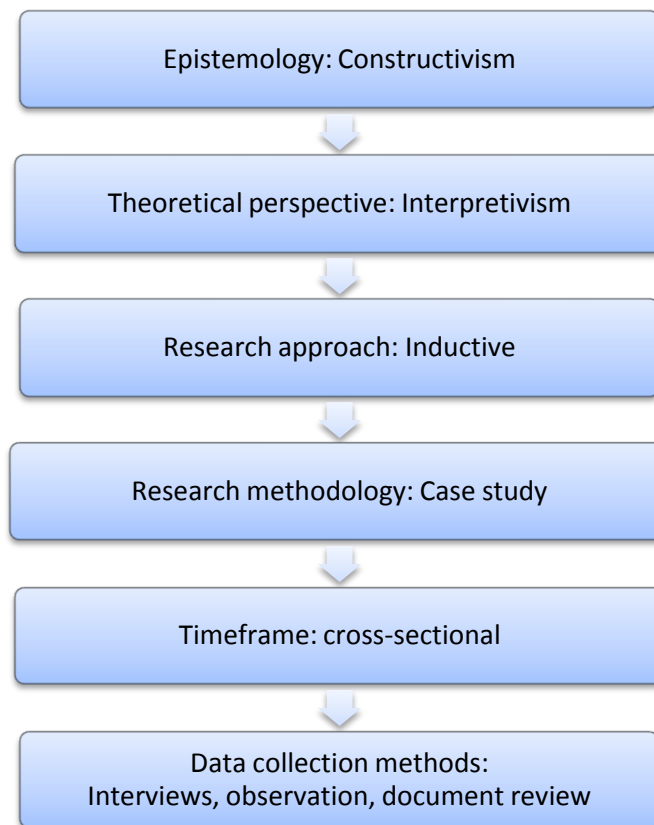


Figure 3.2 Elements of the Research Process (Gray, 2014, p.35)

Epistemology began with a constructivism lens (as opposed to objectivism and subjectivism). Constructivism means that people construct their own knowledge and understanding of the world; the truth being relative and based on people's perspectives. 'Truth and meaning are created by the subject's interactions with the world...meaning is constructed not discovered...in different ways, even in relation to the same phenomenon' (Gray, 2014, p.20). Constructivism and interpretivism are closely related; as Figure 3.3 suggests, it should not be seen as a 'dividing wall between epistemologies and perspectives, but a gradual shading of one into the other' (Gray, 2014, p.34).

According to Bryman (2001), there are three main theoretical perspectives used in research: Positivist, Realist and Interpretivist paradigms. Positivism is often considered more suited to quantitative research and deductive reasoning as it's value-free and assumes the world is one-dimensional, that there is one truth. Though positivism was the dominant paradigm, this has changed. Realism is similar to positivism in there being an external reality but differs in that it allows for theoretical assumptions to explain reality beyond observation. Critical realism for example, allows for explanation that goes deeper than that which is observable, that understandings of reality are temporary and that the scientist's opinion may be mismatched with true reality. The interpretivist paradigm has generally been the most common for

qualitative approaches to explore, explain and understand reality. Interpretivism takes into account differing realities and perceptions of the world (Carson et al, 2001; Trochin, 2006). Positivism tries to apply natural science methods to social reality, is deemed as most objective and robust, whereas interpretivism is about constructed reality tied to particular cultures. But facts can still be subjective and multiple subjective views can reveal a great deal. And there are arguments for underpinning research with more than one approach (Roth and Mehta, 2002). For policy, it makes sense to have a goal of understanding and to elicit meaning beyond causal relationships - showing the 'what' and 'how', and implications (Lin, 1998).

For the present research, choice of research methodology was determined by the intention to 'explore and unpick people's multiple perspectives in natural, field settings' (Gray, 2014, p.29), for which the interpretivist approach is most appropriate, according to some commentators (Harrison in Fulop et al, 2001, p.103). People's interpretation of reality is influenced by their personal world of experiences with social and environmental dimensions (Ritchie et al, 2013). An interpretivist perspective was taken with the view (and researcher experience) that there are multiple perceptions of reality. Allowing for different perceptions of programmes and of experiences to emerge, particularly through the eyes of different players in the field (managers, coordinators, LCFAs) was intended in order to add more dimension to this study. This research approach acknowledges the wider influences on people's thoughts, beliefs, knowledge and behaviours and that people experience the same exposure or situation differently and that each participant has valued views and perspectives worth sharing and contributing. Applying this lens can enrich findings, shedding different light on the problem and solution. This is enhanced by multiple interviews and studying nested cases as well as applying this lens to observation. Interpretivism understands 'how people create and maintain their social worlds through a detailed observation of people in natural settings.' However, 'total immersion in a setting' is not necessarily required (Ponelis, 2015). The researcher interprets meaning from those researched, from the setting and how it is experienced, 'mediated by ideas and assumptions' (Richie et al, 2013).

The timeframe to conduct the research was short-term looking at programmes at one point in time; thus a cross-sectional study was more fitted to longitudinal. Though preliminary research was conducted at earlier points in time, the core data for this thesis was being collected during one time period. This point in time was in fact over several months but the purpose was not to study change over time by collecting data at different stages. However, change over time could be identified (and used as data) in programmes due to their running

for several years. Of relevance is policy which has changed over time in relation to programmes.

3.5 Case Study Approach

The phenomenon under study is LCFA programmes, LCFA programmes being the unit of analysis, considered within the context of Public Health, within a community setting; programmes as a whole being studied and their role in public health in Ontario.

Once programmes were identified as the phenomenon to be studied, the case study approach was considered because it is flexible and enables multiple methods of data collection to be used (Cavaye, 1996; Ponelis, 2015). Both Stake (1995) and Yin (2003) base their approach to case study research on a constructivist perspective. Case studies are useful for uniqueness and giving a rich picture (with boundaries) and gaining analytic insights (Thomas 2011, p.17). Case studies can be used to explain, describe or explore a phenomenon in natural settings (Yin, 2009) where 'the researcher does not attempt to manipulate the phenomenon of interest' (Patton, 2001, p.39). Case study design is a widely used approach across fields of sociology, psychology and political science thus making it suitable for application in food policy research (Yin, 2013).

As with qualitative approaches, case study approaches have been criticised for lacking in objectivity and rigour, however, they are ideal when studying a phenomenon in real-life context and when the researcher has little control over events. It enables insight into how, why and what is happening and seeing things holistically in order to give depth and breadth of understanding, though case studies enable more depth than breadth (Yin, 2003, p.2; Thomas, 2011, p.23, 37). Other approaches such as experiments may leave out important details, of which case studies can bring out, particularly with participant perspectives (Stake, 1995; Tellis, 1997; Crowe et al, 2011). For this research, different perspectives are valuable with an interpretivist approach, and perspectives of participants such as LCFAs themselves have been lacking in the literature. Furthermore, objectivity is not necessarily possible nor desirable when it comes to ethnography (Reeves et al, 2008).

The case study methodology includes: designing the case study, conducting the case study, analysing the case study evidence and developing conclusions and recommendations (Yin, 2013). Case study design can be either single-case or multiple-case studies. The design frame was first mapped out as multiple, parallel case studies. Multiple case studies can increase the degree of reliability. The choice of three case studies rather than one was based on the desire to view different interpretations to programmes. This enables extracting of key themes and to

see the bigger picture, rather than specifics to achieve more generalisable results to contribute to the research field (Gray, 2014, p.18). There is no optimal number of case studies to conduct, but this number was decided upon due to identifying three exemplar programmes that were long established, felt to be 'information-rich' and manageable within a time frame (Devers and Frankel, 2000). Within qualitative research, in Creswell's (2011) view, it is typical to study a few cases as sample size only needs to be small to contribute to evidence. Upon further reflection, the case study design was refined to be a single-case study of LCFA programmes with three 'subcases' or 'nested case studies' within the overall case due to the significance of the wider context of programmes within Ontario. The nested cases receive their wholeness from the wider case (Thomas, 2011).

As Thomas (2011, p.14) points out, a case study cannot just be descriptive, it requires an analysis. For this thesis, the analytical frame is provided by the comparison of LCFA programmes and their role in food and health policy. Importantly, programmes are being compared to one another within a broader context of LCFA programmes. It is helpful to have both descriptive and analytical phases of case studies and to first look at individual cases then the cases collectively to provide a comparison (Crowe et al, 2011). In efforts to present the data adequately without being repetitive, the findings are laid out individually but combined in the findings chapters. A limitation of the case study approach is that case studies are dependent on the completeness of information. Explanatory design allows for internal validity (credibility of findings) (Thomas, 2017). By drawing on several sources of data within each case and by having more than one case, this has increased the credibility that can be applied to the wider findings.

Flyvbjerg (2006) notes several misunderstandings about case studies. One such misunderstanding is that 'theoretical (context-independent) knowledge is more valuable than concrete, practical (context-dependent) knowledge' yet key to advancing learning and understanding any phenomenon is real-life context (and context specifics of LHA/LCFA programmes have been lacking in the literature). Though secondary, Flyvberg argues case study research is of value for researchers themselves, in their own skill development. From a personal perspective, this research has enabled a deeper theoretical and practical understanding of case study design. The traditional view of case studies has been that they can only be of value if linked to an hypothesis, as otherwise they can be 'uncontrollable' (Dogan and Pelassy, 1990, p.121). This too is a problematic view, as social inquiry thrives on context-dependent knowledge, for which case studies are well positioned, and predictive theories do not work well when studying humans. This uncontrollable aspect though is

important to note, that the volume of data generated within case studies can be challenging to manage (Crowe et al, 2011). This volume was experienced particularly with interviews and thus boundaries were imposed (see Binding the Case).

Generalisability

Case studies are contextual, and may allow for internal validity more so than external validity (generalisability of findings) (Fulop et al, 2001, p.10). Generalisability is desirable to advance science but is not always necessary (Flyvberg, 2006; Thomas, 2011). Case studies have not been typically considered useful for generalisability, but this can be dependent on choice of case study and number of cases (Yin, 2009; Crowe et al, 2011). Stake (2005) suggests that understanding the case is more important than the generalisability of findings. Some of the criticisms of case study research can be addressed through the use of a conceptual framework, respondent validation and being transparent about the research process (Miles and Huberman, 1994; Stake, 2005). In this research, respondent validation ie. the researcher checking their interpretations of findings with research participants, was not a step taken (sometimes participants can change their minds or backtrack about what has been said) but there was transparency in that participants were made aware they could have access to the information collected and that findings would be shared with programmes.

The goal of the case study approach is to do 'generalising' and not 'particularising' analysis and being able to draw general conclusions (Yin 2009, p. 15). Yin (2003, pp.31-33) states that 'analytic generalisation' allows for transferability of results in order to contribute to a general theory or argument. Generalisability of interventions such as LCFA programmes can be difficult because of the complexity of the environment and specificity of setting, situation and intervention components. Generalisability too may be limited due to the regional focus of the work, both within Canada and to other countries. The decision to look at three cases means that each will be more limited in detail (in comparison to looking at one case in more detail) but they are all part of a big picture. The generalisability of findings is strengthened by the use of three cases as different examples of programme models but in the same wider setting, with multiple interviews and observations within cases, as well as through relating findings to existing literature (Diefenbach, 2009; Yin, 2009).

Binding the Case

Conducting case studies requires the setting of boundaries and controls to ensure the scope is reasonable and manageable (Stake, 1995; Yin, 2003). Considering the context for which the case is concerned is crucial to establish a true picture (Baxter and Jack, 2008). The case is 'a phenomenon of some sort occurring in a bounded context' (Miles and Huberman, 1994).

Cases have been suggested to be bound: by time and place, time and activity and by definition and context (Miles and Huberman, 1994; Stake, 1995; Creswell, 2011). This includes defining LCFA programmes to include those as connected to Public Health. The research has not looked at different partnering agencies with Public Health but rather at the structure of LCFA programmes and how they operated within the context of Public Health, at a particular point in time. Community agencies were not being studied, rather the programmes themselves and how they were situated were.

Purposeful sampling is commonly used in qualitative research (Devers and Frankel, 2000; Palinkas et al, 2015). Random selection of cases is 'neither necessary, not even preferable' and should be chosen based on relevance to RQs (Eisenhardt, 1989). Selection of cases was deliberate and done so in order to take advantage of their history and learnings (Stake, 1995; Carson et al, 2001). Programmes were chosen based theoretical sampling using the criteria of being long established, exemplar key cases and having some key differences in their structural and operational aspects. Local knowledge of programmes also came into play which helped in the selection process. Only established programmes were selected (programmes that had been running for many years) to gain an understanding of why and how they were sustained and to be more information-rich (Patton, 2002; Thomas, 2011). Sustainability of programmes is a notable issue in the literature and these learnings can be shared with new programmes. Comparing differences of programmes is useful to elicit further meaning and interpretation.

The location has been kept to the one Canadian province of Ontario. Though cases were all in Ontario, they were located within different municipalities and regions. Geographical boundaries for cases chosen had to be set due to the size of the country and individual provinces, as well, due to provincial policy differences (making cross-case comparisons difficult). The inclusion criteria were programmes operating in Ontario and excluded the rest of Canada. The risk of overgeneralisation was decreased by there being geographical differences in programme settings as well as multiple programmes studied, observations and interviews conducted. Qualitative research is labour intensive (Mason, 2010) and there are logistics of doing field work in a country as large as Canada with some contextual differences across provinces. A specific area of Ontario - its most populated region - was the focus, mainly because three established programmes were operating and this was also the area in which I was residing. Ontario too is vast, for example, it can take over 20 hours to get from one end of the province to the other; so from a practical perspective, these boundaries were necessary.

Three models with key distinct differences were studied ie. volunteer versus paid, centralised or decentralised, but were all connected with Public Health and had a healthy eating education

component. Due to the structural differences of programmes, the boundaries on each case were different: Case A was structured as a regional programme, Case B was structured as an overarching provincial programme with 'branches' of programmes in the province and Case C was structured as a municipal programme.

Typology of Case Studies

Case studies have been described differently by different authors. Thomas (2011) has described case studies based on a series of choices that need to be made on: subject, purpose, approach and process. Figure 3.3 outlines how the design of the case study was mapped out.

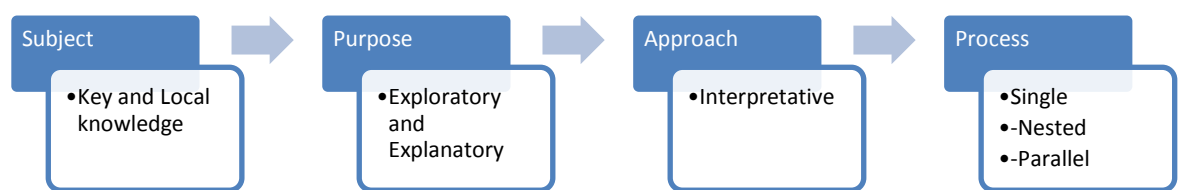


Figure 3.3 Design of Case Studies (source: Thomas, 2011, pp.91-95)

Case studies can be key, outlier or local knowledge according to Thomas (2011 and 2017). The case studies were identified based on scoping exercises and interviews with key informants who had knowledge of the field. Cases chosen were considered key cases as exemplary as they had been established for many years and considered successful programmes. They were also considered local knowledge cases, due to familiarity through work or background scoping exercises. These cases were all chosen because of their distinguishing characteristics, an understanding of which evolved as research progressed.

The purpose of the study was both exploratory and explanatory. The exploratory aspect was planned for phase one, to establish what was happening and why. Exploration is of value when what is known is 'one-dimensional', that is, has only the view of the researcher and knowledge may be limited. The explanatory aspect, the most common purpose of a case study, planned for phase two, enables relating case pieces and providing explanations for interrelationships. However, explanations 'may be limited to the background provided by the case study's circumstances' (Thomas, 2017).

The approach was interpretative and involved starting with a pre-existing direction and focus but being open to new interpretations emerging from the data (Thomas, 2011). This kind of approach is often called ethnographic. Ethnography provides insight into people's

perspectives and the settings. It can typically involve in depth investigation of a small number of cases or just one case (Reeves et al, 2008).

The process could be structured as a single case study or multiple case studies. Studying more than one case is useful in order to gain a broader understanding of the phenomenon (Crowe et al, 2011).

The intention of the study was to compare between cases. A structure of single case study with nested cases enables making comparisons across similarities and differences. One of the important aspects of the study is the comparison and the nature of differences between the programmes. This means that selection has to be on prior knowledge by the researcher of the differences and interpretations being made in the context of this knowledge (Thomas, 2011). The design was a parallel study, carrying out research on the cases simultaneously. The process was planned to involve making contacts, collecting and analysing data all at the same time. There were some differences in the pace at which the process played out across cases. For example, the time to arrange interviews and observations differed with all cases. Case C lagged behind in the data collection stage due to the longer ethics approval process. Thus, the reason for labelling cases as such: Case A field work began quicker, then Case B and Case C was the most delayed.

Though there are different structures to the cases with some differences in the local settings, the wider setting is the same. Because the LCFA programmes under study operated through different Public Health units/centres and were structured differently, it was necessary to have them as three separate cases but embedded in the wider case study (Baxter and Jack, 2008). These aspects made it somewhat more challenging to manage (as compared with only managing one case) but three cases rather than more was still manageable within the time frame, as well as offering enough comparable data.

3.6 Data Collection

In addition to the literature review, preliminary work involved background evaluations and scoping exercises initially in the UK and subsequently in Canada. This work helped to set the groundwork and inform direction of research. Though this research originated several years ago in the UK, the thesis is focused on the research and field work conducted in Canada from 2014 to 2015. Table 3.4 refers to the data collection and analysis schedule.

Table 3.4 Schedule of Data Collection and Analysis

Task	Preparation for data collection -letters of introduction -make key contacts with programmes	Data collection -Conduct interviews and transcribe -Conduct observation and make notes -Review documents -Field notes	Data analysis -conduct interview analysis -collate field notes, interviews, observation and document findings
Time			
June 2014 - September 2014			
October 2014 - June 2015			
July 2015 - December 2015			

In the early stages of development of research topic (2004 - 2006), while based in England, a questionnaire was sent out via the Community Nutrition list-serv in the UK. A scoping pilot exercise and key informant interviews were conducted, this helped to establish the scene in the UK and provide background knowledge and context (at this stage the research was put on hold). Interviews with key contacts (academics and practitioners) were conducted in 2009 and 2010 upon first relocating to Ontario, Canada. This helped to orient in Canada (before taking time off for health reasons). Upon reinstigating the research, a scoping pilot exercise was carried out in order to identify what was happening with programmes in Ontario in 2013. A brief questionnaire was sent out via the Ontario Nutrition Resource Centre list-serv. The questions included areas on the types of programmes, role and function of LCFAs, training and support for them. It was felt that the response rate was low as there were only six responses and it was known that many more programmes were operating in the province. This process helped to establish the scene in Ontario, and to decide on programmes of most potential to explore. Cases identified in Ontario (parallel studies):

1. Case A = Programme A (Regional) - Public Health and community agencies across three cities
2. Case B = Programme B (Provincial) - across Public Health units
3. Case C = Programme C (Municipal) - in one city in one Public Health unit

Preliminary scoping exercises helped inform this research which was proposed to be carried out in two stages. Three phases of field work were anticipated and planned for:

Phase one- arms length programme managers/coordinators (strategic) and observation

Phase two- front line, those more involved operationally ie. LCFAs

Phase three - elite interviews: policy key informants removed from programmes (outsiders)

The first stage was intended as scoping interviews and overt, participant observation (exploratory) with a second stage of key informant interviews (explanatory). In practice, the two stages merged due to logistical and access considerations. Access to key informants and programme observation did not work in the logical order planned through the varying response rates of key contacts, scheduling and availability. Consequently, though the process for data collection was intended as three phases, phase one and phase two access occurred simultaneously. Though contacts with all organisations were successful for the first two phases, this was not the case with the third phase.

There were efforts made to contact elite key informants, those who were policy advisors within the Ontario ministries of Health and Long Term Care (OMHLTC) and Agriculture Food and Rural Affairs (OMAFRA) as both of these ministries have played an historical role to various degrees in the different programmes over the years. Though some success with initial contact was made, those respondents were unfamiliar with the programmes and unwilling to be interviewed due to this unfamiliarity. With some attempts to redirect to potential interviewees, these too were unsuccessful. This experience coincided with comments made by Respondent B, who suggested that it would be highly unlikely to reach anyone with success due to these programmes being low on their radar and priorities, as well as 'just being a researcher.' This experience was a useful insight into how programmes seem to be little known and valued by government.

Type of Data Collection

The range of methods considered for data collection included: interviews, focus groups, questionnaires, observation, documents, surveys, and focus groups.

Interviews and focus groups are the most common methods for qualitative data collection. Interviews aim to collect views and experiences of individual participants whereas focus groups aim to use 'group dynamics' to generate data (Gill et al, 2008). While focus groups may elicit deep discussion on the topic, they may prevent people from sharing their true beliefs and views, only allow for one or a few people to dominate their views or have individual views influenced by others. Focus groups may thus be more difficult to manage due to the group dynamics (Gill et al, 2008). Focus groups were not included in the study due to the desire for all participants to be comfortable with speaking freely with the objective to get individual views wherever possible (Rabiee, 2004). A further challenge is being able to set a mutually compatible time - the more participants in the focus group, the more difficult this would be although over-recruiting could be a way to get around it. In studying programmes for this research, focus groups would be most useful for programme participants, however, they were

not included in this study design due the type of data wanting to be captured (and including observation allowed for participant exposure).

Questionnaires and surveys were not utilised for this research, though a set of questions were prepared for interviews as well as an observation checklist to guide and be intentional with the scope of the field work, but without being too rigorous as questionnaires and surveys can be. The choice of methods were such to enable the field work to be conducted with some direction and flexible and open enough for learning.

Observation was a chosen research method as the researcher can immerse themselves into the field surroundings to increase contextual understanding of cases studied. Different types of observation were considered. Observation can be covert or overt, the researcher being hidden or revealed, to participants being researched. Covert observation has an advantage of not influencing behaviours of participants who are more likely to act more naturally than if they are aware of someone studying them or in any way influencing 'the flow of events' (Flick, 2002, p.137). It can be challenging as a researcher to gain access, but in some settings this is possible. There are also ethical considerations and being transparent to participants of programmes being researched was preferable. The opportunities for observation were such that it would be clear I was coming in as an outsider but in some instances where programme delivery was taking place, it could have been possible to join as a new participant. However, my identity would only have been unknown to the programme participants, and not the LCFA or managers or supervisors of the programmes, as part of the process of getting in to do the research was contacting and connecting with and interviewing people at this level.

Observation may also be participant or non-participant. Non-participant observation means being as invisible as possible and not actively getting involved in the activity or setting whereas participant observation allows the researcher to fully immerse in the setting and/or activity. Here the researcher may very well influence the behaviour of others (Yin, 2013). Participant observation is useful to gain more understanding of interactions of participants, and in directly engaging with them and can be more insightful for the researcher's learnings.

Further considerations going into the research field are gender (Flick, 2002, p.138-141). As a female, the settings were all non-threatening, with many of the participants being interviewed and in settings being observed being mostly female. This may have increased the comfort and trust factor for participants in some of these settings and likely made overt, participant observation easier. It is also important in observation for researchers to conduct themselves in non-threatening and respectful ways. Observation was intentionally planned for after the management/supervisor interview stage in order to first build trust and rapport at this level,

essential in qualitative research (Attia and Edge, 2017). Developing trust with all participants in the process is the first step; getting people to let one in as an outsider cannot be assumed and must often be negotiated throughout the process (Stake, 1995; Bailey, 2006).

Data collection processes are often criticised for their selection not being systematic or objective (Mays and Pope, 2000). Challenges while collecting data can 'seriously threaten the dependability' and efforts must be made to minimise errors that may occur at any stage of the field work process to increase 'trustworthiness' of the study (Easton et al, 2000). Negotiating access to sites and subjects from which to collect data can be a challenging stage (Bailey, 2006). This was not experienced to be challenging with this study, as initial contacts were interested in the research and willing to take part. It did however take some time for identification of interviewees within cases. Conducting different case studies alongside each other presented some challenges. This meant contact with different organisations and key contacts all at the same time, and developing trust and relationships across multiple organisations, as well as adhering to separate research approval processes. Data collection first required obtaining ethical approval and contacting organisations with letters of introduction via email to explain the purpose of the research including developing participant information sheets, consent forms and interview questionnaires.

Ethnography typically involves incorporating participant interviews, observation and documentary data (Reeves et al, 2008). Data collection was qualitative with the use of multiple techniques to strengthen the study: interviews, observation and document review.

Triangulation of Data and Quality

Necessary conditions to ensuring quality, according to Yin, for designing case studies are: construct validity, internal validity, external validity and reliability (Yin, 2003, pp.33-39). Thomas (2011) has argued validity and reliability as not so important for case study design. But there remains differing views in this area in general for qualitative research. For example, Golafshani (2003) conceptualises validity and reliability as 'trustworthiness, rigour and quality.' Triangulation of data, the use of multiple sources of evidence, is important for reliability and validity (Golafshani, 2003). In particular, triangulation helps to ensure construct validity of data and that research findings are accurate (Fulop et al, 2001, p.11; Yin, 2013). Triangulation allows for balancing out any weaknesses of different sources of data and minimising researcher bias (Gray, 2014, p.37). Bias can occur through documents collected (author bias), in interviews (questions asked, respondent bias) and in observation (researcher's presence influencing participant behaviour) (Yin, 2013). Efforts were made to control this by being

aware of bias and recognising these potential issues, and through collection of multiple sources of data.

A collation of methods was used for data collection: observation, interviews and document review to corroborate findings (Yin, 2009). This enabled viewing of the data from ‘different angles and vantage points’ for greater understanding (Thomas, 2011). One of the drawbacks to collecting from multiple sources of data is the ability to manage it. There are databases to help with the organisation of these sources but a disadvantage is that it can detach the researcher somewhat from the data (Baxter and Jack, 2008) – this was not desirable, as staying connected with the data was key. Reliability was enhanced by following a study protocol and the maintenance of a chain of evidence through documentation of the research from initial RQ to conclusion (Yin, 2013). This chain of evidence involved making best attempts to adhere work to RQs and keeping research notes, interview transcripts and observation records together throughout the data collection stage. Reliability, that is, how repeatable the study is, may be not even be suited to interpretative research due to ‘positionality’ affecting interpretation of findings. Interpretative researchers work from knowing the world is complex, collecting data and making interpretations along the way (Thomas, 2017).

Field work for the three case studies included key informant interviews and observation.

Researcher thoughts were documented across the three separate programmes. A summary of the field work conducted is found in Table 3.5. Table 3.6 details coded data collection.

Table 3.5 Field Work Summary

Programme A (Case A)	Programme B (Case B)	Programme C (Case C)
Interviews -Programme Coordinator (one) -Managers/Supervisors (three) -LCFAs (three) Observation -steering group meeting (one) -programme delivery (four)	Interviews -Provincial Coordinator (one) -Local Programme Coordinators (three) -LCFAs (three) Observation -programme delivery (two) + community display and activity (one)	Interviews -Programme Manager (one) -Programme Supervisors (two) -LCFAs (three) Observation -programme delivery (three) + educational training for LCFAs (one) and LCFA meeting (one)

Table 3.6 Coded Data Collection

Case A	Case B	Case C
Interviews: Programme coordinators (past and present): -Respondents Aa and Ab Site Supervisors (Executive Directors in partner agencies): -Respondents A1a, A2a, A3 Site coordinator and previous LCFA –Respondent A2b LCFAs: -Respondents A1b, A4, A5, A6 Including a peer worker - - Respondent A1c Documents (reports were not in public domain): -Report 1A -Report 2A -Report 3A -Website A Observation: -Programme delivery Observation 1A, 2A, 3A, 4A -Steering group - Observation 5A	Interviews: (past) Provincial coordinator: -Respondent B Local Programme Coordinators: -Respondents B1, B2a and B2b, B3 LCFAs: -Respondents B4a, B5, B6 Including an outreach worker - -Respondent B4b Documents (reports were not in public domain): -Report 1B -Report 2B -Report 3B -Website B (access for LCFAs and programme staff only) -Website document (Document B) Observation: -Programme delivery Observation 1B, 2B -Community activity and display Observation 3B	Interviews: Programme Manager -Respondent C Programme Supervisors: -Respondents C1 and C2 LCFAs: -Respondents C3, C4, C5 Documents: -Website C (Public Health unit) -Report 1C (accessible to public) -Document 1C (logic model) Observation: -Programme delivery Observation 1C, 2C, 3C -Programme meeting Observation 4C -LCFA training day Observation 5C

* some interviews had more than one respondent at the same time as denoted by a, b, c

Interview Techniques

A primary source of data in case studies is the interview (Yin, 2009, p.106). Interviews are favoured for the rich data and insights they generate (but this is not guaranteed). Interviews enable descriptions and interpretations of others, and thus, multiple views and realities (Stake, 1995, p.64).

Interviews can be open-ended/unstructured, semi-structured or structured. The open-ended interview may be of value if little is known about a subject but may be time-consuming and be difficult to manage the process - these types of interviews may go either way - they may generate great depth on a subject or very little depending on the participant (Gill et al, 2008). On the other end of the spectrum are structured interviews, and like questionnaires, they are a set of questions that allow for little to no variation. Though more straightforward to administer, they may not allow for depth and breadth of responses (Gill et al, 2008). The semi-

structured interview provides a balance that allows for some focus but is flexible in being able to explore a research domain (McCammon, 2017). Questions were semi-structured (see interview guide)¹⁸ but without commitment to them allowing for open-ended responses, with some direction (and boundaries) (Thomas, 2011). Interview questions can be considered invasive or sensitive, so as a researcher it is important to be flexible and ask them carefully as well as ensure interviewees understand that they have a choice throughout the interview to refrain from answering questions. Each interview concluded with opportunity for participants to add any further thoughts and with my contact information if there was anything they felt pertinent to add upon further thinking. Although interviewees were keen to speak with me during the scheduled time (and some interviews were quite lengthy due to their willingness to share information), no interviewees contacted me after.

Consideration was given to conducting telephone interviews. An advantage is that the time commitment for the researcher is minimised (due to omitting travel time) and this could have allowed for greater scope for the research area geographically ie. covering northern areas of Ontario. However, the study design was such that capturing context was important, including visiting the programme sites (as well as observation being part of the study design). Face-to-face interviews are more personal and enable the researcher to establish rapport and build relationships, especially important if a researcher is trying to immerse into the environment/setting. This makes having one researcher (rather than multiple researchers) conducting all interviews an advantage (Alvesson, 2003; Ponelis, 2015).

Semi-structured interviews possess some challenges: such as guiding interviewee responses and being able to make decisions on completeness of answers while allowing for interviewees to freely speak. However, an interview guide allows for consistency and comparability of data (Flick, 2002, p.92). Interviewees may be influenced by the interview situation, they may all interpret the same questions differently, may consciously or sub-consciously mislead the interviewer or possess particular bias - interviews extract perspectives and the evidence then is based on perception (Diefenbach, 2009). However, gaining different perspectives from the same questions within and across cases enabled data collection that wasn't just based on one person's views.

20 key informant interviews were conducted face-to-face. Some interviews had more than one interviewee participating at the same time (as denoted by a,b,c in Respondent codes), with a total of 26 individuals contributing to the interviews across programmes. Key

¹⁸ See Appendix B. Questions in interview guide differed somewhat depending on whether key-informant was an LCFA or manager/coordinator in efforts to ensure RQs could be answered.

informants were programme managers, supervisors, coordinators and LCFAs. Programme managers and/or supervisors were identified for interviewing, with the managers/supervisors identifying and recommending LCFAs to interview. Interpretations to interview questions varied with some interviewees providing greater depth to responses. It is also recognised that interviews cannot represent or capture everyone's views and perspectives related to the programmes. The number of interviews was largely decided based on interest and recruitment of interviewees and through efforts to strike a balance between getting enough data and saturation of data, while being cognisant of imposing too much as a researcher (Guest et al, 2006). Views on sample size range from that of only a few to 10-15 as a minimum and maximum number of interviewees to reach saturation. This can depend on the position of participants (Crouch and McKenzie, 2006; Guest et al, 2006; Mason, 2010). In some instances, more than one interviewee was present - with a second person (even third) invited to join the interview by the agency/key informant; though this may have resulted in interviewees influencing each other, this also provided opportunity to confirm, dispute or elaborate on answers. This number of interviews conducted was felt to elicit a variety of views without data becoming too repetitive. Interviews were recorded on a hand-held recorder in order to enable focus on questions and responses, and guide the interview process more effectively. Each interview conducted was between one and three hours. Due to the volume generated from interviews, more weight was given to interviews as a source of data.

The selection of interviewees was guided by key contacts within organisations. This could be part of 'organisational politics' ie. choosing which interviewees would be best suited (those who may make the programme look good) rather than random sampling and as such could give favour to ideologies of those who are more powerful and privileged (Diefenbach, 2009). It was important however to respect organisational procedures as a researcher and to include multiple perspectives of interviewees who were not in high positions organisationally ie. LCFAs; this also included welcoming participants to be more active in the process (by speaking to them ahead of time, working to establish a rapport, keeping interview questions open-ended and acting as a participant in observations) and contribute their thoughts during interviews and programme observations.

Observation

Participant observation is considered a useful form of data collection in qualitative research and has been considered under-utilised (Suzuki et al, 2007). Observation was a chosen method in order to gain insight into the operation of programmes, observe interactions amongst participants and understand the activities taking place. Overt, direct participant

observation was conducted with all cases, informally but methodically, supported with an observation checklist (see Appendix B) (Thomas, 2011, p.165).

A total of 13 programme observations were conducted across programmes including programme delivery in the community, as well as participating in programme meetings where accessible. There were a minimum of 10 participants in each of the groups observed. Time commitment involved one to three hours for each observation in addition to travelling to and from locations from June 2014 to December 2015. Multiple observations were carried out in each programme (case) to increase reliability (Gray, 2014, p.18). The number of observations conducted was based on availability and timing of programme components for observation and balanced with the need to be mindful as a researcher going into environments respectfully without making participants feel overwhelmed or over-researched, or imposing on the operation of programmes. For meeting observations, participants were informed of the main purpose to identify big themes and group interaction. For programme observation, participants were informed of the purpose to understand the operation of programmes and that observations would not be recorded; the programme as a whole was being observed and they were not being observed individually. Requests for all observations were made at management level, which included organisational meetings. These meetings were more challenging to arrange, in part because of timing of research (however, several months were allowed for this process) and manager consideration for relevance of meeting. This did result in participating in a training day and programme meeting for the LCFAs with Case C and a steering meeting with Case A. Due to programmes being structured differently, meeting types looked different at strategic level and were not always possible ie. there were different programmes with Case B but central meetings were rare (these had been diminished) and training days for LCFAs were only once every two years. Observations were all different and some were more participatory than others for example, attending a steering group meeting was more discussion -based and strategic level (with some input from myself) and others were more practical such as joining a community kitchen or nutrition education workshop with programme participants.

Observations of programme delivery were chosen by the managers/supervisors based on activities going on at the time of field work and the request to gain exposure to the scope of work. They were also selected by managers/supervisors who first communicated with the relevant LCFAs and then connected myself with each LCFA for further communication where relevant. This involved initial correspondence via email or telephone between myself and the LCFA to introduce purpose of the research and observation, and arranging observation while

establishing consent with participants ahead of time. Personal introductions were then made to the group with the provision of information on the research. Observations were focused on the group context including interactions among the groups. Observations were not recorded; notes were not taken nor were programme participants asked questions – this was at the direct request of the research and ethics committee for one of the programmes (Case C) and another organisation's ethics committee wanting to be non-invasive due to participant vulnerability (Case A); as a result, this process was followed for all observation for the sake of consistency. An observation checklist that was used for Case A and B was slightly modified in order to satisfy Case C's research and ethics committee. These were points around participants' reasons for being there and the difference the programme made out of concern that those would be questions being directly posed to participants; this was not the intention, but rather the hope that some of this information may be revealed by participants more organically. Observation is highly valued in ethnography and this restriction did limit the ability to maximise on the use of participant observation as a data collection method. It was still considered a primary source of data collection. Following the observations, notes were documented utilising the checklist as a guide and adding researcher thoughts.

Document Review

Document review enables looking at data historically and to understand details and context more fully. Programme documents were requested to support the field work process. Documents were reviewed in an organised yet open manner, to support and corroborate interview and observation findings (Stake, 1995, p.68). Document review was considered in order to triangulate findings. Documents included available reports, evaluations, policy papers, websites and newsletters for programmes. These documents are listed in Tables 3.7, 3.8 and 3.9. Due to the nature of studying three different programmes, efforts were made to keep the data collected consistent but to do so for documents was challenging as there was great variation in availability and type of documents. Some documents were more historical such as programme reports and others were more current such as websites but all sources allowed for greater contextual understanding of programmes. Most documents for programmes were not available through the public domain. Some information was collected via the programme or Public Health unit websites, with the majority of programme reports included as documents being only obtainable through the main programme contacts or for example, being given a login and password to access documents on the website as with Case B. Of note, some internal reports and evaluations were not made available for reference to the researcher upon request, although aspects of the reports were shared by interviewees.

Documentation and Field Notes

Field notes were kept throughout the field work process to document thoughts, ideas and reflections for consideration upon the analysis stage (Watt, 2007; Thomas, 2011, p.164).

Recording interviews was an enormous advantage so to enable being present in the process, making notes only of thoughts and ideas (rather than focusing on writing word for word what was said). As well, upon completion of interviews, further notes were made that included attention to any questions and researcher bias. Notes for observation were only made after the observation itself, however, this was done immediately after in order to retain all that was observed and be accurate with notes on insights. Tables 3.7, 3.8 and 3.9 show overviews of Case A, B and C field work details.

Table 3.7 Overview Chart of Case A and Field Work

CASE A (Programme A)	Interviews	Observation	Supplemental Documents
Regional Public Health Unit programme	Current and past programme coordinator --Respondents Aa and Ab Site Supervisors (Executive Directors in partner agencies): -Respondents A1a, A2a, A3 Site coordinator and previous LCFA – Respondent A2b LCFAs: -Respondents A1b, A4, A5, A6 + peer worker A1c Total interviews - seven Total respondents - 11 (some interviews had more than one respondent being interviewed at the same time, as denoted by a,b,c)	One steering group meeting (with LCFAs, programme coordinator and agency partners) -Observation 5A Four workshops/ community kitchens (programme delivery in community from agencies) -Observation 1A, 2A, 3A, 4A Total observations - five	1990 original programme report (Report 1A) 2004 programme report (Report 2A) 2004 programme report (Report 3A) 2014 programme annual summary (Report 4A) Website (Website A)

*Case A = overarching programme based with the Public Health unit and in community agencies

Table 3.8 Overview Chart of Case B and Field Work

CASE B (Programme B)	Interviews	Observation	Supplemental Documents
Ontario, provincial-wide programme	Provincial programme coordinator (previous) - Respondent B Coordinators (supervisors) of local programmes: -Respondents B1, B2a and B2b, B3 LCFAs: -Respondents B4a, B5, B6 One outreach worker - Respondent B4b Total interviews - seven Total respondents - nine (some interviews had more than one respondent being interviewed at the same time, as denoted by a and b)	Two workshops/ presentations (LCFA delivery in the community with seniors' community housing groups) Observation 1B, 2B + one display and activity (nutrition education at a community seniors' centre) Observation 3B Total observations - three	Website (Website B) Website document (Document B) 1994 Programme Evaluation Report (Report 1B) 1997 Programme Evaluation Report (Report 2B) 2011 Programme Evaluation Report (Report 3B)

*Case B = overarching programme B (provincial-wide) and local programmes in Public Health units

Table 3.9 Overview Chart of Case C and Field Work

CASE C (Programme C)	Interviews	Observation	Supplemental Documents
Municipal, city-wide programme	Programme Manager -Respondent C Programme Supervisors - Respondents C1, C2 Three LCFAs - Respondents C3,C4,C5 Total interviews - six Total respondents - six	Two workshops + one support site (LCFA programme delivery in the community) -Observation 1C, 2C, 3C One LCFA team meeting with programme supervisor C2 (regarding programme policies and practices) -Observation 4C One LCFA 'education' day with programme dietitians (ongoing training for LCFAs) -Observation 5C Total observations - five	Public Health website, programme information (Website C) 2006 Programme Evaluation Report (Report 1C) Programme Logic Model (Document 1C)

3.7 Data Analysis

In general, the analysis of qualitative research is a known challenge. Challenges can occur in managing the volume of data generated from the qualitative process, streamlining themes and generalisation. The analytic process was guided by the data in an inductive manner, as opposed to a pre-established theory allowing for emerging patterns (Flick, 2002, p.46; Thomas, 2011). Thematic analysis (Braun and Clarke, 2006) was used as a flexible overarching approach, the process being widely interpreted and thus favourable for qualitative researchers to extract meaning from data (Javadi and Zarea, 2016). Data from interviews, observation and documents was 'converged in the analysis process rather than handled individually' (Baxter and Jack, 2008).

Interview Analysis

The steps for Thematic Analysis were incorporated for interviews and included: transcribing data, generating initial codes, establishing and refining themes and selecting extracts to support. The transcription stage of interviews generated between three pages (1400 words) and 17 pages (7700 words) per interview. Once transcribed, the NVivo 10 qualitative analysis tool was used to analyse the data. This generated 485 pages of coded data from interviews and memos, with 43 nodes. Though NVivo is a valuable tool in qualitative analysis, particularly with organising large amounts of interview data into themes as well as when there are multiple researchers working on a project, it was utilised as a support tool in helping with this stage. Themes were developed in the analysis through the RQs connecting to answers and comments generated by respondents, observations, documents and through the researcher's own assessment of theme as important (Rabiee, 2004; Javadi and Zarea, 2016). As Braun and Clarke (2006) note, only allowing for themes to 'emerge from data' assumes a passive role and 'denies the active role the researcher plays in identifying patterns/themes.' Themes identified through the interview analysis stage were checked against themes highlighted in research notes, observation notes and available documents. This was done within and across cases to elicit recurring themes as well as keeping separate notes of findings that didn't fit with the rest of the data (to utilise for contrast). Previous experience of NVivo (background work) involved utilising the tool to merge nodes. This time around, the process was done manually in part due to this step felt to be unnecessary; the manual process allowed for more fluidity and time for thinking to evolve (beyond the moment of time where coding was done) as well as building in notes, observations and documents. Findings for each case study were analysed first then compared across cases based on RQs with quotations to illustrate themes. In 2017, raw data was reviewed again for further insights and analysis. The discussion continues answering the

RQs with an interpretation of findings and contrast and comparison of cases. Table 3.10 outlines the process of thematic analysis.

Table 3.10 Process of Thematic Analysis

Phase	Researcher steps
Familiarisation of the data:	Author was the only researcher in the study and carried out all the field work Interviews were transcribed – listening to audio recording while author transcribed Notes were made for observations Documents were read through All raw data were reviewed again to re-engage in data collected and searching for meanings and patterns
Generating initial coding:	Three projects (Case A, Case B, Case C) were set up within NVivo Coding of interviews was carried out utilising NVivo tool All transcribed interviews were coded for as many potential codes and themes as possible
Establishing themes:	Overarching themes guided focus, further themes were created based on emergence and interest from the data All interview data was assigned to a theme or node, some sections multiple times Themes were pulled out through observation notes and documents Patterns were looked for in the data related to RQs
Reviewing themes:	Memos were created linked to projects and nodes around thoughts emerging in the process Some codes formed themes, some codes merged and others were discarded (done so manually) Themes were read to see if they made sense, and fit with an overall story
Refining themes:	Themes were first established using NVivo with interview data, NVivo nodes and memos were exported for writing up Overall themes were extracted from nodes generated The second stage occurred during writing up and refining themes from findings, cross-checking of themes from interviews with notes, observations and documents Scope and content of themes were applied to discussion based on RQs
Producing the report/ Writing up:	This process involved merging observation notes and document review notes (done manually as opposed to utilising NVivo) and interviews Findings were written up (many nodes informed headings) with selection of extracts from interviews and documents Discussion was written up utilising and refining themes generated

Source: adapted from Braun and Clarke (2006)

Policy Analysis

Incorporating a policy analysis framework, as discussed earlier¹⁹, enables casting a wider lens on findings. The Health Policy Triangle (Walt and Gilson, 1994) was used as an organising framework to support explanation of findings through the interrelationships of actors, context, content and processes involved in LCFA programmes. This has been particularly useful for LCFA programmes because of their connection with addressing policy priorities. The Multiple Streams Framework was then applied to further illuminate programmes through a policy lens (Kingdon, 1995 and 2010). This was the chosen framework due to recent heightened political attention to food and public health policy issues in Canada; it allows for an analysis framed through problem, policy and politics as related to LCFA programmes.

3.8 Ethics, Access and Informed Consent

This study received approval from City, University of London Research Ethics Committee. In addition, each programme or case had a different process for research approval within their organisations. The university's approval was sufficient for access to Case B. Case A required additional communication with their research committee. A secondary ethics approval process was required for carrying out research specifically within the Public Health unit as featured in Case C. This involved completing an application form as a researcher, the manager of the programme then completing a 'managerial assessment of relevance and feasibility' and submitting a proposal to be reviewed by the Public Health unit's internal research and evaluation committee, as well as providing a letter from the university stating ethical approval had been granted for the study. For Case C approval, the process in entirety took six months, due to submission of the application requiring the manager to sign-off on, proposals and communications back and forth with the committee. This committee specifically requested that participants in the observation were not asked questions directly, nor could notes be taken in the observation. However, permission was given to fully participate and engage with participants in programme delivery. This experience is not unlike what other researchers who have been put through this process have shared and is similar to other experience of working with this Public Health unit. This knowledge was partially a reason for omitting programme participants from being interviewed as part of the research (as this aspect was unlikely to get approved by this committee).

All three programmes identified for inclusion in the research expressed interest in participating at managerial level. For inclusion were decision-makers/policy-makers, programme managers

¹⁹ Theories of Policy Analysis, including those chosen, are discussed in Section 2.5.

and coordinators, LCFAs and group programme participants. Exclusion criteria were those without involvement specifically in these programmes and policy areas. Consent for access to programmes was first established with programme managers and subsequent interviewees. All participants provided verbal and signed informed consent to take part in the research.²⁰

Organisations for case studies and participants of observations and interviews were informed about confidentiality and that no identifiable information would be used that was attributable to them as individuals or programmes; programmes were only identifiable as Case A, Case B and Case C; as such, they were anonymous. Assurance was given that participation was voluntary and participants could choose how much they were comfortable with sharing, and this would have no negative bearing on them and any aspect of the programme with which they were involved; they were also made aware that they may withdraw from the research study at any time. For interviews, efforts were made to ensure that any questions asked did not overlap with any existing evaluation, research or information already accessible. Data throughout the project has been kept in a secure place, to be destroyed upon completion of the project.

3.9 Researcher Bias and Reflexivity

Researcher bias can be both positive and negative. Subjectivity inevitably occurs because of a researcher's own experiences and closeness to the research (Diefenbach, 2009). A great deal of personal work experience has shaped this research. Experience was both as insider and outsider, and collaboratively working on public health programmes (being part of Public Health and part of community agencies). While recognising there is both conscious and unconscious bias, efforts were made to mitigate researcher bias by being objective and aware of preconceived values, emotions and opinions and working to separate these thoughts while being present in the research process. Keeping research notes that included thoughts throughout the process helped to recognise and exercise some control over prejudices and subjectivities which was even more necessary due to personal experience of programmes.

Researcher reflexivity is considered essential since the researcher is the primary instrument for data collection and analysis (Stake, 2005; Reeves et al, 2008). 'Writing notes to one's self permits researchers to discover things in their heads that they did not know were there' (Watt, 2007). Being part of many discussions (and debates) around a range of LHA roles, though not formally part of the research, has shaped my thought process. This has meant working hard to consciously challenge my own views and experiences. Could I be objective and be

²⁰ See Appendix B for study information and consent forms for participants.

dispassionate about this research? While this is important to let the findings speak for themselves rather than influence them or omit findings that may skew the results and impact the credibility of the research, having a personal connection or interest in the research shapes it. It is thus important to be transparent as to researcher background, as presented in the beginning of the thesis (Section 1.1).

'A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions.' (Malterud, 2001)

As well, I had partnership work experience with one of the programmes studied (Case C); this meant familiarity with the programme's operation, however, none of the interviewees knew me (I did not interview those with whom I had worked) nor did any of the participants in the observations know me. Comparison of cases and across a number of interviews and observations helped to lessen any bias at this stage. Setting aside preconceptions is important (Mays and Pope, 2000) but preconceptions should be distinguished from bias, 'unless the researcher fails to mention them' (Malterud, 2001).

Researchers must be mindful of the impact of the social setting in which the research takes place. This includes: researcher background, experience, gender, age, nationality, class and/or social status (Alvesson, 2003). There may be a power differential (perceived or real) between the researcher and researched (Mruck and Breuer, 2003). This was felt in some interviews and observations, whereby some participants perceived me to have more power, however, in a positive way in that there were high expectations on the results of the research project creating change. For example, that I would be able to secure more funding for the programmes. The physical setting in which the research takes place can also have an impact (Alvesson, 2003). All research conducted was on participants' terrain, such as in interviewees' offices or in programme spaces. As such, this was an environment where they could feel more comfortable and in some way gave them more power. While there may be no known physical risks as all the research settings planned were in low-risk environments, it was necessary to remain vigilant and aware. I was not present with participants without at least one other staff member on the programme and other staff on site. The research activity was not expected to create any additional risks to participants except for the physical and social presence of the researcher. Even though observational research is considered relatively non-invasive, remaining aware that there can be some effect over the group dynamics just by being present: self-consciousness, discomfort, feelings of being judged, threatened or distrust could be felt by the participants and facilitator. There may be cultural or social sensitivity and emotional risks

to the participants. Having experience working with low-income, multi-ethnic, multi-racial communities and running programmes sensitively with an awareness of the possible conflicts people may have was an advantage. Efforts were made to safeguard participants' well-being in the observations as well as consideration as to how myself as a researcher would be experienced such as with the division of poverty and privilege ie. researcher may be perceived as exerting power over the researched.

It is understood that a topic such as 'healthy eating' can generate emotional feelings, responses and stresses for people. Participants of these programmes are generally already motivated through their voluntary participation in these programmes to learn and make healthy changes. The setting was in a group environment, participants commonly amongst others with some element of shared background and experiences where there was social support. The environments these programmes take place in are intended to be comfortable and non-threatening. The interactions were observed within the confines of group meetings and programme delivery with a group of participants, and therefore not deeply personal. All field work was conducted with adults.

Language or terminology used by the researcher is also a necessary consideration (Alvesson, 2003). Having some awareness of the participants ahead of time helps. It was known that many of the LCFAs in certain programmes would have English as a second language and/or may not have lived in Canada for a long time. And understanding of terminology can differ significantly amongst people. This was found with interviews, however, efforts were made to simplify and explain or expand in interviews as well as leaving opportunity for interviewees to share their thoughts and views, and interpretation, without being restricted.

3.10 Summary

The theoretical perspective taken to this research was that of an interpretivist lens incorporating an inductive research approach seeking to answer the RQs. A single, nested case study approach was used as the research methodology: a cross-sectional, cross-comparison of three cases comprised of three programme models. Multiple sources of data collection provided a triangulation of methods: key informant interviews, overt participant observation and document review. Policy analysis was by way of the Health Policy Triangle to organise findings within a policy framework and Multiple Streams Framework to provide a deeper policy analysis. The following chapters will present findings based on context, mechanism and outcomes of programmes before applying the analysis framework and themes generated in discussion.

PART THREE - FINDINGS

The findings of the research are presented by considering each RQ in turn (Chapter Four, Five and Six) and presenting Cases A, B and C simultaneously in order to contrast and compare programme models. Findings are reported in a converged manner through interviews with LCFA programme managers, supervisors, coordinators and LCFAs themselves; through field notes from observations at strategic and operational level and programme (available) documents. Tables 3.7, 3.8 and 3.9 refer to the specific data collected through each case in Chapter Three.

Chapter Four. The Context for Different Programme Models

4.1 Introduction and Overview of Programmes

This chapter sets out to answer RQ1: What contributes to programme function at strategic level; why and how are they sustained and what are their challenges? Due to the literature pointing to limited attention to the context in which lay helping occurs, chapter headings are laid out to answer contextual questions and the reality of programmes at strategic level. Findings in this chapter are primarily reported through interviews and documents. This chapter mostly features data from interviewees who were managers, supervisors and coordinators of programmes. The introduction includes some background to Cases A, B and C.

Case A was a regional Public Health unit programme with shared ownership amongst community agencies and was based within a regional Public Health unit in Ontario comprised of three municipalities. There were two streams to Case A's 'peer' programme: one stream of the programme focused on child and family health, the other on food and nutrition. The two roles are distinguished by: 1) a peer worker focusing on programmes that support parents in the health and development of their children and 2) a peer worker focusing on programmes to help people learn more about healthy eating, planning and cooking healthy meals (Website A). The focus of the research is specifically on the latter peer worker, the LCFA; however, there were some overlaps due to the interconnecting of roles, training and support of workers. Respondent Aa pointed out that over the years, the two roles had 'merged somewhat so there were a lot of similarities.' This will be distinguished when referring to peer workers in general (encompassing both roles) and referring to LCFAs specifically.

Case B was a programme recognised and labelled provincially, operating throughout several participating Public Health units in Ontario. This case differs from Case A and C in that there

was one overarching provincial-wide programme, but was functioning as individual local programmes or ‘branches’ within different Public Health units throughout the province. Programme B was first piloted in three communities in Ontario with different Public Health units rolling out the programme over the years. There were multiple programmes running throughout the province, in 2014, there were reported to be programmes in 14 areas of Ontario (Website B). Thus, there are two programme components: the provincial level (overarching coordination) and the operation in multiple Public Health units (local coordination).

Case C originated as part of the provincial network of Programme B model delivering the programme and then branched off to become its own separate model at municipal level. Programme C was a city-wide programme, based within a municipal Public Health unit in Ontario covering a large urban area. This was different from Case A and B in that it only covered one city.

4.2 Programme Actors

This section describes the key players of programmes within the boundaries set. Programme models ranged from having actors at provincial to local level. Table 4.1 refers to key players across programmes. This is mostly reported by respondents as well as identified through documents and observations. Here it can be seen that many players are the same across cases, however, there are some differences. Notably, there was higher level government involvement in Programme B.

Table 4.1 Key players on LCFA programmes

Programme	Actors and description of roles
Case A	- Regional Public Health to fund and coordinate the overall programme, provide initial training, ongoing training and networking for the peers (Respondent Aa) - Ontario Ministry of Health and Long Term Care (OMHLTC) funding Public Health units and driving the OPHS (Respondent Aa) - Community organisations/ neighbourhood associations: recruit, hire and supervise LCFAs and promote and run the peer-led programmes in the community (organisations with boards, directors, multiple programmes), and provide internal training and professional development (Respondents Aa, A1a, A2a, A3) - LCFAs - ‘peer workers’ plan, promote, facilitate and evaluate local community programming for participants (Respondent Aa) - other community partners provide referrals, outreach, collaboration on programming or space (ie. Social Services, Ontario Early Years Centres, YMCA settlement services) (Respondent Aa) - Municipalities providing various levels of support (Respondent Aa) - community members/ programme participants

Case B	• Ontario Ministry of Food and Rural Affairs (OMAFRA) had been a key player over the years, originally as the sponsoring agency (Report 1B) • Ontario Ministry of Health and Long Term Care (OMHLTC) funding Public Health units, funding the LCFA programme for some time, and driving the OPHS (Respondents B, B1) • Ontario Public Health Association (OPHA) housing the resource materials for the programme (funded by OMHLTC) (Respondent B) • A provincial steering committee - had been formed early on to oversee the development and implementation of the programme (Report 1B) • various community organisations, schools, churches - partnerships in the community were valued (Respondent B1, B2a, B3) • local coordinators in Public Health Units • LCFAs - programme planning and delivery • community members/ programme participants
Case C	• Ontario Ministry of Health and Long Term Care (OMHLTC) (funder of health unit and driver of OPHS) (Respondent C) • municipal government (Respondents C, C1) • Public Health unit - as the employer of LCFAs and as holder of the programme (Respondent C) • Internal partnerships: multiple inter-programming connections/ integrated work eg. Canada Prenatal Nutrition Program (CPNP), early years, healthy babies, preschool speech and language - working with all those programmes to make sure 'clients' were referred where needed and were not waiting long for services (Respondents C, C1, C2) • Community agencies (External partnerships) - for partnerships to deliver programme in the community, to do more, be more effective, to cost-share components of the programme and outreach to participants ie. community health centres, schools, churches (anywhere as long as there was space and a kitchen) (Respondents C1, C2, C3, C5) • LCFAs - programme planning and delivery • community members/ programme participants

Respondents across programmes expressed the importance of multiple players, partnerships and collaboration (both internal and external), as these comments from two respondents show:

'well, we make referrals and make connections so if we have a mum who needs to go to a shelter or special needs children we can do this through our partners etc.' (Respondent A2)

'without the community partners, we can't do anything because this is how the programme was designed - for the cost-sharing purpose and to get community members, this collaboration is so important' (Respondent C3)

This collaboration aspect looked different across programmes. Case A was a partnership model at strategic level (community agencies actively sharing resources and participating in processes); this was observed through attending the steering group consisting of the Public Health programme coordinator as well as community agencies (supervisors and LCFAs) actively

involved in discussions and decision making (Observation 5A). Examples were given around internal collaboration such as with Case C, that collaborating with internal departments such as chronic disease and injury prevention, which had food skills programming and that the LCFA programme should align with their policies and procedures and possibly provide training together. And they were trying to 'figure those things out' (Respondent C1).

'So I am on a workgroup - it is called the food portfolio workgroup and we just finished, it was a series of seven meetings and an external consultant was hired to lead us through the process and we were working with the food strategy group and we started out by looking at food systems. Where are the organisation's programmes from a food systems perspective and how within the organisation with our food programming specifically, looking at the food system map from growing it to throwing it, where we fit all of our programmes. Where can we collaborate with the organisation? ...this is the food portfolio workgroup. So the purpose of it is to find those collaborations. So for instance, there is healthy corner stores which is not under early years but we might run a program close to one of these corner stores and we are providing fruit and veg from Food Share, but instead of that, why not (and we did this way back when) give a voucher for or to give culturally specific fruits and veg in the food box. They would say I want plantains and bring them in from a small community grocery store and they would bring it in and put it in bags and give it out. And clients prefer that over the Food Share box which was you get what you get. Whereas LCFAs would call up and say we want guava etc, and they loved it. And by working with the corner store, they would have the power to purchase some of those foods they knew the clientele would want. So there is a collaboration there that could happen. We are trying to get that across the organisation, from the community health officer and food inspector, so all the different lenses – everybody.' (Respondent C2)

And respondents expressed there was potential to collaborate more.

'We may have had a larger group of partners when the previous coordinator was here because she had more time to connect with them and developing those strong links. We do have connections with some groups we provide services for, so the seniors centres we have placements with regularly. We did some work with the family health team they were doing some cooking classes and LCFAs were helping but that sort of has fizzled out, some of the neighbourhood groups we were hoping to provide more ongoing support for them but that hasn't exactly panned out the way I had hoped. There is definitely key players in the community we connect with so we can continue to be involved.' (Respondent B3)

Respondent B pointed out that beyond the programme, there had to be multiple players, as a programme like this could 'not do it all.' This was reiterated by Respondent B2b, stating the programme 'could not play the only role', with complementary programmes helping to address broader issues. There were similar comments by respondents in Case A and Case C.

Respondents were consistent in their views around the importance of collaboration and partnerships. This was seen clearly in observations as these were all based in different

agencies and community environments ie. in-kind space being provided, different agencies recruiting participants; all requiring multiple actors and some level of collaboration.

4.3 Food and Health Policy Drivers

This section introduces the rationale and policy context to programmes and describes their involvement. The inception of programmes, as reported through respondents, was driven by the community (Case A), by the provincial government (Case B) or the Public Health unit (Case C).

Programme A began in 1988, identified as a need for 'supportive and collaborative programming' (Respondent Aa).

'Community groups came to us and said 'we know the community and their needs' – teaching them to cook and learning in that context, and involving Public Health as a partner in that...then Public Health got into it with the feeling that this is an extension of how Public Health does our work and it's our mandate – reaching people we can't.' (Respondent Aa)

'The originator of the programme was need – a need for programmes that targeted practical, hands on every day issues that the people we were serving were dealing with and a need for opportunities for leadership.' (Respondent A3)

Respondents (supervisors and LCFA) reported a need for practical knowledge and skills development, and learning within the community, social and economic context as well as community-building (Respondents A1a, A2a, A3, A5). This was a fit at a time when the government was promoting 'community-based health care and health promotion work that factored in socio-economic status and tailored programming for low-income populations' (Report A1). Though the cost-effectiveness was cautioned in an early evaluation (Report A2), the programme was considered a cost-effective way to increase capacity (Respondent A1a).

'It has kind of started out as having a peer worker who can outreach to the community and build on community, help them out of isolation, do food safety and healthier eating for them and their families.' (Respondent A1a)

'The programme began as a way to get people together in a group, when they come and cook together and take home the food - it bonds them. And then they come back for other programmes that we do - parenting, child programmes, we do a multitude of things. It's a really good fit for the beginning, especially if you have people who are a little bit shy, the whole idea is to get people who are isolated to come in and parent together, and that is a really good beginning.' (Respondent A2a)

So, Programme A was seen as a way to get families in the community into agencies and start accessing their different programmes as a way to address need.

By contrast, Programme B originated in 1991, driven by provincial government as a way to 'fill gaps created by fiscal cut-backs, dismantling of services and subsequent unmet consumer wants' (Report 2B). The programme was a way of having a 'lay/peer model that promoted food and healthy eating in communities.' It was reported that this had a lot to do with the ministry (OMAFRA) recognising that food skills weren't being taught as much in schools and that little was happening in communities, while at the same time discontinuing home economists who were previously in every community advising on cooking, food budgeting and finances. Over time, many communities had shifted from having home economists, to dietitians to LCFAs delivering many of the front-line services (Respondents B, B2b).

'so this model was very appealing because you could have the Public Health professionals involved in doing the training and have volunteers trained to deliver the programme which is a really good way in extending the programme out to the communities because they had a gap there in terms of resource support' (Respondent B)

'I think it has changed over the years and it depends at which point of time you are looking at...along the way, every kind of trend and agenda, LCFAs have often been recognised as an opportunity, a vehicle to help implement goals and objectives...so it has been tailored a bit over time because of this...I think here we have stayed very true to the original.' (Respondent B2b)

'the dietitians used to do a lot of programming - supermarket safari, training, newspaper articles, front-line programming and tried to really engage with community, a phone line to call in and ask questions ...but a few years ago strategic direction shifted to focus more on policy, advocacy and built environment... we no longer do that kind of front-line stuff, so there's a gap for providing front-line nutrition services...so the LCFA programme kind of fills the gaps...the other thing is the public continues to show immense interest in food and nutrition...we would like to continue to offer that kind of services' (Respondent B1)

So, Programme B essentially was a way to meet community and organisational needs filling service gaps and interests primarily around nutrition, food skills and food safety, coinciding with a shift in dietitian roles to focus more on policy work. Respondent B remarked that they were looking at getting more food literacy into the community and it was felt that policy needed to focus more on food literacy, be more comprehensive and this needed to touch on other areas such as mandatory cooking programmes in schools, food and beverage policies (some already in place, such as in schools) and the Ontario Food and Nutrition Strategy.

Programme C was reported to fit as a non-traditional way of doing programming in order to reflect the high number of people from different countries and the variety of languages spoken; the idea being that services were delivered in the languages by the 'peer'. This rationale was based on traditional programmes (programmes delivered in English and/or by a health professional) not meeting the needs of those who were new to the country and/or marginalised (Respondent C).

'this was a way to move on from the traditional programme (Programme B) that they had before...this was a way to be a peer, someone who has the cultural background, the language, they understood' (Respondent C2)

'They can understand the community but at the same time they can understand the Canadian way. A way to move on from the traditional English programme (B) and the newcomers don't feel comfortable, don't speak the language, don't understand.'
(Respondent C3)

Report 1C referred to reports and census data for the city between 1996 and 2000, the results of which drove the creation of the programme. The main highlights were the existence of 'under-served, high needs communities' that were not accessing existing Public Health programmes. As well, the need for supportive child development and parenting programming was reported.

'So we had at the time, the LCFA programme (Case B model) which was meant to be a peer to peer, so there was the concept of peer to peer and we were also going through amalgamation at the time (six former cities becoming one) and services were either being levelled up or levelled down or looked at and some carried on for some time but basically we were looking at our services as a city and a couple of people - a manager and a consultant applied for funding for this with the idea that the services were delivered in the languages by the peer...So the idea is that if you are new to the country or if you are marginalised in any way, traditional programmes or things that are online around feeding kids in books or traditional workshops or classes, may not work for you.' (Respondent C)

Programme C evolved into more of a multicultural peer model to reach diverse communities, and became core for the Public Health unit (Respondent C). It is notable that Respondent C stated the concept of 'peer to peer' existed before it evolved into the multicultural programme. However, Respondent C2 commented that when it changed, it was at this point that the programme 'evolved into more of a peer model.'

Programme policy drivers were reported by respondents to range from global to national to provincial to local. Some commonalities and differences can be seen below:

- *Ottawa Charter* (Respondents Aa, Ab, B, B1, B3)
- *Canada's Food Guide to Healthy Eating* (Respondents Aa, A4, A5, A6, B, B1, B2b, B3, B4a, C2)
- *Ontario Public Health Standards (OPHS)* (Respondents Aa, B, B1, B2b, B3, C, C1, C2)
- *Healthy Weights, Active Living – 'in light of attention to obesity'* (Respondent Aa)
- *Local Food Act* (Respondents B, B1, B3)
- *Ontario Food and Nutrition Strategy* (Respondents B, B1)
- *Eat Right Ontario* (Respondents A4, A5, A6)
- *City policy – 'healthy city for all'* (Respondents C, C1, C2, C3)
- *Health equity* (Respondents C, C2)

The Ottawa Charter was not mentioned by respondents of Case C and Canada's Food Guide, as core guidance to support messaging, was reported mostly by respondents of Programmes A and B.

'I think here we have stayed very true to the original and I often say that the core content of the programme has continued to be related to Canada's food guide which I think has always anchored us. It's kept us grounded in terms of content and messages we are trying to promote. So the issue would be getting the basic information around healthy eating and food safety to our public.' (Respondent B2b)

'the fact that there is a food guide and nutrition labelling shows the government does care' (Respondent B4a)

Respondents across all programmes pointed to the Ontario Public Health Standards (OPHS) as the main policy driver, some pointing to food skills and others elaborating on the programme meeting more components of the standards.

'There are a number of OPHS the programme applies to, which the Public Health unit is accountable to.' (Respondent Aa)

'OPHS mandate that we have to provide food skills opportunities for vulnerable populations' (Respondent B1)

'yes, it's the food skills piece, the standards around food skills - it's the direct service and because so much of our work has been pulled back from that direct service they are the one component who are doing those food skills' (Respondent B3)

'OPHS is the main one, most of the funding and support comes from OPHS' (Respondent C2)

Respondent B2b reported how the provincial government's interest in food was not continuous.

'the original concept was under OMAFRA, but you know, food and government, comes off and on, but they originated the programme' (Respondent B2b)

A recent policy driver had been the Local Food Act and OMAFRA wanting to make sure that any programmes they were funding were following the directives of the Local Food Act (Respondent B).

'So I think the government priorities are shifting toward health and wellness, healthy food systems, more local foods, healthy economy. You know the time is right, for food literacy to be the top of the agenda. So, if anything, this programme should be blossoming.' (Respondent B)

Respondent C3 pointed to the multi-factorial aspect of a healthy city.

'Healthy city means everything - clothing, housing, shelter, food, access to doctors, mental health, it is so much wider...it is hard...we can do little things, if we can change one person's life, we have done a good job.' (Respondent C3)

Organisational strategic plans were cited as drivers of programmes: to support child health (under early years, Healthy Families directorate) and more recently around food and how they 'could do it better' (Respondents C, C1).

'We have to support child health. If you look at policy, it's to champion public health policy. But this is for the Public Health unit, not the city, the city would have their own strategic plan.' (Respondent C2)

In summary, though the rationale for programmes emerged differently: from Case A beginning with the community voicing the need for such a programme to Case B arising through the idea of government to Case C originating as a Case B programme 'branch' to redesigning as its own separate model, programmes were developed in order to meet community need, demand and fill gaps in service. The policy context for programmes was consistent, mostly supported by Canada's Food Guide (HC, 2007a) and the provincial standards (OPHS, 2008).

4.4 Programme Funding

Funding was reported to be necessary for programmes to function and to keep going. It was found to be limited and varied over the years and as an issue to some extent across programmes - whether attached to provincial government or to the Public Health unit.

Programme A had received various levels of funding over the years, which could change somewhat from year to year. Respondent Aa explained the funding was cost-shared with the province through the OPHS structure and region with the health unit deciding how and whether to commit to the programme because it was voluntary. Funding comprised of provincial monies going to the health unit (from OMHLTC), municipal funds contributing to the programme and the community partner organisations.

'Public Health (regional) took over the funding role...then a number of sites asked for money to cover coordination on sites so regional city council chipped in...then Trillium money to reach out to the immigrant community for three years.' (Respondent Aa)

It was noted by the programme coordinator that the policy of how funding gets allocated on provincial level meant most of the funding went towards health care such as hospitals.

'on one level that could be seen as a barrier, or policy working against the programme but we worked around that by framing it in terms that impact on health and that the programme did achieve those health goals, and that was working within this existing policy and funding structure' (Respondent Aa)

It was acknowledged though that it would be less of a barrier if the province provided 'proportionately more funding towards prevention' (Respondent Aa). It was pointed out how invested the community was in Programme A.

'Regional funding means more control - it keeps the balance with us...we have been lucky to be untouched with funding cuts because organisations are so heavily involved....and there would be lots of uproar from the community if there were cuts.'
(Respondent Aa)

Municipal funding looked different for each city (as the programme operated across three cities within a region) although all three cities were part of one Public Health unit.

Municipalities provided core funding to the neighbourhood organisations, 'ad hoc' or 'in kind support', space for groups and the public to access community centres; all considered a 'significant' contribution to support the programme (Respondent Aa). Partner organisations had various sources of funding dependent on their mandate, for example, one agency as an Ontario Early Years Centre had provincial Ministry of Education and United Way funding. One agency pointed to 42 partnering agencies and that Public Health was a main partner. Many of these partnerships were through 'staff resource exchange' (Respondent A2a).

The funding structure for Programme A worked with Public Health getting budgeted every year with contracts and budgets going out to partnering organisations on a yearly basis. At the time of writing, the funding had increased from 100 to 200 hours per year of work for main sites of the partner organisations and 100 hours for their satellite sites. Sites would get money for hours (\$13 per hour), programme expenses and coordination. The continued funding as well as other resources from Public Health was appreciated by the community organisations.

'Public Health has a pot of money that they pass down to agencies or associations each year and we have been fortunate for it to be consistent, it has been wonderful.'
(Respondent A1a)

Respondent A1a said that their association was very supportive and would 'top up' the programme with some extra funds because they saw the value of it and 'think it is such a great programme.' Others were not in that position due to very specific sources of funding.

Respondent A2a acknowledged that they could only have the programme because it was entirely funded by the region (Public Health) and that 'if there wasn't that money, it would have to be volunteer-based.' Programme A had grown over the years with increased partners and resource allocation. It began with 10 peers and at the time of interviews in 2015, had 32 peer workers (Report 3A, Respondent Aa). However, respondents from sites reported the hours were not enough to plan, outreach and deliver programming.

'right now it is 260 for the nutrition position for the whole year, and A gets 75 hours for the mentor piece on top of that and if she saw a full time position for similar work she would be gone in a flash...that's why she works in the other site too' (Respondent A2b)

'yes, there could be more...without additional funding we can't do more, which I think is challenging...so with more funding you could really increase it and get creative with what kind of programme you do...it would be wonderful if the provincial government could see the benefit to the programme and provide some sort of support...because the programme is only 16 hours a week and this includes everything - planning, delivery - and there are 16 sites...it's not a whole lot that the region funds...we don't have another source of funding and have looked for grants but it's hard to get them' (Respondent A1a)

There was also a recognised demand for the programme externally - new community organisations wanting to come on board - but there was not enough funding to be able to 'completely open the programme up' and enable these organisations to participate in the programme (Respondent Aa). The biggest challenge reported by respondents of Case A was the limited funding (Respondents A1, A2, A5, A6).

'At present I don't know of any challenges except budget - we have to stay within our budget...we could do lots of stuff with nutrition but we are capped at so many hours.' (Respondent A2) This was reiterated in Report 4A.

'It's a win-win for the region because they are able to pass that money down to the agency who can pay the \$13 an hour and if you were a nutritionist or dietitian they would be paying these people three times the amount of money...they couldn't afford to put these people in the community agencies to do this.' (Respondent A1a)

'We have lived through budget cuts and changes to funding, players have come and gone because they couldn't sustain...so there was no real reason for us to last but other than we just got the right vision, and I think it still hits a cord for people - they like to be here, they want to be here and part of it is they have relationships here...pretty important.' (Respondent A3)

Though there were some concerns expressed by partner agencies about the continuation of funding (Respondents A1a, A2a), overall, the main source of funding (Public Health) for Programme A was reported to be 'very stable for the organisation (Public Health)' (Respondent Aa) that also allowed flexibility for the programme to adapt. This core source of stability was in contrast to what was found for Programme B.

When Programme B was developed, it was joint-funded by two ministries: OMAFRA and OMHLTC for provincial coordination. From 2001, the programme was coordinated by the Nutrition Resource Centre, at the OPHA. From 2013, the programme was transferred to the OPHA, providing the provincial coordination and administration. Funding for provincial coordination resulted in loss of funding by OMAFRA in 2014 (Respondent B).

'It has become more localised, we don't get any money from the province...there used to be a provincial coordinator so they would supply us with some incentives, training opportunities but all that stopped.' (Respondent B1)

This loss of provincial funding (for the LCFA programmes) translated to health units participating in Programme B no longer receiving any funding for their individual programmes. A big component of this was trainer funding, which included having tools available and money to deliver training. The funding and coordination responsibility then fell on the local programmes and their Public Health units (Respondents B, B2a).

'The OMHLTC funded provincial coordination of the LCFA programme and the contract to do that was awarded to the OPHA through their nutrition resource centre. But the ministry decided three or four years ago that they no longer wanted to fund provincial coordination of programmes. So, NRC still exists but they were told to divest themselves of all the provincial programmes that they had and no one else picked that piece up for a while when temporary funding was provided by another ministry which at the moment has decided to put its funding support on hiatus. So, it's been a very rocky road for the programme provincially for the last three years or so.' (Respondent B2b)

It was reported by some respondents that the withdrawal of ministry support was due to funding and the programme being resource intensive. 'It is a costly programme as well as funding needed to support it' (Respondent B3). Respondent B noted she was putting together some provincial proposals for funding again. Others reported that because the ministry mandate had changed, the programme just didn't fit and it was difficult to get grants (Respondent B2b, B3). Some felt the change of direction was for the ministry to put more into the availability of information for the general public, for example, providing Foodland Ontario recipes in supermarkets (Respondent B5). All respondents voiced frustration with the lack of funding and support.

'they should step up to this...we are under a government system, our group is under the health unit which is a government system and it's all part and parcel, our group only gets so much money and that just trickles down the line' (Respondent B5)

'they (government) should put their money where their mouth is' (Respondent B4a)

'there is a huge funding crisis...the government is working to reduce the deficit so it's a slash and burn budget, no new projects are getting funding, you have to work with what is there...so we have to defend the programme, profile the programme and show outcomes' (Respondent B)

The province, as a key player originally for Programme B, was highly valued, and this being reduced presented the most concern for respondents. However, the cost-effectiveness of the programme model was highlighted (as was in Case A), that the financial impact was less with LCFAs compared with paying dietitians to go out in the community - 'our programme has a positive impact on our financial resources because we are engaging volunteers' (Respondent B2b).

By comparison, Programme C was reported to be well-funded. This was a cost-shared programme, meaning that the funding was part provincial (75% by the OMHLTC) and part municipal (25%). The provincial contribution was based on the municipal contribution, so if the city cut back, then the province would too (Respondent C). Programme C was originally funded through a grant, the Children and Youth Action Committee, which funded it for a couple of years.

'Since there was evidence the programme was working, and we were reaching people, the programme was built into the base funding of the organisation.' (Respondent C)

The budget had grown over the years for the programme, this led to LCFAs moving from part-time to full-time positions as well as an increased number of LCFAs. In 2000, the programme budget of \$400,000 and in 2005 the budget increased to \$1 million, at which point it doubled in size (Respondent C). The funding for the programme was reported to be as stable as it could be.

'In theory any programme can get cut but I don't apply directly to the ministry every three years and then I am not sure whether I will get the funding. That does happen with some programmes. But this is in our base budget so I don't have to apply for funding. But there is always a chance.' (Respondent C)

So, although all programmes had funding to keep going, there were some expressed challenges with the limitations, particularly amongst Programmes A and B. How this limited funding translated to programmes in practice is reported in Section 5.8 and 5.9.

4.5 Theoretical Basis for Programmes

This section explores the theory underpinning programmes. This was mostly revealed through managers, supervisors and coordinators (as this was where the question of programme theory was directed) as well as found in some documents. Overall, health promotion theory was commonly reported across programmes, some reports and respondents detailing different theories and others being less specific.

Respondents Aa and Ab reported that although there was no one specific theoretical model the programme was structured around, it was informed by elements of certain models and theories around health promotion and community development. Empowerment Education, referred to in Report 2A, was most common - that the 'peer workers bring some knowledge and experience of the community to the learning process and are group oriented' (echoed by Respondents A1a, A2b, A3, A6); 'it's education, empowerment, and behaviour change' (Respondent A2b). Report 1A referred to the Food Access Model, 'where some lower income neighbourhoods had a food bank or food cupboard on site' or were referred to elsewhere for

food assistance (Respondent A1a). Respondent A3 heavily praised the community development aspect of programmes.

'So the impetus was a need for programming and a need for opportunities for leadership because my background is community development but my background was in community development before I even knew what community development was... so what I am getting at is programmes that are done for and to people are inevitably going to be short-lived...because they don't run deep enough into the infrastructure of the community...you are just serving it up to people - they can take it or leave it at some point...but if they are invested, if they are involved, their personal growth is engaged in the process of the programme life then what you are really doing is creating community... I realised pretty quickly that that was what we were doing, we were creating community...and keep in mind it's a community supported by yes the larger community, region and so on...' (Respondent A3)

The sustainable livelihoods approach was referred to in Report 3C which was 'underpinned by a commitment to poverty eradication.'

'you could even map it to an organisation, but the bigger impact when we modelled it were the clients of outreach workers on an individual level, because they could come and say I don't have anything - give me food, clothes, but this is flipping it back and saying, 'look, you have x, y and z' so to not just focus on the financial piece you need social connections, personal skill development, opportunity and that kind of thing... so this kind of flipped the mindset - the concept is shared, so ok 'I have five friends', x amount of things' (Respondent Ab)

Respondent Ab pointed out that at certain points of the programme this model was tried in order to measure the impact of poverty prevention 'how to empower, build skills, how to build assets' while focusing on people's strengths rather than weaknesses.

The overarching programme model of Case B was underpinned by health promotion, with an emphasis on education and learning within a peer, social context. Other specific models emerged in Case B, with a few respondents readily able to give details (Respondent B1 was referring to her own notes at the time of interview). The comments reflect some diversity in responses.

- *'Adult learning theory' – 'a lot of times you are teaching to adults and looking at it as 'what's in it for me, why is this relevant? so we understand that'* (Respondent B2a)
- *'Social Learning Theory' - 'LCFAs facilitate learning through modelling of healthy eating behaviours'* (Respondent B1)
- *'Stages of Change' - 'programme assumes people will progress through a series of changes: first knowledge then attitude, then skills acquisition, then its application'* (Respondent B1)
- *'Peer Education' - 'why not have them do it but keep us involved for the quality assurance, for the multiplying effect' (Respondent B2b); training the peers and then they train the community'* (Respondent B1)
- *'Behavioural Change Theory' - pre-contemplation, contemplation, motivation, to change...educating and hopefully empowering'* (Respondent B2b)

- *'Health Promotion' - with a comprehensive strategy - every piece of it matters, developing personal skills, building community capacity... 'it is on that health promotion model of engaging your population so that you are more sure that what you are doing is based on need, so that it has the right impact' (Respondent B2b)*

Health promotion theory was reported to underpin Case C, this came up again and again by respondents (Respondents C, C1, C2, C3) and in Report 1C.

'all of health promotion - start with healthy pregnancy, healthy birth weight, don't smoke, don't drink - all aspects of health - physical, mental, a good support system, doctor access, all of these things that can be a barrier to a healthy city' (Respondent C3)

And within health promotion, education and empowerment models were stated to underpin the programme, with some contrast (Respondents C1, C2).

'We want them as much as possible to do activities and engaging. We know with adult education principles it's 'do'. They will learn by doing something as opposed to be talked at.' (Respondent C1)

'Yes, health promotion. Even the title that they are given - it used to have 'assistant' in it, and now that has moved to 'educator' because they are educating. So I think the education model is there. I don't think empower so much.' (Respondent C2)

So, consistent across Case A, B and C was health promotion theory and attention to education, empowerment and community development.

4.6 Programme Structure

Each programme was organised differently with how LCFA's sat within these structures.

Programme models ranged from being centralised to decentralised, varied in remuneration and level of autonomy.

Organisationally, the overarching structure of Programme A involved two key features: regional Public Health providing a centralised source of support by way of funding, training and resources ie. staff, materials/ guides for nutrition education and community organisations providing local, neighbourhood context and the vehicle for delivery of the programme in the community. The structure was described as 'decentralised' with 'equality of all partners rather than a hierarchal approach to health' (Respondent Aa, Report A1). The programme, at time of writing, had 13 active partnering community organisations, which could have more than one site. Each organisation had one to six peer workers (a mix of LCFA's and peer health workers) (Respondents Aa and Ab).

Programme A was made up of a steering committee involving the programme coordinator based within the Public Health unit and the community organisations as partners of the

programme. These partners supported and backed the programme and were noted to have been fairly consistent over the years (Respondents Aa, Ab, A3). Supervisors and peer mentors sat on the steering committee. Figure 4.1 illustrates the programme structure of Case A and as related to the field work, with community agencies and the Public Health unit as equal players, and LCFAs connected with both. Though there are more community agency players, the figure shows three as taking part in the interview and observation process.

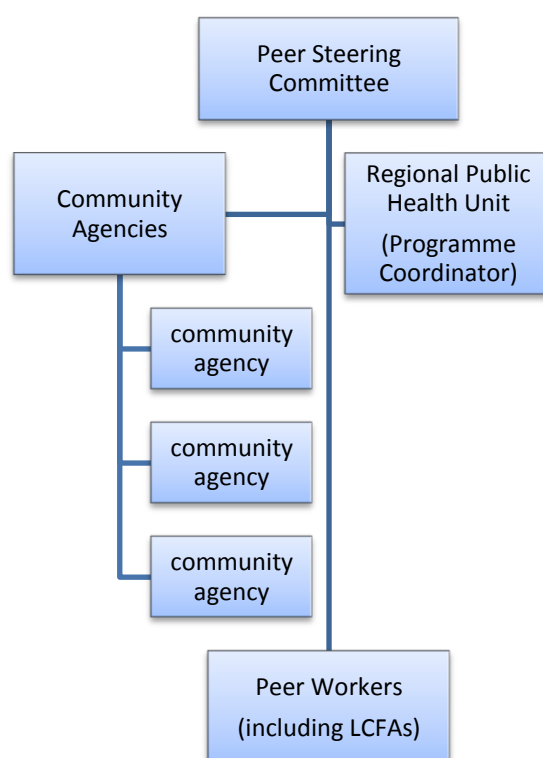


Figure 4.1 Programme A Structure

Programme coordinators (past and present) noted that the decentralised approach was a challenge because it could leave for ‘less consistency’ but this was felt to be a strength in that the approach enabled being responsive and having the ‘trust and connectedness’ with the community. Partnering agencies had broad decision making capacity around strategic and operational aspects of programmes within their agencies (Respondents Aa and Ab). Anyone from the community agencies could be involved with the programme - executive director, supervisors or coordinators. As a steering committee meeting in Programme A was observed (Observation 5C), it was apparent that community partners were engaged in the decision making process. Representation from Public Health was only by way of the programme coordinator, and LCFAs (including those in mentor positions) were represented in addition to managers and supervisors from partner agencies.

The pay structure for Programme A was hourly. Respondent Aa provided a rationale for this.

'they are paid \$13 an hour (minimum wage is \$11) partly because it's people's first job back into the workforce and partly because the organisations don't generally pay well - managers may not be on much more than that so to keep that balance' (Respondent Aa)

Respondent A5 pointed out that because the funding source was limited, it would be tricky to increase pay as this would likely just reduce the number of hours for the peers (including LCFAs).

Programme B had two components to it: a provincial coordination element and a local health unit coordination element. The extent of the provincial coordination piece had varied over the years. At the time of interviews, the provincial coordinator position (Respondent B) had just disappeared and the programme moved to be housed under the OPHA for resources and materials. The provincial coordinator then was temporarily employed as a policy consultant for the OPHA. Figure 4.2 shows the programme structure and specifics as related to the field work (there were three local programme branches included in the research, but there were more branches overall in Case B).

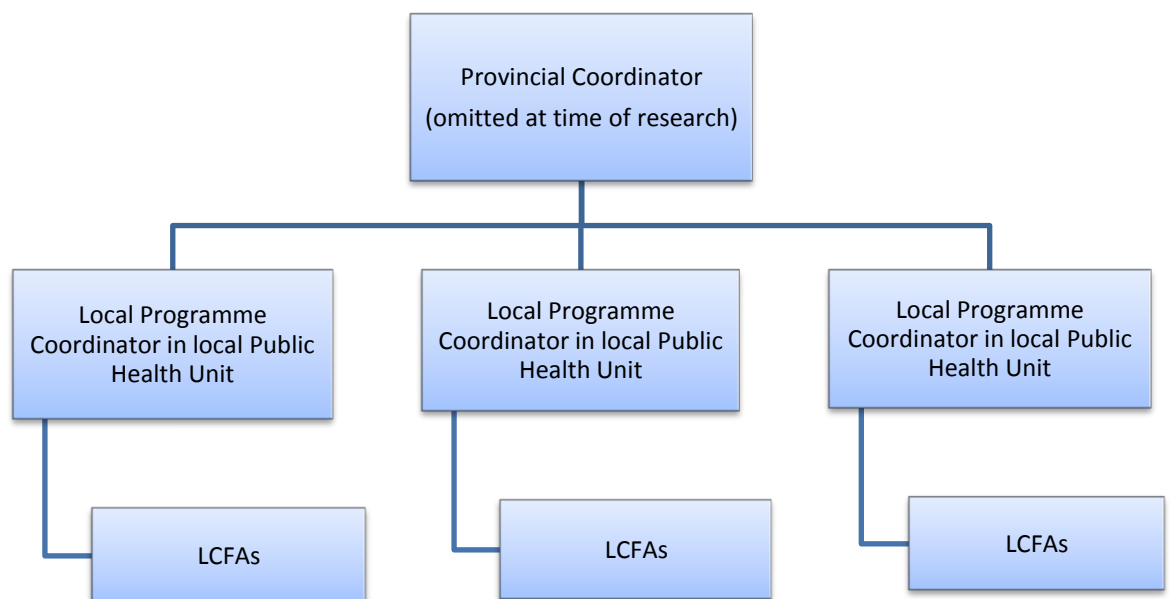


Figure 4.2 Programme B Structure

The programme was in operation throughout the province but was not a mandated programme. Programme B was not under every Public Health unit: out of the 36 health units, there were about 13 health units signed up at the time of interviews. Because Case B was a provincial programme, it had received some attention in the past, such as being profiled in a Health Canada report (HC, 2010) on cooking and food skills which looked at promising

practices in Canada and abroad (Respondent B1). Each Public Health unit was responsible for supervision and support of the LCFAs who were volunteers. Local programmes and the supervisors had some degree of control over the programme (Respondent B).

'it's unfortunate but we do still feel this programme is very much needed in our area and it is up to the local Public Health unit to keep it going' (Respondent B2b)

Provincial coordination provided a level of administration and resources, including 'shared training, learnings and programme materials' (Respondent B). This was reported as an important support piece and at the time of interviews, interviewees, including Respondent B, were uncertain what this meant for the programmes since the withdrawal of provincial coordination and ministry involvement. There was a website which remained and was designated to the programme, providing background information and resources for internal programme staff and LCFAs (Website B). However, the centre responsible within the OPHA was 'told to divest themselves of all provincial programmes they had' and since then funding was put on hold (Respondent B). There was some provincial communication of programmes such as teleconferences with coordinators, but this was noted to be limited (Respondent B). Although there remained a connection with local coordinators, LCFAs 'lost the connection' with other LCFAs in other health units; the networking and sharing was deemed valuable (Respondents B3, B6).

The issue of consistency and standardisation, that the programme model was accustomed to through its provincial coordination element, was raised.

'we are still calling ourselves this provincial programme though which is a bit of a quandary... at one point in time it was a provincial programme so if you were going to a programme in one region, it would look exactly the same as in another area because it was the same messages' (Respondent B2b)

'but this is what people know it as and to change its name would be confusing...and I still line up with it...it's just become different across the province' (Respondent B1)

With standardisation being lost, programmes were becoming more diversified. Many respondents reported some degree of concern over this (Respondent B, B1, B2b, B3).

'I already see it as sort of rogue - people are doing things on their own and we are not staying together, we don't know what people are doing, they are using different materials now and I think that is detrimental to the programme if we want to keep it as a standard programme that people know what an LCFA is.' (Respondents B3)

It was also expressed that the programmes had individual differences but the core was the same.

'dealing with individual people, promotion of healthy eating and doing with it 'what is available and food skills around what is available - the concepts and basic stuff is the same across the province' (Respondent B)

Within the Public Health units, which encompassed a main city and surrounding area of towns, LCFA programmes were reported to fit within the chronic disease, injury and prevention division with a mandate of 'helping people stay healthy' (Respondent B2b). Respondents all reported that they were supported by their local Public Health unit, and the programme was valued locally. Public Health involvement was important in providing 'credibility and quality assurance' (Respondent B2b). Respondent B1 commented that their board of health endorsed food strategies and local food programming but that agendas were set locally and continued support for the programmes was dependent on the strategic direction of the Public Health units.

'At this point we are unsure because the programme could be gone like that, in other health units they have stopped the programme...there is a strategic plan every five years, they don't specify which programmes stay so the programme is not protected, it would be sad because we have been supporting this programme since 1996.'
(Respondent B1)

Programme C was a city-wide programme supported both provincially and municipally, operating through the Public Health unit. This programme is distinguished from the others by being completely centralised within one health unit. The programme was operationally split between the east and west end of the city. Figure 4.3 shows an overview of the structure of Programme C.

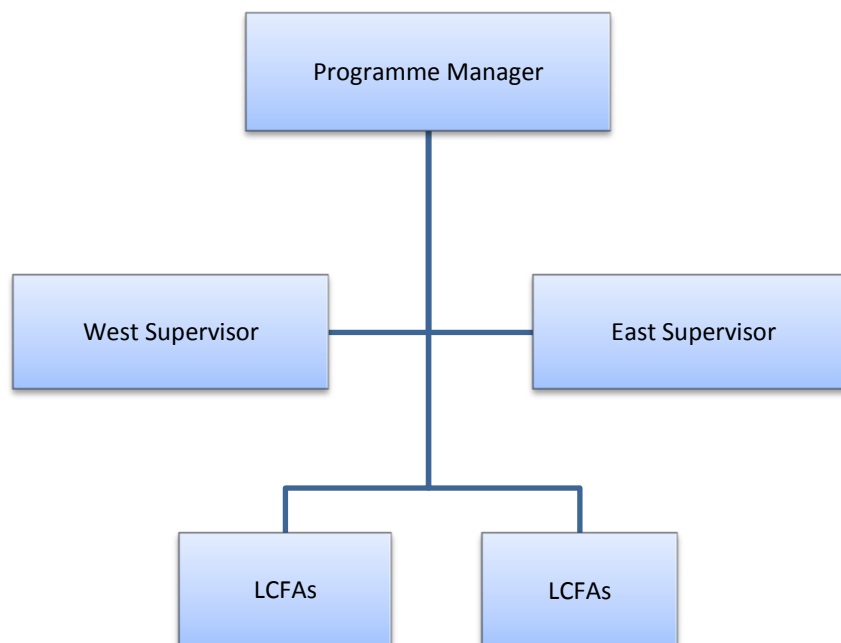


Figure 4.3 **Programme C Structure**

Programme C was based within the Public Health unit's early years stream of healthy families. It was structured with one overall programme manager (Respondent C) who supervised the dietitians, two consultants working on broader programme aspects (supporting research projects, programme logic models, evaluation of programmes and satisfaction of participants), two supervisors who were responsible for supervising LCFAs based on area and support assistants (Respondents C1 and C2). There were a total of 30 positions on the programme (16 full time LCFAs). The programme operated as one, with a team in the east of the city and a team in the west, based at different Public Health offices. This structure had changed following from an internal review in 2011 to be a more 'effective and supportive structure' (although this was not elaborated on, and there was no access to this review) (Respondent C). According to all respondents, Programme C was well supported both at organisation and programme level with full and part time LCFAs.

Programmes were all optional for boards of health and Public Health units to support, with Programmes A and B reporting the most issues. Level of support included how or whether LCFAs were paid. Programme A paid LCFAs hourly, Programme B was a clear volunteer-LCFA model, and LCFAs were part-time or full-time staff. Programme A evolved from peers being given an honorarium to being paid an hourly rate, which had also increased over the years. All respondents from Case A reported that the pay and hours allocated for peer workers were limited; with a set amount provided from Public Health but varying within agencies how this pay structure worked for the peers. Case C LCFAs originally were part-time and with increased funding for the programme, were then made full-time along with the addition of other personnel (Report 1C, Respondent C). Whereas Programmes A and C were structured to pay and evolved to pay LCFAs more as programmes developed, Programme B remained a volunteer model. This is further explored in Sections 4.8 and 5.9.

4.7 Aim and Objectives of Programme

This section is drawn from documents (including websites) and interviews and explores reported aims or goals of programmes and their stated objectives.

Derived from Report 1A, 2A and Website A, Case A's peer programme was described as having one overarching goal of addressing the SDH through a community-based peer model:

- *'to provide people with the knowledge and skills to increase the overall health of themselves, their families, and their communities'*
- *'to build social connections and reduce isolation'*
- *'to promote a healthy, active lifestyle'*
- *'strengthen supports that contribute to the resilience and health of individuals'*
- *'enhance the personal development of peers'*

The objectives specifically for the LCFA stream were described through Report 1A and 2A as:

- *'to increase individual capacity by providing LCFAs and programme participants with knowledge and skills around healthy eating and food skills'*
- *'to prevent and reduce social isolation and social disconnectedness within a community, through group programmes centred around healthy eating'*

Respondent Aa commented that the programme aimed to 'increase the capacity of individuals and communities to improve their health, both physically and socially.' He explained two key changes over time on the programme: the language and how they framed the issues more positively.

'At the beginning it was very much high-risk families and helping them improve food selection, preparation and cooking skills. And as it evolved, the language was more around the SDH and using the Ottawa Charter language a bit more. And more recently with the OPHS dictates around food skills and using that language. And at the beginning the second goal of isolation, talking about decreasing social isolation. As of late, we are less talking about framing that in a negative, saying people are isolated but rather in building social connections and putting that on the positive side - so what are we trying to do rather than what are we trying not to do.' (Respondent Aa)

This was being done with a 'two-pronged approach of increasing skills and knowledge and building supportive social connections' (Respondent Aa).

The goal of Programme B was stated as providing 'reliable information and education that promotes safe and nutritious food selection, preparation and storage practices to consumers in Ontario' (Document B). This overlapped with the programme mission:

'to achieve excellence in local LCFA programme models that improve people's food literacy and food skills through ongoing LCFA training and development of reliable and client-focused information and skill-building opportunities...the health and well-being of Ontarians is improved through easy access to learning opportunities provided by well-trained volunteers in vibrant local LCFA Programmes across Ontario.' (Website B)

Respondent B described the overarching goal of the programme as to 'get people to eat well'.

'And that's why it's really important to have targeted messaging, basic understanding of what the values are of the programme, what kind of messages are we promoting. We try to promote Canada's Food Guide, we try to promote healthy eating, we are trying to promote eating local, eating within a budget - so all of those things are things that are goals...you are looking at the population level - getting people to eat healthier, you are looking at how to create change.' (Respondent B)

'when the LCFA programmes came in, it was a way to meet the valid need - it was awareness raising, a little bit of skill building, the whole food literacy thing - although we probably didn't use that term back in the day' (Respondent B2b)

Specific objectives were reported to be (Report 2B, Respondents B1, B2b, B3):

- *'increased access to credible nutrition education, information and resources'*
- *'increased food skills opportunities'*
- *'increased leadership skills'*
- *'increased coverage and reach'*
- *'increased food-related awareness, skills and behaviour change among consumers/ clients'*
- *'increased partnerships'*

One LCFA commented on the goal being to 're-attach Canadians to the idea of eating food from home' and that 'the idea is clear - good nutrition leads to good health outcomes'

(Respondent B4a).

'Along the way...every kind of trend and agenda LCFAs have often been recognised as an opportunity/ a vehicle to help implement goals and objectives. So it has been tailored a bit over time because of this.' (Respondent B2b)

There were comments on the concept of food literacy rather than food skills: 'food literacy is old but new again' (Respondent B).

'Food literacy includes the knowledge of how to make choices, and why choices matter and the impact of the choices you make - how to grocery shop, how to read a label or how to cook food safely... I have a hard time with the original model of food skills...well you are not going to increase food skills in a one-off...you are going to increase knowledge that may lead to a change in behaviour...but food literacy, yes, because this is much broader and a more comprehensive concept...and I don't know how communities are supposed to do that without a programme like the LCFA.' (Respondent B2b)

Respondent B2b pointed to the localisation of the programme.

'I think it's really important to point out that the original intent was around healthy eating and food safety, there have been a lot of overlays of the programme...and local programmes have customised the programme to their local needs' (Respondent B2b)

So, although the programme was operating throughout the province with consistent aim and objectives, individual programmes were tailored to the different communities they operated. This was seen as positive, but was also concerning as previously stated, without overarching provincial coordination.

Programme C was described as a nutrition education programme for parents and caregivers of children six months to six years of age, 'culturally adapted to the city's diverse population' and offered in many languages (Website C) with a main goal to 'enhance the nutritional status of children six months to six years within the diverse, ethno-cultural communities in the city' (Document 1C). Report 1C covered the main goal but stated multiple 'goals' for the programme, which encompassed objectives:

- *'to enhance the nutritional status of children in diverse communities by improving food selection, purchasing and preparation skills among participating families'*
- *'to deliver multicultural and multilingual healthy eating messages that are appropriate and sensitive to culture, faith and literacy levels'*
- *'to encourage activities that integrate food-related beliefs and practices from diverse cultures into Canadian guidelines for healthy eating'*
- *'to share information with participants about the influence of nutrition on various stages of child development'*
- *'to share information about different stages of development and cultural practices...in a way which is both culturally sensitive and grounded in the most up-to-date research'*
- *'to deal with food insecurity issues by showing participants alternatives to being funnelled into the culture of food banks'*
- *'to provide additional nourishment by offering social supports and building leadership skills among participants from under-served diverse communities so as to increase their participation with society'*

Respondents all pointed to the programme feeding into the broader goal of Public Health, to improve health and 'a healthy city for all.' Nutrition and children in the early years, with the whole family eating healthy, playing a vital role in meeting this goal (Respondents C4, C5).

'if we define what the programme does, it is to look at how we can improve eating habits in families...we know that children don't cook for themselves and we also know that if parents are equipped with the understanding of how healthy eating works, they can make better decisions' (Respondent C5)

Further comments included the goal of decreasing obesity and getting newcomers out (Respondent C). The programme was noted to be continuously changing and growing, reflecting the changing and growing population (Respondent C).

Cross-sharing of different programmes was a shared goal by Respondents Aa, B and C. Whereas Programme A was described as aiming to improve health through strengthening personal and community capacity, Programme B was described as improving health of the population through the provision of information more generalised to the population and that of Programme C was aimed at enhancing children's health but family health in general for specific populations. Opportunities for leadership emerged as objectives in all programmes.

4.8 Recruitment, Training and Retention of LCFAs

This section explores the background of LCFAs, the recruitment strategy, demographics, training and retention of LCFAs.

Case A was frequently referred to as a peer programme, and LCFAs as peers. The 'peers' on the website video described themselves as using their own lived experience to 'support and foster hope and bring different skills and experience to the role' (Website A). Respondents described LCFAs as coming from diverse backgrounds, who may be 'foodies' (love food and cooking) and having leadership qualities. The website video stated that peers are 'one of you'

and though heritage, language or culture may vary, 'we all face similar life issues' (Website A). LCFAs were reported to be mostly past or current programme participants (Respondent Aa and Ab).

'usually it is participants from the group who have been in the group for a while and then want to lead...that's the whole idea of the peer aspect of it, not so much have a professional' (Respondent A5)

Case A's recruitment strategy involved peer 'fit', described as someone who was perceived by the programme participants as 'like them' (Report 1A).

'not a professional: leading to a more effective connection with many people and the ability to reach some people professionals cannot...'
'someone who shares similar life experiences with people with whom they work: may live in the same neighbourhood or community, be similar in age, have the same ethno-cultural background, or face similar challenges as the participants in the programmes' (Report 1A)

'Historically, there have been a number coming through the programme, and I think historically the programme doesn't select people for their experience or education but for their peer-ness: for being a community leader. So a ton of them will come in for their experience, for their education in that field, some come in with lots but a number came in without and grew in their role and moved on.' (Respondent Aa)

Respondent A2a reported that the programme was 'not top-down' and that most of their staff at one time were parents, so the programme came 'from within'. This was typically commented on, due to the recruitment strategy of the programme.

'Some have come through as participants, some have been volunteering at sites, they are linked somehow and they are recommended. For some it has been the first time they have done a training, having sat through training and received a certificate, doing something formal. We only provide training for people for which sites put forward and have said we are going to hire this person. So the sites have already committed to them. The site is more responsible to oversee the peer, we do not get involved in the recruitment piece. They know their target, who they need and then they make those recommendations. It is up to them to decide that peer-ness.' (Respondent Aa)

Training for LCFAs was both initial and ongoing, much of it was for all the peers: LCFAs and peer health workers. The training Public Health provided was described as 'base training' so that peers knew how to plan and promote, get resources and reliable sources of information.

'We provide the training every two years now because we find people are staying longer - training is six and a half days once a week. The training does not make them 'experts' or to do individual counselling but do referrals to Public Health and Eat Right Ontario, Canada's Food Guide, etc.' (Respondent Aa)

Training was provided through Public Health staff - nurses and dietitians with contributions from some external staff, with the existing peers playing a role in the training. There was also additional twice-yearly optional training offered by Public Health. Once a year Public Health

brought together peer workers and site supervisors. Every two years peers were required to participate in mandatory refresher training to ensure everyone was 'on the same page'.

Respondent Aa noted that with the ongoing training piece, because of scheduling and other commitments of peers, they had to have a balance between mandatory and optional training. In the past, peers were paid to do the training but this was no longer the case. Respondent A1b commented that some people were 'just doing the training to get the money' and wouldn't stay for long. Respondent A1a echoed this point, and that those recruited really needed to be a good fit.

'And I think to look at that person and make sure they really reflect the philosophy of the organisation/community centre. Because if they don't it's not going to work.'
(Respondent A1c)

Respondent Aa commented that they looked at providing new training in relation to obesity (through Healthy Weights, Healthy Lives), but that they required more funding to scale it up. LCFAs interviewed reported their commitment to the position, many of whom had been around for many years and some had developed into peer mentor positions. Peers were committed because they really liked what they were doing, had always been interested in food and nutrition, they lived in the community, were invested in it or it fit with their lifestyle (Respondents A1b, A4, A5, A6). It was reported that there had been high attrition with the peers in the first years of the programme. Respondents commented on the reasons for many of the peers having moved on: that the pay and hours were not enough as well as for employment and other opportunities (Respondents A1a, A2a, A3). Retention of peers was a noted issue by some respondents in Report 4A. In the last few years, changes were made to the programme: increased support, wages and hours, incorporated peer mentor matching to see what they could do and peers being able to be at more than one site (Respondent A5). These changes resulted in less frequent turnover of the peers. Prior to these changes, the average peer stayed around two years; this improved to four or five years with some 'positive attrition' ie. peers, including LCFAs moving on to other opportunities. Respondent Aa commented there was a 'good mix of stability (people staying) and leaving.' One respondent commented that 'the community development aspect was more prominent at the beginning of the programme', and though that was an intention of the programme, many peers moved on but did not go into the same type of work, they 'just went out and got other jobs' (Respondent A1a). Respondent Ab acknowledged the pay was 'nothing' but that many peers still stayed a long time because 'it was engaging for them and they were making a difference.' Respondent A2b noted though that there remained a high turnover. She described the position as 'really being a volunteer position, because 'at the end of the day, people have to pay bills.'

'it's so few hours, and the pay, it's just not enough for people...at least now the pay is \$13, and for about 15 years it was \$10...the region gives so much money and some agencies give even less so it's not like something you will stay at for a long time' ... 'the same thing happens with outreach workers, funding comes from the regions to agencies, they can then pay them less than a social worker' (Respondent A1a)

These views around retention, pay and hours were reinforced within a steering committee meeting observation which included a discussion around living wage and comments that this was not necessarily what agencies could provide because even if the hourly rate went up for peer workers (still above minimum wage), there were not enough hours - peers did not work full-time nor did they get benefits, and community organisations were not in positions to make this happen due to budget constraints (Observation 5C).

Some tensions were reported with the notion of peer and the criteria for being a peer worker.

'The one thing I do find is a problem is the whole peer-to- peer part of it, you know, they don't like you cooking with the children...peer-to- peer is not really true to its word anyway ... I don't know if they can achieve the peer- to- peer unless you put the Muslim peer over at that centre and the white middle aged woman at this centre - that is the only way - as people are signing up you go - ok, you are Muslim so you have to go there and you are white, you go here, you are never gonna get that... If you have someone who has these connectors at all different levels, well, they are a peer. It has a lot to do with their policy on what peer- to- peer is. You are either not going to have it or have to cancel your programme, because you are looking at women - my age, same income bracket - that to me is very non-inclusive, and prejudicial... I find it really offensive that I have to make a judgement about who comes into my programme - who I think is poor and who isn't - you could be very wealthy and come to the programme with a tracksuit on with holes. I would have to then make a judgement on whether they have money or not, and that to me is very offensive.' (Respondent A1b)

So, as Respondent A1b drew attention to, it wasn't clear by whom or how 'peer' was being defined. However, this was not raised as a tension by other respondents. Respondents across the board reported that LCFAs should represent the community in some way, be able to make community connections and act as a bridge between the community and Public Health. A previous evaluation recommended that peers not be required to be geographically-based, from the same neighbourhood for example, as this had been found to be challenging in the recruitment (Report A2). Respondent A1a reinforced that being from the community was not considered necessary, but rather the 'peer strengths and skills' were.

For Case B, the recruitment strategy was for volunteer positions. Respondents commented about individuals wanting to become LCFAs for personal and other reasons: to get the training, to go further into the field of food and nutrition or to enhance their resume, as a result of a

health scare, to be part of the community and to get engaged and helping others (Respondent B, B2a, B2b, B5).

'Volunteer engagement is important and key to the success. They have to really want to make a difference and they do. Whatever reasons for wanting to come on board, some because of changing their lifestyle and lost a significant amount of weight, or they have had a health scare and looked into healthy eating. They want to go out and help others.' (Respondent B2b)

Respondents were consistent in the main criteria required for becoming an LCFA: to be passionate about food and cooking, being able to do presentations, to speak with and engage with participants, speaking in front of groups. So though there were no formal education requirements of the LCFA, it was reported that by default, many of those recruited were educated individuals with this experience and honed skills because the role involved presentations (Respondents B1, B3). This was confirmed by those LCFAs interviewed who came from backgrounds of public speaking, home economics and microbiology/food science.

'you can do a certain amount of training but the truth is that it's just easier if someone already comes with that, to train the trainer than it is to train someone who isn't comfortable speaking in front of a group' (Respondent B4a)

Respondent B6 reported how she had a job for 17 years, then became redundant and came into the LCFA position because she already had all the skills and it helped her 'rediscover herself.'

'I was a professional in my field, this was a way I could reach the community in a safe way and fun way and gave me an opportunity to meet people' (Respondent B5)

It was reported that recruitment of LCFAs was through local papers and job websites (Respondent B1) but mostly targeted for existing skills and interests 'rather than just general advertising' - through Toastmasters (public speaking organisation), the retired teachers federation, the local dietitians' group (people interested in food and nutrition and looking for something), food events, and farmers' markets 'looking for foodies' (Respondents B1, B2a).

'we have no way of knowing what are effective methods of recruitment but if you advertise to no one in particular, no one in particular will respond' (Respondent B2a)

Some reported that LCFAs represented all ages, stages and areas, others spoke to the demographics being less diverse, and some stating they were mostly 'students and retirees' (Respondent B1).

'our volunteers are from every area across the region...so we are located here but also have a huge area to cover and the volunteers are from those areas so they are going out speaking to their fellow community members, their neighbours, people they work with' (Respondent B2a)

'(laugh)... It really is white, Canadian women - older it tends to be, I would say it is probably split half and half - half are working and half are retired...now one of our LCFAs has been with us 22 years - she was working and now she is retired. But it is middle class. We have not had success recruiting the more vulnerable populations.' (Respondent B3)

This last comment was confirmed in the observations of Programme B delivery, with LCFAs seen to be middle class and revealed when arrangements were being made to observe (Observations 1B, 2B). One respondent pointed out that this programme was more of a peer 'fit' than other programmes (Respondent B2a).

'we engage in the peer educator programme here as opposed to some of the other programmes you would be looking at that have paid employees because we know that peer education works and we know that peer educators are more relatable than staff would be...having people who are very interested in healthy eating, food safety and are interested in wanting to help people and so we find that works well' (Respondent B2a)

However, Respondent B3 contradicted this idea.

'but when you don't have peers, when it is not a peer going into the group it doesn't carry the same amount of weight because if you have not lived my experience you don't know what I am doing, how can you tell me what to do, how can you help me if you have no idea' (Respondent B3)

'when we do the next training we would like to get into those neighbourhood groups and really target some of the cultures and economic backgrounds because I think they speak more loudly when they go into the groups...I think it carries more weight than your middle class, retired, white, housewife...you know what I mean...they don't necessarily identify with them...so we would like to have a broader range but it's tough to recruit' (Respondent B3)

It was reported to be challenging to fill placements which were often in the daytime.

Respondent B1 expressed that her ideal candidate was retired and/or available during the day, and that next time she recruited she would purposely select those who fit that criteria. This response was echoed by Respondents B2a and that by focusing their recruitment and training in the daytime, 'it sort of self selects people.' One LCFA reinforced this point and stated that she was more available than most of the other LCFAs and was able to fill many of the requests because she was retired (Respondent B5). Respondent B4b remarked that the appeal was to people who were retired because very few people of her age were not working 'so if it is going to be volunteers - where are they going to come from?' The programme began 'when fewer women were in the workforce' and this was reflected in the recruitment of volunteers – being 'less successful in recent years.'

'And they already have that volunteer mentality. So they are not just volunteering as an LCFA, they are volunteering in their church, in other community programmes so that is part of who they are, that's part of the spirit they have is the volunteerism. And that may not be as common perhaps in other cultures coming in because they are just trying to survive, just trying to make it and keep their kids in school and get enough to put food on the table. So the volunteer piece doesn't necessarily fit in or maybe it's not part of their culture.' (Respondent B3)

It was reported that though people might be interested, the level of commitment required was high and it was difficult to get many people because 'they were working or had young families' (Respondent B3). This was reiterated by an LCFA, that this was not just any volunteer role due to the 'level of training, background and professionalism' people were bringing into it.

'and so are we then limiting it to too much of a high calibre rather than lower people who may be able to communicate on a level with the low-income people' (Respondent B5)

Some new models of delivering the services were being explored though there were reported to be 'only a few models and there is no model that's perfect.' This included train the trainer, working with people who were already doing something in the community and training them so they could provide reliable information ie. Early Childhood Educators 'talk about nutrition so getting them trained so it is consistent' and this would expand the scope (Respondent B1). Some neighbourhood groups with vulnerable populations had expressed interest in putting forth people to train as LCFAs, but there were issues with this as the programme was structured.

'if they want to be an LCFA, they have to stay under the auspices of the Public Health unit...so that is something down the road we would have to look at...we do have several neighbourhoods who can then go back and do programming in those neighbourhoods...if they leave our programme they no longer are our volunteers, you can't then be an LCFA, you can't have that title unless you maintain your certification' (Respondent B3)

The benefits of being a volunteer were reported but the role required a lot of work too.

'I think you don't get monetary but you get other kinds of benefits. Just being in the community and being able to help people. This is a rewarding kind of thing and you also can keep up to date with changing trends ie. vegetarian...but there is a lot of work involved. There must be willingness to that. A lot of the presentations are going to be in town and so you might not be putting a lot of mileage in for that, but sometimes you are running around to the grocery store, it is a lot of running around and sometimes you are putting time into going around buying stuff and putting time into preparing for that.' (Respondent B5)

The screening of the LCFAs was noted as important: 'making sure they follow the guidelines of the programme and the coordinator needs to know where they are sitting in terms of values' (Respondent B2b). Candidates underwent an interview and training once successful. LCFAs

were required to complete initial training which was first developed and provided by OMAFRA (Report 1B). This initial training was one year in length. Though it has since been condensed, it was still considered 'intensive' by respondents and costly. The trainers didn't want it to be 'too daunting but at the same time, they wanted to ensure commitment.' It entailed: 10-12 sessions, 30 hours in total covering skills required, how to be effective, answering participant questions, key messaging and food handling. Training was reported to vary, in terms of the focus of each Public Health unit, whether it be presentation skills, demonstration skills or cooking skills (Respondents B, B2b).

Upon completion of the training and two supervised placements, LCFAs became certified (at provincial level specific to this programme). LCFAs were required to maintain certification through Public Health on a yearly basis. This required doing a minimum of three presentations a year and two education days. There were often monthly LCFA meetings with relevant educational updates provided by the local coordinator with LCFAs required to participate in six out of 10 meetings. Training was done by the Public Health units utilising standard provincial training material but since the changes in provincial coordination, training was becoming more localised. Respondent B3 noted they were holding off on the training because of 'all the provincial stuff going on' and some of the policies and procedures that hadn't been 'straightened out here and because of the cost.' Respondents commented that if LCFAs could commit to the training, they were committed because this in itself was a big commitment (Respondents B1, B2a, B3).

Challenges of recruitment and retention of LCFAs were recognised. Respondent B1 acknowledged this straight off 'first, retention and recruitment for the programme is a big challenge, this year I just lost five LCFAs.' Respondent B3 stated that they had trained 18 LCFAs in 2013 and had already 'lost a significant number' of people. Though respondents recognised some issue with retention, they also pointed to long-term and committed volunteers (and it was pointed out that their longest serving LCFA was middle class) (Respondent B3). It had previously been reported that though there was reasonable commitment from the LCFAs, there were also high attrition rates (Reports 1B, 2B). Report 2B suggested a reasonable commitment was two years in total including training and service (at the time when training was one year long). Commitment asked of the LCFAs varied from one to two years for the local programmes and was not something that could be controlled, 'sometimes people are only interested in getting the free training and they end up not staying' (Respondent B1).

'realistically when you start the idea is to commit to two years and not a lot, and then move on to a different position but you basically get sick of doing that and just move on to another volunteer position...a lot of people do it because they like food and they like teaching, and I can see how they feel that after a few years they have learned everything and move on' (Respondent B4a)

Respondent B3 reiterated the commitment to the position was not as good as before, 'there wasn't that same connection', that LCFAs were moving on more quickly in recent years, although some LCFAs had been around for many years, including Respondent B5 who was part of the initial cohort of LCFAs in 1991, so there was some dedication. It was also pointed out that the fact that LCFAs were volunteers, 'you have to respect that people's priorities change' and that money was not always the issue (Respondent B1). Report 1B found that reasons for LCFAs leaving were 'other commitments'.

'this group is one of the oldest, and the numbers are coming down so whoever takes the role now, it is time...not everyone will want to do volunteer training...so even if there was an incentive...it takes time, it is intense, it is a commitment and to retain your credentials, your placements and meetings, it is a lot' (Respondent B6)

For Case C, LCFAs were universally described as peers and purposely not being professional so there would be a greater comfort level and flexibility of knowledge (Respondent C).

'To truly have a peer go out and do it, and that means there are such unique things about them that the programme is designed to support that'...

'We are always trying to match to the community, but it's tough to do, right? So the idea was that we hired people who didn't necessarily have to be a health professional, they are not regulated or anything like that, they are community or lay workers. A lot of them are health professionals in their own country or have quite a bit of education but what we look for is someone who is community oriented, understands how to run groups, group facilitation, someone who speaks the language and/or understands the culture. So, for Aboriginal we might hire someone who has a background and is Aboriginal but languages, we have hired ones who don't speak any of the Aboriginal languages or some who speak some but not all. So the idea is she or he is a peer to that community.' (Respondent C)

LCFAs were not expected to be experts in nutrition or child development for which training was provided. Examples of backgrounds of LCFAs included: nurse, home economist, foreign trained dietitians, social workers, psychologists or mental health workers; one LCFA had a PhD and other candidates for positions recently posted were reported to have Masters degrees. LCFAs who were key informants had backgrounds of a food and nutrition degree in Canada (Respondent C4), one who previously worked as a social worker in Canada (Respondent C5), and a foreign-trained Home Economics teacher (Respondent C6).

Recruitment of LCFAs was based on Statistics Canada reports on the predominant languages and the need identified in the community. It was felt that there was a lot of support needed

for participants, and for this reason respondents thought it was important to ensure the LCFAs reflected the community in order to meet those needs (Respondent C). It was also considered challenging as the hiring process for the organisation was lengthy (Respondent C1, C2). Language for Programme C was considered important, LCFAs were also recruited for their experience and skills in facilitation and healthy eating. It was pointed out that although the latter was not a prerequisite, more and more they were looking for this (Respondent C2). Respondent C2, who began as an LCFA but since became a supervisor, stated that people's background coming into the role made a difference; both supervisors pointed out that they wanted a strong team.

So for me, I never learned English, I came here and the manager looked at my resume - well, she is a dietitian back home, speaks Portuguese and has the experience... this is why I was hired...I think my background was huge. I just came here and got the job...It is something that helps a lot so we do look for. I don't think it is something that was before but has become more and more. So they don't have to have that, but if they do, they will be at an advantage. If I saw someone who has experience they would be more likely to get it. (Respondent C2)

Communication skills were deemed important in their language but in English too, both spoken and written. This was posed as a tension by Respondent C1 but Respondent C2 (both supervisors) did not feel this was a concern.

Recruitment normally consisted of an interview and a food demonstration. The way recruitment of LCFAs was done had been changed over time, although they were not having to do frequent hiring as their retention of LCFAs was considered good. Respondent C1 referred to the hiring process as a 'sore point' because they were finding some inconsistencies around language and that it was crucially important to have the language they (potential LCFAs) were recruited for. A recent change, as part of the hiring process, was to do both English testing and specific language testing internally to ensure candidates had the communication skills required.

'My English was not so good...But now, this is why I say I was lucky. Now they are going to be testing in English and in the language as well. And we do have an LCFA who is Aboriginal and was hired because of that, but she doesn't speak any of the languages. But for her, because she has lived in Canada, the main point is that she knows the community. But now there will be a test... I don't think the language would be a problem. We had a candidate who passed everything, but she didn't pass the English. This means that if you don't have the language, this door that was open for me, would be closed now. I see it as a barrier for some.' (Respondent C2)

LCFAs received regular training, both internally and externally. This was matched to organisational, programme and individual LCFA needs and requirements. For the programme, there were quarterly education days provided by the dietitians - these were both to ensure

knowledge of nutrition and current guidelines were up to date for consistent delivery of messaging, and to focus on practical delivery of the programme such as how to improve facilitation skills with sharing of different LCFA styles, skills and delivery methods (Observation 5C). As well, the 'learning from one another' was an important aspect of these trainings (Respondent C3). Respondent C1 noted that each LCFA on her team had a learning plan, which was a 'mutual plan of what they needed to learn and wanted to learn.'

Retention of LCFAs was reported to be good. The programme had both a core group of LCFAs who had remained from the beginning and those who had moved on to other jobs (Respondent C). It was reported that the programme had lost many languages, that at one point they had LCFAs speaking a total of 33 languages and this was recently reduced to around 15. This had been mostly due to development and moving on, some retiring, some going back to their home country, some getting their formal Canadian dietetic qualifications - for which they were all supported in (Respondent C). And some LCFAs stayed on for many years - Respondent C4 had been in position as an LCFA for almost 15 years. It was commented on that LCFAs stayed on because it was a good position, with benefits and it paid well, as well as the freedom and being able to be in the community (Respondent C2).

Peer was a consistent term describing LCFAs, though this varied in interpretation: having lived experience, life-stage, geographical, cultural or linguistic commonality with some reported tensions. All programmes had challenges and successes with recruitment, training and retention of LCFAs with most LCFAs coming into the role with some level of background experience and skills.

4.9 Outreach and Target Population

This section explores outreach strategies for programmes, including target populations.

Outreach to the community and building on community was reported as key aspects of Programme A. It was also reported to be a challenge.

'So we thought, how do we bring what we've got to neighbourhoods, how do we connect more in areas where they might need programmes...and that's how we deliver programmes now - through the peer programme. We think of the programmes as not a place, it is what we do but it is a way of connecting out there in the community.'
(Respondent A3)

Programme A in general had limited outreach. The Public Health unit played a role in promotion to partners and potential funders, promotion to outreach workers and sharing of knowledge, but would 'not do much media exposure' (Respondent Aa). Community organisations reported doing some outreach such as through their agency flyers, and relying

mostly on word of mouth, partnering agencies, other programmes and community networks as well as via social media.

The target population for Case A was identified as 'low-income and other SDH identified individuals and communities.' This remained universal (open to all) but in targeted neighbourhoods and with priority populations (Respondent Aa), thus translating to being a universal reach (Respondent A2a, A3). Some programmes specifically targeted parents with young children (some programmes being based within early years centres) and families in general (Respondents A1a, A2a).

There was recognition that outreach capabilities could be both strengths and weaknesses of the community organisations and peers themselves (Respondent Aa).

'so the reach would vary within each of the neighbourhoods by partner organisation - one of the benefits of the programme is that it relies on their (peer) existing network and connections but one of the downsides is that it relies on its network and connections...so if they are only reaching this one townhouse complex really well and the rest not really, then that is a downside even though they may be reaching that one group really well' (Respondent Aa)

Respondent Aa reported further challenges with outreach, reflected in Report 4A, in particular, that those most isolated were hardest to reach and peer-community connections were important.

'I was just talking to a peer worker, in one community at one point they had struggled to reach out to the high proportion of Muslim population. They brought in a Muslim peer worker who was from the community, with Trillium funding we had for four years to specifically outreach to newcomer populations. So they were able to build some really good connections and in some ways it became only that community but they were able to work with that - some programmes were mostly from that community and others less so, so they could make that bridging...I was just talking to them last week and they were saying that that connection with that community has really dwindled just through gaps of peer workers coming and going. And so I was talking with a couple of peer workers and how we could do things better with reaching out to newcomer Canadian populations so we can support some of these sites in engaging some of these communities. So in each site it would be different in terms of who they are and who they are not reaching and as these things come up we will get a conversation going about how to do these things better, how do they as individual site organisations or how do we collectively do this. So it would vary with community.' (Respondent Aa)

'And then we realised that you know what, as long as we are defining the need, this thing is not going to last but if we connect with people, I phoned, I visited, I connected with people...and that's what made the difference. And that taught me a lot about who we were serving, who was defining the need, and what it means to be in community with people. Because if you think you are going to serve them, that's not what being in community means. You are in community when you are alongside.' (Respondent A3)

Thus, the importance of being in the community, working with the community and connecting with the community was key to outreach successfully with Programme A.

Increasing coverage and reach was a stated programme objective of Case B. Respondents noted the ability of the programme to extend its outreach to 'much greater than what staff can do on their own' (Respondent B2a). Respondents reported increasing the reach in the community, through information events, booths or local TV food demonstrations (Respondent B1). It was commented on that LCFAs extending the outreach of the work was beneficial 'because it was at the grassroots level' (Respondent B2a).

'it is offered to the population to address a population's needs and interests - so it is public health in that regard...I will add that it (the programme) really engages in a variety of ways. It engages our populations out there who otherwise might think 'oh, it's the ivory tower that exists out there' (Respondent B2b)

Some community tension was reported of working together with other organisations.

'sometimes you go into community centres and they have healthy eating for kids but they are not really doing healthy eating but they don't always want to work with us...they don't really want to involve Public Health, they see us as policing them, they don't really want that...everybody is doing nutrition but that is not always evidence based' (Respondent B1)

Some respondents stated that it was difficult to promote their programme in a way that it was well known, word of mouth being just as important. One LCFA commented that because all of their placements were in response to community requests, they were dependent on those requests being done and they could do it differently.

'we don't do this now but the best way is to go into the community of where they are, go to them instead of them coming to us, because only the brave ones come out, those hard to get are still at home, go where they are concentrated in large numbers, or as close as you can get to them, and go and do something hands on, cook, show them how to do things that fits for them' (Respondent B6)

She also suggested having key contacts from the service provider agencies attending presentations to see what they did, and then they could promote the programme as well as front-line workers to understand the scope and the need. They had a new Public Health kitchen for which they could do this (Respondent B6).

Respondents reported that vulnerable populations were a focus area of the Public Health units and there were generally some challenges when outreaching to areas and pockets of higher need (Respondent B3). There was targeting to groups who really needed the services such as youth, people on low-incomes/ social assistance, those in community housing, those who were using food banks and recent immigrants. Requests for neighbourhood groups were filled as

best they could, and some adjustments were made with training, for example, having a youth engagement health promoter provide training to the LCFAs on how to engage with youth and training on poverty awareness.

'we have done the Bridges out of Poverty for our group for two hours just to give them a bit of a taste about what's it like to not be middle class, why do they do things differently, to get more of an understanding of where they are at and why do they do certain things...we felt that might be helpful but it is hard, people have pre-conceived ideas' (Respondent B3)

These pre-conceived ideas came through with some comments from LCFAs.

'probably the most complicated thing about it is that people who need it most are not using it...will we ever get some obese 24 year old mother of four to come and cook? I don't know...I mean if we can't get her off the couch to exercise...that sounds terrible but you know what I am saying' ...I kind of feel like those are the people who are never going to be reached...but maybe there are ways, maybe through another part of Public Health...because then it can become a bigger part of the picture, instead of just me trying to find someone...we did a cooking class with a bunch of kids last week and they were really into it, but the truth is they may be going home to a house where they may not even sit down for dinner' (Respondent B4a)

'But you see them coming in loaded with the latest gizmos but haven't eaten, either they or pressed for time or there is no food at home which I don't understand. You can buy a loaf of bread for \$1. I don't know what it is, again, lack of knowledge maybe for parents, for their kids to have a nutritious breakfast, you know, a jar of peanut butter. I fail to understand but who am I to judge anything?' (Respondent B6)

Community partnerships were considered key in establishing contact and accessing groups. It was reported that multiple agencies were dealing with the same clientele that could be connected (Respondent B6). It was also reported that it was a more effective and efficient strategy to 'piggy-back on existing groups that people were coming to anyway', rather than advertising to the city about events LCFAs might be doing (Respondent B3). There were mentions of outreach workers recruiting participants, and this was observed (Observations 1B, 2B).

Though there were multiple connections, the programme wasn't as well known as it could be - 'it could be broader, it could be stronger' (Respondent B3). There were also some attempts to link with OMAFRA, by going along to a presentation and sharing some recipes, Respondent B5 reported, 'to make our presence known and draw attention to the programme' despite the fact that OMAFRA was the originator of the programme, it had fallen off the radar.

Programme C was a well known programme in the city and outreach was done through the interconnecting of programmes, referrals coming in from different agencies, through LCFAs

doing outreach in their communities, by way of health fairs, or going into a parenting programme and doing a workshop (Respondent C1, Report 1C).

'it is about feeding kids, and about feeding kids in different communities who may not be reached via traditional methods...so it is about being a service that meets the needs of the community' (Respondent C)

There were different access points to the Programme C. This outreach model was reported to be 'unique' in the organisation and was a way to get people in and connected to Public Health (Respondent C1). When the programme began, the LCFAs spent more time outside promoting the programme, but since it had become established, there was a central number for the organisation that could be called to request the programme, either as a host agency or as a participant. The programme sat within the large body of Public Health and respondents used these resources to the best of their ability for families (Respondent C5). There were also 'gatekeepers' in the community who would get people into the programme, which was considered useful (Respondent C1). Community agencies as partners played a large role in outreaching (Respondent C).

The target population of the programme was parents and caregivers of children six months to six years of age but really this was open from birth, in particular, to emphasise breastfeeding and weaning at the recommended stages. Although the target was not explicitly low-income populations, the programme wasn't being offered in higher income areas because people in more affluent areas could access other programmes (Respondent C, Report 1C).

'So technically everyone or anyone can go and it is not like we are trying to make them feel unwelcome but it's not likely people will travel to a programme where they don't have anything in common with anyone... but we do have to make sure that for those who need the programme, we are offering it in the right place.' (Respondent C)

Respondent C commented on an outreach project they were working on.

'We have a community outreach project underway. Our two nutritionists are looking at this - what are our hard to reach populations, where do we focus because we are not reaching them now. But at the same time, our supervisors are sitting with the LCFAs and talking about outreach with them. So what we are trying to do with the nutritionists is to get them to identify, understand from a higher level who we are missing out on. It's easy when you are an LCFA and you go back to the same community over and over again and you just build on that. My question is what about the few people who don't live in that area. Are there people we are missing we shouldn't be missing? We also know we are a well advertised programme, and people know to come to us and to request us. So there is a lot that comes to us, but the question is do we just keep doing that or do we make sure we are doing more?' (Respondent C)

Providing incentives such as supermarket vouchers, was an effective outreach strategy, though it was thought that some 'didn't need the extra supports, even when they said they did'

(Respondent C3). It was pointed out that LCFAs had 'good reputations in the community', and that word of mouth was most powerful for outreach (Respondents C, C1). Though it was for the city residents, there was interest beyond this (Respondent C2). 'I can tell you when I go anywhere in the city, I see people who are just breaking their necks to come' (Respondent C5).

Some common outreach strategies across programmes were reported to be partnerships, utilising LCFAs' knowledge of communities and piggy-backing on other programmes. Word of mouth was also mentioned as quite powerful. The practical aspect of programme beneficiaries is explored in Section 5.7.

4.10 Summary

Chapter Four explored the context of programmes and has shown the value of RQ1 in revealing commonalities and differences across cases. Cases presented the importance of partners and collaboration, funding and support for programmes at provincial and organisational levels. The aim and objectives of programmes were consistent. There was some tension reported around who the LCFA was and what that meant, with reported advantages and challenges around outreach. Next, Chapter Five explores the mechanism for programme delivery, addressing RQ2.

Chapter Five. The Role of Programmes in the Community

5.1 Introduction

This chapter sets out to answer RQ2: How does programme delivery occur; how do they work to address healthy eating across the socio-economic spectrum? Due to the literature pointing to limited attention to the mechanism in which programmes work, including role and function of LCFAs and beneficiaries; chapter headings are laid out to answer mechanistic questions and the reality of programmes in practice. Findings are reported through interviews, observations and document review. This chapter mostly features data from interviews with LCFAs and observations of programme delivery.

5.2 Role and Function of LCFAs

This section seeks to add some clarity to the role and function of the LCFA, revealing some similarities across programmes as well as some distinct differences as expressed through interviews, found in documents and observed.

The LCFA role in Case A was described on the website as:

'a natural connector who listens to others...to make people's life easier' by: helping to provide opportunities, build healthy relationships, explore leisure activities, learn new skills, share stories and ideas, find ways to meet new people or get back to skills and employment' (Website A)

This notion was reinforced by respondents throughout interviews. 'I think it's about transforming people's lives. I have three main goals: to build skills, build knowledge and build community' (Respondent A5). As well, comfort, trust and relationships were terms used repeatedly by respondents: the importance of this between site supervisors and the peers and most notably, trust between the peers and participants. 'Being responsive to the community is a strength - having trust and connectedness, the trust and relationship is key' (Respondent Ab). The comfort factor was deemed important with food skills in particular, for participants to be open to learning and sharing (Respondents A1b, A2b, A4, A5). Respondent A5 lived in the community and Respondent A6 didn't, however, both pointed to the value of living in the community.

'I don't live in this community but it is the nature of this position to live in the community. That is the ideal. I think there is more opportunity for development that way. Connecting them to, not just food but other relationships. You can be more influential that way. They can see how you live and being a role model.'
(Respondent A6)

The diversity of the groups allowed for 'sharing of cultures' (Respondent A5), some respondents mentioned the cultural value of the peer and that contributing to the comfort level. And some recognising that having that cultural 'fit' enabled more understanding of the issues and support for participants (Respondents A1b, A6).

'She (a participant) would have those skills and work along side of them (participants), whereas I wouldn't be able to provide so much support in the sense that I have grown up here, I am from this country. But someone with food security issues, someone who has walked the same path as some of the participants could be even more of a support.' (Respondent A6)

Respondent A2b pointed to different cultures sometimes separating out by sitting in different areas in their community centre, and the challenge was to do something that brings them all together. Being comfortable and having a 'sense of belonging' meant that they would keep coming; and that cultural fit wasn't as important as making people feel welcome (Respondents A2a, A4).

'I think belonging community - that it is community based. I think also because we are flexible and we look at as I mentioned all the different cultural dishes and people feel like they belong and they come back.' (Respondent A2a)

Respondents reported how participants would get comfortable enough to ask questions, or the peers would get to know people enough to provide further support over repeated sessions (Respondents A1b, A2b, A6).

'Talking about trust is really key, often people in your group are vulnerable in one way or another - either financially vulnerable or emotionally vulnerable, so your site supervisor has to have a lot of implicit trust that you are not going to abuse any of those things...and sometimes you need that but to come to a programme first and get to a space where you feel comfortable to go and get that extra help.' (Respondent A1c)

This comfort factor was observed in programme delivery, even with being an outside observer in the rooms, participants freely spoke and engaged with one another and the LCFA (Observation 1A, 2A, 3A, 4A). Respondent Aa commented that there were sometimes challenges with having a peer 'fit'.

'and they (agencies) are constantly trying to balance how do they run really strong programming at our location and how do we ensure that there is a strong peer fit and sometimes you get someone who would run great programmes but isn't much of a fit and sometimes you get someone who would be a peer fit but not so strong in running programmes...so trying to balance that in large measure' (Respondent Aa)

Respondents reported LCFAs' key functions as:

- *'outreach to groups or individuals in the community and build on community'* (Respondents Aa, A3, A5)
- *'helping people out of isolation'* (Respondents A1a, A4)
- *'doing food skills and healthy eating'* (Respondents Ab, A1b, A2a)
- *'supporting behaviour change'* (Respondents Aa, A2a, A2b)
- *'having flexibility and adaptability'* (Respondents Aa, Ab)
- *'not acting as a professional and not preaching or judging'* (Respondent A1b)
- *'recognising skills in participants, encouraging sharing'* (Respondent A2b)
- *'providing/ linking to basic needs support like food, income etc. or family cohesion and support'* (Respondent A4)

'and I say this all the time when I go into a group - I am not a nutritionist, I am not a dietitian...you folks probably know more than I do, and some of them do' (Respondent A1b)

'Our aim is to educate people to live a healthier lifestyle. Maybe just to get out of social isolation. It may mean giving people bus fare so they can get out of the house and having flexibility with being able to do this.' (Respondent A4)

The flexibility was observed through the LCFAs' different delivery styles and content, reinforced on the website.

'while we have common goals, our work takes the shape of the wants, needs and likes of our participants... they get to make new friends and benefit from each other's uniqueness' (Website A)

Report A1 emphasised that the peer model should be seen as 'enhancing' rather than 'replacing' health professionals, the LCFA was not expected to be an expert or able to do individual counselling (echoed by Respondents Aa, A1b). For many, the programme was seen as a first step for participants who were then connected to various other programmes as well as referred through the LCFA for extra support or help. LCFAs were in a position to provide referrals both internally and externally, in a connector role. This meant they could do referrals to the Public Health dietitian/nutritionist or to resources such as Eat Right Ontario (telephone service and website) or beyond (Respondent Aa). Other examples given were LCFAs referring mothers to shelters or for special needs children through their partner agencies or for food aid such as food banks (Respondents A2a, A2b, A4).

'it nurtures the philosophy of people helping people, neighbours helping neighbours and using that as a complement to a staff person, a professional providing services as well; in no way does it replace expert-driven, professional-driven services but it's a very strong complement to those things and a very adaptable one too' (Respondent Aa)

'and people have become quite vulnerable so if they are together and the group gels then they are open and you hear things about family life...and you can point them in the right direction for resources so you have to be prepared for this' (Respondent A6)

The programme coordinator (Respondent Aa) stated that at the beginning of the programme, there had been a desire for the peer worker to play more of an advocacy role.

'I think we have moved back from that somewhat and partly because we realised that we are not and probably cannot train the peer workers enough given they only have 200 hours for programming to effectively train them to do broader provincial-wide, community-wide, city-wide advocacy - so that is kind of going beyond the scope of their role, what they can be trained and expected to do. I think it is great if they do those things but we can't expect that of them. We can't be training them sufficiently to do that.'

He noted that though some peers took on advocacy, but the programme couldn't take full credit for that. In observation, one LCFA pointed out that she had been successful at pushing her local councillor for functional kitchens in neighbourhood organisations (Observation 4A).

'As a peer worker they have built their connections, getting a feel for what is happening and then they move into this...so though it is not a big goal of the programme, it is one of the off shoots...so they almost become a neighbourhood leader, we should have a ward councillor - some of them have potential because they are perfect, they have come from the ground up... then we could get more funding too.' (Respondent Ab)

Respondent Aa spoke to the opening up of the role of the dietitian/nutritionist.

'Since the inception of the LCFA role, there has been some shift in the role of Public Health nutritionist role that they have very much focused on the community-wide, collective impact stuff and I suspect that they feel more free to do that, that we as Public Health feel more free to do that because we have the LCFAs doing some of that stuff we have that outlet.' (Respondent Aa)

The complementary and interconnecting nature the LCFA role and function was emphasised by many of the respondents of Case A. Similarly, respondents of Programme B commented that the role of the LCFAs was to be complementary and a front-line credible source of information and that being seen at the same level (as a peer) was important as well as representing Public Health.

'you have the best of both worlds...I have often thought of it as covering off that aspect to lay the ground work and then free up and able those who can then pick up where that leads off...so there was a time where dietitians in Public Health used to go out and do a lot of one-off presentations and that could easily eat up every minute of your day...that is not really good use of their skill set to be teaching things at that level...besides, they come in as the high and mighty versus the peer model which is a more effective way to convey messages...it comes across if you are having a peer teaching that to you, it is more meaningful, than say coming from the white tower of Public Health' (Respondent B2b)

LCFAs talked about the sharing nature of the role amongst the participants and aligning with people's living situations in a simpler way.

'To share more knowledge, and to have more knowledge - so to share with others what they have learned in their family and community...because we are not a dietitian, we do not give them the information a dietitian would give them, we just point them in the area and open them up so that they can know, for example, how to cook rice - for some people, that is a big thing' (Respondent B6)

'I see our part as, how does this idea of good nutrition really play out in an every day household where they are shopping at a convenience store around the corner...how can you make a healthy meal out of something like that, how can you come close to it?' (Respondent B4a)

Respondents reported only a limited demand for specific cultures, cultural representation or languages from the LCFAs in the community, despite LCFAs speaking some different languages (Respondent B1, B2a, B3). Though one respondent suggested there should be that focus, making programming language specific so people were more comfortable (Respondent B6).

LCFAs had a set of activities and scope they could do (Respondent B1, Document B):

- *teach people how to cook*
- *organise community kitchens*
- *do food demonstrations*
- *set up displays at fairs*
- *have information booths*

It was made clear this did not include: counselling, focusing on individual health conditions, prescriptive diet planning or recommendations on supplements.

Respondents highlighted the following key functions:

- *'talking and engaging with the audience', 'sharing of knowledge and information amongst groups', 'with positive reinforcement back that people appreciate'* (Respondents B1, B2a, B3)
- *not just the 'what', but the 'how', transferring of personal skills* (Respondents B2a, B3)
- *providing 'social aspect'* (Respondents B3, B6)
- *LCFAs did 'more than just educate, they made connections'* (Respondent B2b)
- *'positive messaging', reinforcing it many times, in different ways* (Respondents B4a, B5)
- *'relationship and trust building'* (Respondents B1, B2a, B2b)

Positive messaging was considered both valuable at individual and community level, as well as for the LCFAs themselves (Respondent B3). And that being about food was key.

'I think food in particular, food and eating, resonates with people on a personal level... it gets to people at an intrinsic level.' (Respondent B2a)

As with Case A, developing relationships in the community was seen as important.

'if they do want an ongoing long-term relationship and the LCFA is willing to do this and commit to being this person which does bring trust and credibility' (Respondent B3)

Some respondents remarked that boundaries of their role could be an issue, as well as tensions between different roles.

'they are trained to learn where that line is, you are always going to get someone who wants to go beyond that, or if someone is a vegetarian - well, they are going to have to get past that as an LCFA and be mindful that not everyone is a vegetarian and of course it will influence them...or someone who believes in not having any sugar and they ramp up their presentation that way, but we don't say this - it is about a healthy, well balanced diet' (Respondent B2b)

There was variation of scope of activity reported by supervisors. Respondent B1 said this was difficult because they were working with people who 'would talk and ask questions', so although there were boundaries, LCFAs weren't being 'policed'. She also noted that the benefits outweighed the risks, and in the community 'everyone is doing nutrition anyway, at least they (LCFAs) have the training' as echoed by other respondents. And that this could happen in any field, but because the programme was run by the health department, the credibility was important and that this helped to harness trust (Respondent B2b).

'The credibility of the message coming from the LCFAs we have trained. So you know, if someone says 'why get up in the middle of the night to put your turkey in the oven, do what my mother does - she cooks half of it one day and the other half the next day'. Well, no we have health inspectors who teach our LCFAs that that is an unsafe way to cook turkey and if someone says, 'all you need to do is eat a tablespoon of coconut oil every day and you can eat what you want. Well, you know - we have LCFAs to teach information and key messages that we know is credible from Health Canada called Canada's Food Guide.' (Respondent B2b)

Respondent B3 pointed out that though the LCFA scope of practice was limited, that was what most people in the community were looking for and being more practical in the front-line service. It was also suggested they could go further with their scope, and that LCFAs had 'a great sphere of influence' and this function was 'mutually beneficial' (Respondent B2b).

'so above and beyond the presentations and food demonstrations that they do every year, I suspect that they have more of a ratcheting up value than that and we have shamelessly used them over the years to literally ratchet them up for some of our other purposes' (Respondent B2b)

One respondent expressed how she wanted to see the LCFAs do more, such as supermarket tours, but other dietitians within the Public Health unit 'firmly believe that the LCFAs don't have the skills to do that.' She expressed how she was up against opposition from them for expanding the role and function of the LCFAs (Respondent B1).

'to do this it has to be with volunteers, that's unfortunately the reality of that...do they (Public Health) have the money? Of course they don't, it's too expensive but then you have dietitians who don't like us as volunteers so you say okay, well then what? Do you just not offer it at all?' (Respondent B4a)

LCFAs complemented other roles: the work beyond that of the Public Health dietitians to food inspectors, nurses and teachers. As well, LCFAs had a role of complementing existing community programmes or work in schools. It was noted that 'they could provide that expertise that may not be within the group itself' (Respondent B1). Food and nutrition was in the school curriculum but it was felt that teachers weren't really delivering, that it was only done at a 'very basic level' (Respondent B). Respondent B5 reported they were helping teachers to fulfil their responsibilities. Health brokers (outreach workers) used their established relationships with the community groups and bringing in the LCFAs to do workshops which were complementing other offerings to those groups. Different community workers were reported to make referrals to the LCFA programme when need was identified in a group. Respondent B1 reported there were two women health educators within their health unit who were paid staff and did the LCFA training so that they could incorporate the healthy eating aspect into their work, and they were more multicultural workers. Respondents highlighted the complementary role of the dietitian in particular for referrals but some Public Health units only focused on population health and no longer provided individual dietetic services. The most predominant referrals were by way of Eat Right Ontario and to Canada's Food Guide. There were also referrals for extra support and other sources of information. This information was observed to be given out in the programme delivery activities (Observation 1B, 2B, 3B).

LCFAs were able to fill some of the gap in front-line services, which was meant to open up the role of the dietitian to focus on the higher level pieces to fit their strategic mandate (referred to in Section 4.3). It was pointed out that although LCFAs did not have a direct role in advocacy, they were 'necessary to help create healthy environments by engaging people' (Respondent B1). Respondents B2a and B2b expressed LCFA potential in working on policy areas. But this wasn't consistent across local programmes.

'Definitely the policy piece, that is not part of their scope to talk about it or try to initiate any changes in policy so if they are going into a group that is not their focus. It is really about working with individuals in a group setting which is a bigger focus of our health unit - the policy piece. Sometimes it is a gateway, get the LCFAs in and sometimes there is a way we can connect them with more health services that might lead to policy change within organisations, that kind of thing, but that isn't their role at all.' (Respondent B3)

Respondent B3 reported not having a large pool of volunteers to carry out the work, however, Respondent B2a reported the opposite situation.

LCFAs in Case C were described as playing a role in 'creating alignment' with the city and promoting Public Health to the community so they could build trust with government agencies'

(Respondent C). This comfort and trust factor was considered crucially important across cultures 'food and nutrition is universally culturally acceptable to talk about, bringing people together' (Respondent C).

'we can't do everything, but we can do a portion...we give them information about agencies they can go to, we do referrals for those who really need it, we go into more issues, give vouchers when needed...we tell them where the food banks are, some of them don't even know there is a food bank...so connections' (Respondent C4)

'so we bridge the gap...if we see a parent who is struggling or is not eating or does not have adequate food, we recommend they see a dietitian...so the dietitian can see them and give them some money...it is a short-term fix but better than no fix... or we help them access a food bank and show them what to do with the food, how they can use it to make healthy meals...whatever is in their community so they have more access' (Respondent C5)

The advocacy potential was described for LCFAs in their 'unique position'.

'the LCFA is in the middle between the community and the organisation, and sometimes a third agency comes into play and trying to see that as how can you advocate for each of those people to the other, rather than seeing it as oh no there is that tension' (Respondent C)

'if you're a peer worker and you work for an organisation and you feel that you have alliances to the community and you have a background with them you are basically caught in the middle - so 'the community wants me to do this, the organisation wants me to do that...so I think the LCFAs can learn to advocate to the city, to me about how to do things differently with the groups...and I think that that connection is really important...I would say that that is the biggest thing' (Respondent C)

LCFAs were described to have a number of functions:

- *'develop partnerships'* (Respondent C2), *'to be a resource for partners'* (Respondent C4)
- *'to do outreach'* (Respondent C)
- *'to be a connector, to be a bridge - between cultures, between services and resources (within Public Health and beyond)'* (Respondent C)
- *'providing information'* (Respondent C5)
- *'to facilitate healthy eating workshops'* (Respondent C2)
- *'respond to the needs of their own group'* (Respondent C)
- *'to help new immigrants feel comfortable, to help understand'* (Respondent C3)
- *'to help reduce isolation through trust and socialisation'* (Respondent C4)
- *'helping people to make healthy choices'* (Respondent C4)
- *'promote the health of children'* (Respondent C5)
- *'working with culturally and/or linguistically matched communities'* (Respondent C2)
- *'to promote the cross-sharing and learning within different cultures'* (Respondent C5)
- *'to be able to also deliver programming in English, with diverse groups; being adaptable and flexible too to different communities, and meeting the needs of mixed groups'* (Respondents C, C1)
- *'to be engaging and open to learning themselves from other cultures'* (Respondent C3)

The programme evolved in terms of title of LCFA to reflect their role and function more appropriately - from assistant to educator (Respondent C2).

'The purpose of the LCFA was to link, how can I learn the food, how can I adjust, adapt the recipes, how can I have this reality? How can I find these ingredients that I want. So having the LCFA as the bridge they should understand what the community was. ... So the LCFAs speak the language, they come from your background, they understand, and that way they promote the health of the children. This is why the programme is received very well.' (Respondent C3)

Many respondents emphasised the cultural relevance of issues, and how they needed to be addressed such as with certain cultural practices, particularly with infant feeding (regarding safe and healthy practices) and LCFAs had a role to play here, and in being sensitive to people's feelings, history and beliefs.

'we are not here to change their culture, we are here to help show them how to make things healthier' (Respondent C3) ... *'and they can make an informed choice'* (Respondent C1)

'When you think of Canada as a melting pot, when you have people from all these different cultures living here, all these different foods here, some of these foods are far away or cost a lot, I encourage parents to try different foods and show them different foods...and when you look around the table, different cultures, different methods of cooking, you learn so much about cooking and a lot of the issues they are faced with.' (Respondent C5)

Though a key function of the LCFAs was to be culturally and linguistically matched, this was not always the case and they could and did work with more of a broader representation in the community. It was not always possible to make matches because of variations within cultures or further sub-group distinctions, or there could be different languages within one country, but they still may have shared something in common (it was also pointed out that not everyone wanted to participate in groups of the same, shared culture). Programmes were flexible and responsive to this, for example, Muslim groups may be run in English because of the different languages or a Spanish-speaking group from multiple countries (Respondent C2).

Building comfort and trust of the community along with a social aspect emerged over and over.

'another thing is trust, they don't trust people, they don't go out - so they become isolated...when they have groups like this, apart from the healthy eating, it becomes a social group' (Respondent C4)

Programme observations of Case C showed the cultural diversity of participants and all engaging in meaningful and trusting relationships between fellow participants and with the LCFA through casual banter and small talk, as well as directing an array of questions to the LCFA and sharing openly their situations, their struggles and their successes - observed mostly

in the small group observations (Observation 1C, 2C).

Acting as connectors, developing trust and relationships were the most common themes reported throughout Case A, B and C as well as observed across programme delivery, with some differences around how they were expressed to be connected with community, culture and Public Health. Issues with boundaries and scope of role emerged mainly within Programme B.

5.3 Focus and Approach

This section explores focus areas of each of the programmes and LCFA approach to this.

Programme A focus was reported to be mostly nutrition education and food skills as well as reducing social isolation, and would depend from group to group (Respondents Aa, A1a, A4, A6).

'Food skills, nutrition knowledge, empowerment, it's all of them that are really tied under a cooking programme. My group, when we sit and eat, sometimes it's good and not good, but they have gone online and researched different foods and sometimes they say - 'can you substitute this or that'. It's just everything. I think it's just the name of the programme that it's a peer programme but it does all of those things - it empowers the women, it gives them knowledge, confidence, friendship.' (Respondent A1b)

'It's everything. Depends on the group. With the Muslim women the focus is on education and the facts about health. With the young parents group the focus is on food skills and low- income. 'Make and take' is getting people out of isolation and enjoying a good meal with others.' (Respondent A4)

All respondents commented on the non-judgemental and peer-to-peer nature of the approach with a flexible model of delivery, and responding to the needs and wants of the groups. The practical and informal aspect of their approach was also reported, 'I do think just having the knowledge of how to shop is key' (Respondent A2b).

'I would say food skills I emphasise the most. We haven't talked about food safety. And nutrition is a big one too. Approach is always practical. People learn more. Usually, we talk when we are sitting down eating, and chat about the messaging. Now it's become a lot more informal because this group has been through all of these topics, so now we just sit down to eat and one of them will bring something up. Very informally sharing of information. This is a different group focusing on making food from scratch, even, make your own pasta and pita bread and yogurt.' (Respondent A6)

According to Respondent Aa, the programme was structured in a way to incorporate elements of multiple health promotion approaches - 'educational, behaviour change, social change and empowerment'. Other respondents reported empowerment and behaviour change, with some education incorporated into their approach (Respondent A1a, A2b, A6).

Observations found LCFAs to be confident with strong leadership skills. Participants were engaged and well connected with one another on the programme, and seemed to have developed relationships with fellow participants as sessions went on. Informal discussions among participants revealed that they were trying new foods at home and eating differently, more healthily since participating in the programme (Observation 1A, 2A, 3A, 4A).

Areas of focus for Programme B were reported to be predominantly food literacy including food skills and nutrition education such as food labelling (Respondent B, B1, B2b, B5). Food safety and safe food handling continued to be emphasised but local food had emerged as a focus area more recently (Respondent B, Respondent B2b).

'food skills, the understanding of food labelling, and also the new Canada's Food Guide - you know low fat meals, what changes with low fat foods and just a general understanding of those kinds of foods, high fibre - especially with seniors, and of course food safety' (Respondent B5)

Some contradiction of focus area was reported with the original funder.

'So I think there is a bit of a struggle - when OMAFRA started this it was a good fit because they had a broader mandate, now their mandate has changed and it doesn't fit ...we try to promote that local message where we can but it isn't always appropriate to push that one hard.' (Respondent B3)

It was reported that the programme focus had changed over the years, from at one point being mainly obesity to local food and healthy choices in relation to local food (Respondent B2a).

'Local food as an example, and I think we are at a point now where it really needs to be really focused to address issues, whether it be local food, or childhood health issues or food skills in general. So we can improve health and have a healthy food system as well because the more local foods we eat, the more robust our economy is, so there is the whole food systems approach is what's helping to drive the interest in food skills, food literacy, local food. These are all government priorities now whereas before it was like active living and that was it.' (Respondent B)

According to Respondent B1, the approach was based on the Ottawa Charter strategies.

'The approach would be to build personal skills, create supportive environment, reorient health services. For example, health services focuses on clinical and disease, whereas this programme focuses more on prevention by teaching people skills to eat healthy and preventing chronic disease.' (Respondent B1)

Having LCFAs was deemed as a more effective approach to deliver messages.

'One of the benefits to being a volunteer is that I am just an everyday person who is a mother who is cooking and I am going to go home and that folksy home-ness makes it accessible to people and that message may be the same as one someone else is giving, it's just a different conduit for the message...and I would like to think that is effective.' (Respondent B4a)

For some local programmes of Case B, LCFAs worked in pairs. It was noted their individual approaches differed, 'we negotiate and find what works for us.' This respondent commented on difficulty with some of the 'foodie' LCFAs, that their vision with what they wanted to do with food sometimes didn't mesh or they were 'preaching or lecturing' on how people should eat; and that they needed to be on the same page as their audience (Respondent B4a). However, other respondents (Respondents B2a, B2b) had reported they wanted foodies (relevant to their chosen recruitment strategies) and didn't raise this as an issue. And one respondent commented about being professional.

'The one thing that bothers me is that some of the LCFAs don't treat this as professional as they should. I have always taken this as a professional duty... It is different personalities but if you are in the general public you should always make it look like ok, I am a volunteer but to still be professional.' (Respondent B5)

Observation of Case B programme delivery revealed that the LCFAs were friendly and took time to mingle and build rapport with the groups first. They came across as knowledgeable but practical, realistic and honest in their approaches. Participants were not being told what to do, but rather were being given ideas; LCFAs being responsive to the groups. The learning and social aspect was apparent through questions, sharing of ideas and general discussions (Observation 1B, 2B, 3B).

The approach of LCFAs was referred to as 'a peer teaching' approach (Respondent A2b) but Programme C made efforts to distinguish this. For Case C, it was reported that the education workshops were like 'healthy eating 101, the basics' and then the support sites covered broader concepts of health (see type of programme delivery). Respondent C1 stressed that they were a nutrition education programme more than food skills/demonstration programme. Others however said that the focus was both education and skills, with varying degrees of emphasis, the food skills piece being more of a focus on the support sites (Respondents C, C2, C3, C4, C5).

'so food skills is education...because a lot of them don't have a lot of food skills...they can cook but maybe only a certain way or they just don't know how to...so you teach them basic skills that will allow them to get in the kitchen and feel comfortable and confident' (Respondent C5)

Two education workshops were observed for Case C. The focus of the first workshop (Observation 1C) was mainly nutrition knowledge and food budgeting with the facilitation being discussion and activity based. The LCFA was encouraging with the group sharing, small group tasks as well as handouts and recapping of key messages - 'reduced fat, salt and sugar.' The interaction amongst participants was observed to be positive and it was clear relationships had developed over the six weeks together (this was the final session) as phone numbers were exchanged between participants and there was discussion about which support site each would attend, hoping they would meet again at these sites. Participants shared how much they loved the programme, that there were so many new things they learned. The other observation (Observation 2C) was for a session on education and awareness raising, healthy mealtime environments and feeding relationships. The session was all discussion based, although there were plans for a participant to show how to make yogurt. Everyone was friendly and talking freely, sharing their experiences of what worked and didn't work with their children. The LCFA was working from some notes and developed materials but in an informal manner in a way to elicit input from participants. Participants were engaged and offered how much they enjoyed the learning. The focus of the support sites for Case C was reported to be around the SDH, 'a wider focus than food', identified in terms of needs and wants of the group (Respondent C1). Food and nutrition remained one of the focus areas, with the provision of healthy snacks, building food skills activities in, promoting food security and dietitians facilitating workshops - this was observed (Observation 3C). Support site activities were planned by the LCFAs and also had physical activity components, with both Public Health staff and other agencies coming in. Another big emphasis was to provide support in accessing healthy fruits and vegetables, and broadening acceptability of different available fruits and vegetables (Respondent C).

Programmes were described as having a peer approach, with a 'mixed model of delivery - combining culture and language skills of peers with specialised support of professionals' (Report 1C). This multicultural emphasis remained strong with that component changing as the community changed, as well, it was found over time that the programme needed to open-up how it was delivered and be flexible with the multicultural aspect. Programme supervisors described the approach as education with a facilitation lens (rather than teaching), and that adult education - learning through doing - was important (Respondent C1, C2). Respondent C2 commented that by educating 'you empower people' (which somewhat contradicted her comment about it not being about empowering so much). Tailoring to group needs and wants 'as long as the key messages are there' (Respondent C3) and giving the 'right information' so that they can make informed decisions (Respondents C1, C5). Although facilitation was the

approach emphasised by the manager and supervisors of the programme, 'we want them as much as possible to do activities that are engaging' (Respondent C1), some LCFAs noted they were teaching, they were educating (Respondent C4) but they all described their approach as facilitating learning. One of the supervisors (Respondent C2) spoke to some concern over the approach of the LCFA, interpretations of it and potential power imbalance.

'the programme is about sharing, because participants bring knowledge and skills...you can't deny this one, you have to validate it and respect it, so it's cross-sharing...but sometimes LCFAs are confused and they teach a lot -'I am going to teach you about Canada's Food Guide' rather than 'I am going to present Canada's Food Guide' and we then lose the sharing...if I am there, I am teaching, somehow I carry different power - I am the teacher, you are the participants and I will teach you what to do and I am right and you are wrong...I go to workshops and I see the participants and they ask questions, and they see the LCFA as having all the answers... I have one LCFA and the participants call her 'teacher'...then you see a different power...I think somehow we can miss the purpose of the programme because of the education...if I facilitate I don't need to know everything, maybe I facilitate something I know nothing about...but because I am from Public Health and I have the Public Health concept and model, I have to guide my group and I have to facilitate, but not that I have the power...the programme is designed like this but I think the opposite happens' ...sometimes there are issues with what the LCFA does, but this is because the LCFA assumes a teacher role...if the LCFA assumed themselves as a facilitator, I don't think there would be an issue' (Respondent C2)

However, the LCFAs interviewed showed understanding of this and acknowledged the programme was about shared knowledge and experience.

'facilitation is not an issue because this is something I have done all my life...it's not hard to get people to talk, I know how to get people to focus and I think when you can actually get people to focus, you can do a good job...ceasing their attention and holding it, they can learn a lot of things...they all learn from each other' (Respondent C5)

'we get them encouraged to learn, to use their skills...we all learn from one another...I provide them with ideas, I can get them engaged and to participate and to learn from each other so we participate in the cooking, one doing this, another doing that, and then they become comfortable' (Respondent C3)

Though there was a basic structure, LCFAs had flexibility to decide how they would run the programme (Respondent C) and all LCFAs commented that this was in response to the participants feeding into it and doing what was feasible (Respondent C5). LCFAs tended to work differently, some more hands-on than others (this was observed across different delivery approaches of the LCFAs). It was reported that participants did learn through seeing and doing, so being practical in approach made a difference (Respondent C5).

It was also pointed out that if there was a mixed group, with varying levels of English, that a practical approach like cooking was a great way to learn and understand, as well as to share the different cultures (Respondent C5).

'the best thing we can do is help mothers to feed their children well... if we get this, we start them on the right path for healthy children and they grow up healthy...I tell the mothers 'don't cook for your husband, cook for your children' - not meaning that literally but that they focus on the children first and their husband will eat what they cook...because many cultures, many women are coming from countries where the focus is on the husband first...they need to get this' (Respondent C4)

As the support sites were more mixed groups, LCFAs worked on building trust with the initial workshops and with an idea of having the different cultures come together and develop their comfort level. This would depend on the group, but encouraging participants to learn and use skills was what they did, as well as being broadly supportive (Respondent C3).

'and lifestyle is not just about food...and I can think of loads of things that we face as we go through life...how do you solve a problem? do you have anyone you can talk to when you have a problem? so it is all those little components that you put together that makes life worthwhile or makes life miserable' (Respondent C5)

It was shared how LCFAs would go beyond the focus of the programme (Respondent C4). For example, schools would call upon the LCFA as a resource to talk with parents when issues arose. LCFAs were able to talk with parents to help them understand more around healthy eating.

'anything they don't know, we have pertinent information that we share with our parents so that they know where to access programmes, community agencies, what is available out there that they can access' (Respondent C5)

Respondents across all cases pointed to the need to be community-oriented and flexible in their approach that recognised people's realities. LCFAs focused on helping to increase practical understanding of healthy eating with a peer approach emerging as important.

5.4 Setting and Location for Programme Delivery

This section focuses on geographical coverage of programmes and structural locations— how and where delivery took place and the challenges.

Community was the setting for all programme delivery (Case A, B, C), within the province of Ontario. This meant delivery was mostly within the Public Health unit, community agencies and schools.

'We think of the programme as not a place, it is what we do but it is a way of connecting out there in the community.' (Respondent A3)

The settings for observation of programme delivery across cases took place in community agencies and social housing buildings. These locations were in areas that would be classified

as higher priority based on income level of residents. Priority neighbourhoods or strong neighbourhoods were most commonly reported as the geographical area of programme coverage.

'We don't have priority neighbourhoods anymore, we have strong neighbourhoods - this has changed. Before there were 13 priority, now there are 31 strong. So Public Health has to be there in the community, to be the bridge with the community, and to impact on the community.' (Respondent C3)

However, the locations could be anywhere in the 'community' as location was not just decided upon based on priority areas and community 'need' but also based on requests by the community. For example, Programme B was mostly reliant on and responsive to any requests put forward from the community and this could take place in an agency or school in any area and it was commented on that there 'wasn't always a match between what the community was asking for and the programme priorities' (Respondent B1). Programme C was delivered on Public Health sites and in the community through partnerships with agencies. This involved the agency and the LCFA creating a partnership agreement to establish which agency took responsibility for which piece, 'we have created a lot of partnerships and that helps' (Respondent C). This allowed for cost-sharing, for example, the agency might provide the facilities, budget for snack and childcare workers and Public Health would provide the LCFA in-kind and may cover the cost of childcare (as the researcher's own work experience has found). Based in areas of high need, they did also respond to requests for agencies to host the programme (whether it be for the six-week education sessions or for longer periods of time for the support sites). At the time of the field work, there were 17 support sites across the city, a number which 'ebbed and flowed', with some closing down at times if they were not well attended, as well as new sites opening up in different areas (Respondent C). It was reported that there were not many support sites in relation to the coverage area (Respondent C1). Programme A most commonly located its delivery within the community agency partner sites which were located in low-income areas (Respondent Aa).

In all cases, programme delivery was mostly concentrated in urban areas – Programme A covered a whole region with three municipalities but delivery was in the cities; each branch of Programme B covered areas that were both urban and rural; Programme C covered one large urban area. Respondent B3 reported some challenges with covering a large urban and rural landscape.

'Our concern is it is not just the G area it is the WDG area so we have to be careful and we do like to provide service equally in all areas. We do struggle with providing service in the north of the county (NW), we have trouble getting our volunteers to go up there.'

Especially this time of year with the weather and it's a long way so we generally service much better this area and the O area. NW is tough.' (Respondent B3)

However, other respondents reported that they had LCFAs from all different areas and were adequately covering their area which was broad (Respondents B2a, B2b).

Community was the setting for all programme delivery, with large coverage areas. The main difference across cases was that some programmes covered both urban and rural areas, and others were only urban. However, the challenges of covering all priority areas and rural areas was recognised by respondents from the different programmes.

5.5 Type of Programme Delivery

This section explores how programmes were structured in practice, whether more educational or practical and the intensity of sessions.

Delivery with participants of Programme A in the community for the most part happened in a series of sessions ranging from five to 10 weeks, all within a group context. This was flexible and could be by way of a community kitchen (this could operate differently depending on the LCFA), workshops (around a table) or a combination of both (Respondents Aa, Ab, A4, A5, A6). The delivery was observed to be practical, tailored to the group, social and informal as reported by Respondents A1a, A1b, A2b, A5, A6. Workshops observed all had real life discussions and activities, some even having homework or take-home tasks to consolidate learning from week to week. Community kitchens were participatory with ongoing discussion, some being led by participants themselves sharing recipes, with the group sharing the meal together afterwards. Respondent A6 noted how 'it comes from them and doing it, it's very hands on.' LCFAs were encouraging, participants discussed their successes and challenges, asked questions and openly expressed the value and enjoyment of the programme (Observation 1A, 2A, 3A, 4A).

Programme B was delivered in the community in a group context with a shared learning approach mostly by way of presentations ('talking to people - knowledge') or food demonstrations ('showing people how to - food skills') (Respondent B3). This approach was reported to depend on the groups and their level of food skills as well as on the skills and personal approach of the LCFA. The main design of Programme B was to provide 'one-off' presentations, workshops or food demonstrations. Because relationships were built with these groups (agencies, schools) this could translate to more ongoing sessions with the groups (Respondent B3). Programme B observations were all predominantly with seniors. In each case, the activity was part of a bigger programme of activities for the groups which stemmed

beyond the LCFA programme scope. The LCFAs promoted healthy eating messages that were tailored to the groups, demonstrating recipes, giving meal ideas and practical tips, with time for sampling of the dishes (Observation 1B, 2B). According to the LCFAs, that although these groups already knew how to cook, they were keen to learn; many for whom their cooking habits had to change as they no longer had families to cook for, were mostly living alone and eating habits had changed. Both LCFAs did food demonstrations and then participants were able to try the foods. Participants commented how much they liked coming and learning new things and they were going to make changes at home as a result of what they learned. The interest of the programme was reported to be 'predominantly for food demonstrations and presentations.' Respondent B3 stated that the programme used to focus more on presentations and that they recently made more of a shift to emphasise food skills, going out and showing people how to do things and being more 'hands on.' This was reiterated by Respondent B1.

'Food demos and they taste the food. Depends on the request, we facilitate cooking programmes or in a place where there are no cooking facilities we bring our own stovetop cooking and demonstrate easy recipes... but community kitchens, people request this, there is one in community housing right now and we invite them to cook together and it's almost tenant led. Once we show them the skills, they are able to show leadership skills...we would like more of that, however getting facilities, a proper kitchen, is sometimes hard.' (Respondent B1)

Lots of requests came from community centres where there was limited cooking and food preparation facilities so the LCFAs had to limit what they did or be creative and this was observed in both locations; however, the hands on aspect wasn't clearly seen in these instances: it was a telling, sharing and showing rather than doing. It was mentioned there had been some talk of doing community kitchens but these were decided to be 'too much work' and they would need help with coordination and set-up (Respondent B5). However, another respondent in a different area mentioned they would like to see more community kitchens and would like to see a whole range of services with a 'more coordinated approach' (Respondent B1). The Case B respondents who were LCFAs reported that though they had guidelines, they had freedom to plan their own work. Though there wasn't a standard format, certain things had to be approved. All LCFAs recognised the amount of work they put into planning and delivery of the sessions and that sometimes they really did have to 'think on their feet, it could not be too strict because it could be 'who knows what' (Respondent B4a).

Whereas Programme A delivery was characterised by series of sessions that were varied in how they were delivered, Programme B delivery was characterised by one-off sessions and

often information and demonstration oriented, Programme C delivery had more than one component: education sessions, follow-on support sites and community gardening.

The educational workshops for Programme C were six weeks in length (sometimes one or two weeks longer if needed) and described as 'language and culturally specific workshops that provide parents and caregivers with information on how to improve food selection, purchasing and developing basic food skills through hands-on learning' (Website C). Participants must first have participated in the workshops to then get connected to further programming (Respondent C). Participants who graduated from the education workshop six-week series were invited to attend follow-on support sites, offered twice a month. These sites were a build-on to what was learned in the education workshops and participants were able to attend these sites for one year with a workshop component and food component (Respondents C, C1). The programme had a built-in component to provide internal referrals to the programme dietitians for individual counselling with participants who were identified as needing further support. Participants could also get further referrals to other Public Health staff.

Originally the programme was described as just 'community programming with healthy eating workshops' and follow-on support sites for participants to attend. It then moved to also include more supportive internal programming - supporting other existing Public Health programmes including prenatal and parenting programmes (Respondent C, Report 1C). With every workshop there was opportunity to have a food skills activity which could be quite broad, and amongst LCFAs this would vary (Respondent C2). Though the workshops observed were smaller, more intimate groups (Observation 1C, 2C), the support site had a large group of participants, consistent with what was reported by respondents as many workshop groups fed into each support site. The group was facilitated by two LCFAs, and involved warm up exercises and stretches. This involved going around the room and participants showing their own exercises. This was then followed by a nutrition workshop, facilitated by one of the dietitians supporting the programme, with a focus on vitamin D, calcium and some label reading. Facilitation of the workshop piece was imparting knowledge with samples of food packaging, a quick session. Afterwards, the LCFAs gave a small group activity for participants to consolidate the learning and followed with discussion. One of the LCFAs was wanting to share information about the programme being amazing, expressing how much participants enjoyed the programme and became attached, not wanting to leave once the year was up but that they needed to move on, because part of the objective was that they were empowered and self-sufficient and making friends. She also shared about how much she loved her job and what she did. She noted that they had community gardens and whole families came out - that

it was on a Saturday and many people didn't have anywhere to go (as they were new to the country) and this was a great thing to do, getting outside and socialising with the whole family. Participants were happy when harvest time came around and they would get to bring home plenty of fruits and vegetables (Observation 3C). There was expressed desire to do more with the gardening aspect of the programme that had potential to build knowledge and skills around growing food and increasing access to produce native to the region as well as a chance to grow some more culturally diverse produce. As well, increasing focus on the children coming to the programme, rather than solely focus on the parents and caregivers and the translation to their children.

'For us it was on a Saturday, we'd run a programme and provide a snack and do some gardening. But we need to do more education on that. It's like 'come and weed the garden' and then we do a harvesting piece but then we have this issue with one partner where they let us use the kitchen but not the dishwasher. So these are run in partnership with an agency. We are looking at a new one as we have a new partnership with an agency and they are going to run them with clients on their beautiful roof top garden.' (Respondent C1)

'my personal thing is we are in the early years stream, and the food literacy piece for kids, why are we not doing more of that...I think we are missing that...so the children who come for the programme and are in childcare could be doing activities around food' (Respondent C1)

Programme delivery had some differences across programmes. This ranged from more educational based to more practical delivery, as well as variation across intensity and length of sessions - from one-off sessions to five-10 week sessions to six week sessions including follow-on support. All programme delivery took place within group rather than individual contexts.

5.6 Programme Delivery Content

This section explores topic areas for the content of programme delivery which finds some general trends across cases.

Case A reported topics to be based on general healthy eating messages, Canada's Food Guide (HC, 2007a) with emphasis on fruits and vegetables, menu planning and eating on a budget (Report 1A). Some respondents stating that it was mostly about getting 'back to basics' and 'learning to cook healthy foods' (Respondents A1a, A2b). This could range from kitchen skills such as knife safety, to educating that 'cooking a ready-made frozen pizza is not really cooking' to literacy and math 'learning to measure and reading recipes' to learning about food availability ie. in the community - supermarkets, food banks, 'Canadian' food, adapting and sharing cultural and family dishes to time management skills (Respondents A1a, A2a, A2b, A4, A6).

'Getting people to cook healthier food at home, greater variety, more specifically more fruits and vegetables in their meals. That confidence of working in the kitchen, time management, a big one I hear from people is 'I never have time' so teaching people the simplicity of cooking and methods. Then they take the food home and try it on their families and then they are more likely to make it if their family has already tried it and likes it. So they will take a sample size home and realise their kid will eat broccoli if it's in a tree.' (Respondent A6)

All LCFAs for Case A reported using 'Colour it Up' Public Health materials (Respondents A4, A5, A6).

'I do Colour it Up because it is adaptable, I do 10 weeks in a practical way in a kitchen and the other LCFA does it more journey-based and sitting around a table. This is our choice to do it, it is not dictated to us. I think you can take on a coach sort of role - you have to be intentional about it. I have total freedom, I am more self-governed.' (Respondent A5)

As Respondent A5 reported, the general flexibility to choose what they delivered and the means by which to deliver was consistent with all LCFAs and supervisors, who felt topic areas could be broad.

'I don't know though if they even realise how much scope they have, other than food, food safety, nutrition etc. but there is so much more.' (Respondent A1b)

Echoed by the programme coordinator, who pointed out that they as a programme did not dictate topics for the LCFAs, but provided guidance through the training, and as such, LCFAs had a great deal of flexibility with the delivery content (Respondent Aa).

For Case B, Canada's Food Guide (HC, 2007a) was used as a core tool to help with messaging in the community and was considered a shared and valued resource (Respondent B, B1).

'core content has continued to be related to Canada's Food Guide which I think has always anchored us...it has kept us grounded in terms of messages we are trying to promote' (Respondent B2b)

'starting any presentation with Canada's Food Guide is the best as it is really good, it covers everything' (Respondent B5)

One respondent pointed to some people's (not participants) comments about the food guide as being obesogenic, but this was dismissed and not felt to be valid (Respondent B2a).

Topics LCFAs could cover were listed in Document B:

- *cooking for one or two*
- *preparing quick and easy meals*
- *menu planning*
- *food safety, safe food handling, hand washing techniques*
- *cooking basics for children; preparing and choosing healthy snacks for children*
- *food preservation, canning*

Respondents reported topic areas of food labelling, eating on a budget, teaching food safety and food handling (Respondent B2b, B5, B6). 'Food skills and engage people in cooking together, that's how they learn' (Respondent B1).

'If people divert we bring it back to food. So with money, we might make suggestions on how to save money on the grocery bill. or suggest to go to Eat Right Ontario for budget-friendly meals.' (Respondent B5)

There were some difficulties, as reported earlier, in the scope of the LCFAs.

'One time one of the LCFAs was doing a talk in the community and did not realise there was a dietitian in the group. So later the manager told me 'your LCFA gave out this information you know'. A lot of the dietitians are territorial.' (Respondent B1)

It was broadly reported by respondents that they needed to make sure messaging was tailored.

'not how to eat more fruits and vegetables but how to eat well on a budget or coping strategies...so if eating with food bank foods, how to make healthy choices with that' (Respondent B)

'I know that I am not necessarily selling the nutrition part as much as I should but I am being realistic about what they can afford...and the two don't necessarily meet very effectively.' (Respondent B4a)

Respondent B reported that because the programme needed to focus more on local foods, this needed to be reflective in its content, with recipes and more food messaging around how to buy and prepare it. Foodland Ontario materials were observed to be given out in all of the programme observations showing seasonal produce and recipe ideas. However, the messaging of local food was not felt to be a good fit for all, because they didn't 'just promote local foods', they promoted 'all' foods and there was recognition that eating locally could be more expensive. So when dealing with vulnerable populations, that could 'not necessarily be the top message and by no means could it be the only message' (Respondents B3), echoed by Respondent B5.

Canada's Food Guide again was the anchor for Programme C's workshop content. There was a set curriculum for the workshops. Topics for the workshops included (Website 1C):

- *eating well with Canada's Food Guide*
- *introducing solids/ making your own baby food (including promoting breastfeeding)*
- *preparing healthy family meals and snacks*
- *developing basic food skills*
- *reading food labels*
- *safe food handling*
- *budgeting food selections*

Respondents additionally commented on the workshop content to cover:

- *'parents having knowledge to eat healthy through Canada's Food Guide'* (Respondent C1)
- *'increasing access to and consumption of fruit and vegetables'* (Respondent C4)
- *'addressing cultural issues, adapting dishes and trying different foods'* (Respondent C4)
- *'the healthy eating environment'* (Respondent C1)

Consistent and key messaging was emphasised.

'all those things that we drive to our parents is low salt, low fat, low sugar, and if we manage to keep those three components at a minimum we will be healthier people...and when they get it, they get it, key messages are so important' (Respondent C5)

The practical and comprehensive aspect of the programme was commented on: 'learning new things and making healthier choices' and the 'whole family eating healthy' (Respondents C, C3).

'so we know that the population we serve is generally the low-income population so we have to go in with those adjustments, so we don't tell them to buy steak, maybe they buy tough cuts of stewing beef and tell them how to prepare it, so we tailor it...we give them scenarios like if you have \$10 and you and two children to feed and they say they can go to McDonalds but then you tell them you can buy A,B, and C for that and get two whole family meals from it' (Respondent C3)

'now we give them nutritional information, a better insight in terms of making a better decision in terms of healthy eating...so we are equipping them with some information so that when they go to the supermarket they can make better choices in terms of food purchase, in terms of nutritional purposes and making sure that whatever decision they make, they make it based on having some knowledge of how to eat better' (Respondent C5)

'food literacy is a determinant of health - if you don't know the language, if you don't read you don't speak the language, you can't do anything...we talk about eating on a budget, comparing foods, even community gardens, how to shop without a nearby supermarket, helping to read labels and recognising foods... I think the programme really does a lot for food literacy' (Respondent C2)

Though the education workshop series had a curriculum, which could be tailored to the group, there was no set curriculum for the support sites (Respondent C2). Whereby the focus of the workshops was around food and nutrition, the focus of the support sites was around the SDH. These topics were described as 'a whole gamut of things' (Respondent C5) and were in response directly to requests and identified need within the support site groups. There might be workshops on city recreation programmes, gardening, dental hygiene, sexual health, sun safety or broadened to relationships, housing, financial supports, Revenue Canada talking about how to do tax returns or the police service talking about community safety

(Respondents C1, C2, C5). These support sites could also include topics on healthy eating from time to time, as was observed.

All programmes were consistent in utilising Canada's Food Guide (HC, 2007a) as a tool to guide their content. Content generally revolved around knowledge, awareness and skills of healthy eating. And this could include more tailored content in this area around eating on a budget. Where the food content of programmes was expanded was mostly reported through Programme C's support sites that centred around SDH content, that could translate to a much broader scope of work. There were also some indications of Programme A being open to this expansion of topic coverage for LCFAs, however, not for LCFAs operating within Programme B as their topic coverage was for the most part more restricted.

5.7 Programme Beneficiaries

Section 4.9 covered target population of programmes at strategic level and outreach strategies, this section explores the reality of programme beneficiaries – those who were actually participating in the programmes.

Case A respondents reported that it was both easy and challenging to get people to come to the programmes. And there was also general recognition that some people weren't being reached. Respondent A2b expressed the challenges in their centre with different cultures, and to 'get something happening that pulls them all together.'

'getting people to come is only the first step, then we have to keep them interested'
(Respondent A4)

'It started with me cooking food during the food distribution at the community centre and enticing people in' (Respondent A5)

Participants were reported to be new to the community or new to Canada and included mothers, fathers, grandparents, single parents and young men (Website A). Respondents reported that some participants drove to the centres, and didn't come from the low-income housing nearby (Respondent A3, A6).

'The women who come to the programme are typically less needy. They love it. It was free for awhile and they were coming then, and that's a little harder to see people accessing the programme who don't really need the food in that sense.' (Respondent A6)

'most, almost all, in low-income communities so that would certainly be key...but with the acknowledgement that we are not just running a low-income programme, it is universally open to anyone...a lot of the sites actually encourage people from a variety of backgrounds to attend to build those inter-connections within groups, within the communities...because that then makes the community stronger...but where we place the LCFAs is usually within neighbourhoods with higher proportion of low-income...it is

that balance between being universal and somewhat targeted to being open to all but trying to address that' (Respondent Aa)

Respondent A6 reported that though their target population had been low-income, she found over time that she typically wouldn't see this, the participants were the stay-at-home mothers, with support, with a decent household income, who were used to preparing meals at home and came to the programme for the enjoyment of it, and this was observed (Observation 1A, 2A, 4A). This was reported to be the case for the last couple of years and there was some repetition with people 'piggy-backing' on other programmes. Respondent A6 noted that those accessing the programmes were often those who were aware of what was going on in the community and just kept coming, often going to multiple programmes in the community.

'the lady today was going off to another community kitchen straight away after this...and that's the thing, there is a programme here on Monday morning and some of them are in both, and that kind of defeats the purpose of having two different times and getting more people in' (Respondent A6)

It was also observed that one of the same participants was present in two community kitchens, in two different sites (Observation 3A, 4A). One organisation started doing draws to fill the spaces and would exercise some control over ensuring others had a chance to participate (Respondent A6). One observation was clearly reflecting the immigrant population and quite diverse, with a YMCA settlement worker bringing participants in (Observation 3A). Another observation that was in an agency with a food bank (targeting the low-income population) had participation from women who did not fit in the client group (Observation 2A). Respondent A4 pointed this out, that these participants were 'more likely to be food bank donors than food bank users.'

'Even the families who do have an income eat a lot of processed foods.' (Respondent A1a)

'I would say that those people who we should be targeting most are those families. The ones on lower income, I would say a lot of them have the knowledge and are cooking from scratch and fruits and vegetables. Whereas those on two incomes and having kids in all kinds of programmes are going out picking up food all the time, a lot of times they pick up what they think is healthy and it's not ...that's why the class on Saturday mornings even though they have money, they work and are then cooking bulk food that they can freeze and it's healthy meals.' (Respondent A1b)

The main groups of participants in Case B were reported to be seniors, school children and immigrants. Observations revealed participants to be mostly seniors (Observation 1B, 2B, 3B). It was reported that this was because seniors and immigrants cared about their health, that they recognised the importance of it at that stage in their life or had that enthusiasm for learning (Respondents B4a, B6). Participants were reported to come to the groups for a

variety of reasons; for some groups, social isolation and mental health was the biggest reason (Respondents B4a, B4b).

'People, my peer group (neighbourhood based) all think that cooking from home is more expensive and harder to do than fast food. And they really believe that because they don't know how to cook.' (Respondent B4b)

'you have this group of 20-50 year olds who just think cooking is a nightmare, it is so hard to do' (Respondent B4a)

'some of it is we are trying to reach the low cost, you know, trying to encourage, but we haven't been very successful with that because of their location - low-income groups, and certainly with the schools as there hasn't been much support on that in the Public Health unit' (Respondent B5)

There were a number of reported challenges with participant reach. One high demand group respondents talked about was schools and that there were many requests that were increasing; they could not reach all the schools (Respondent B1).

'Kids are learning the food guide which I think is a very well organised piece, it is not complicated. The schools like us but there are not enough of us to go into schools (classroom based).' (Respondent B4a)

Some 'high-risk' populations were reported to being reached but there were many that weren't. Respondent B3 raised some challenge with the peers and outreach to vulnerable groups, and that some groups were hard to work with because they 'didn't necessarily have a good handle on who they were and their needs.'

'Because we only have so many LCFAs it is impossible to reach everybody so we try to focus on people who really need the services. Youth, people on low-incomes, the people we reach are usually the ones who need the services. But there are a lot of people we haven't reached, like the homeless, teen mothers but serviced by other groups, community housing - LCFAs go into.' (Respondent B1)

Indeed, there were mixed feelings on who was being reached. For example, Respondent B6 stated that 'only those with the most resources were coming out to the programmes', those who were already 'ahead of the game'; that they were still not reaching those with the most issues. This was echoed by Respondents B3 and B5. Another challenge was raised of responding to community requests but having no audience or low attendance due to different factors including: not promoting the event very well, people not being interested or not motivated to attend and this was 'common in the community housing.' It was pointed out that it could not be expected that everyone would be motivated to learn or even care (Respondent B1). Respondent B3 reported this as well, and the time and motivation to learn was key to get people to come out, that they were for the most part getting people who had the skills and were motivated.

Participants of Case C were primarily those who had immigrated to Canada at some point, and targeted in particular were those who had newly immigrated, as they often no longer had their wider family support and were considered most isolated, so to enable them to keep healthy habits and adjust to a healthy lifestyle in Canada (Respondents C, C3). It was pointed out that they often got participants who were new to Canada and couldn't get a job so in the meantime were connected to agencies and participating in programmes being offered in the community; these participants were often well educated professionals who were keen to learn. Report 1C found that many of the participants were 'living in poverty and dealing with food access and insecurity issues' (Report 1C). Most respondents confirmed this. Though the programme was for everyone, one respondent questioned whether this was the best use of resources (Respondent C3).

'at the end of the day, are we only reaching some people, some people may still get left behind... I always say that if it is a hard to reach client, the poorest of the poor, they may not be able to travel, they may not live in a house, it may just be a rooming house or shelter, those are the people we want to get, but they are at a different stage... we have so many problems here, so even though we have a healthy city for all, people are still not accessing or we are still not able to reach them because maybe it's a mental health issue we have to address first, then after that maybe it's housing, then something else...we have to do these different steps, so maybe we need more housing first, maybe it's more job creation first...then we can start with nutrition afterwards, but if we start with nutrition, maybe we don't get the people who really need it' (Respondent C3)

All respondents reinforced there were groups not being reached, the challenge of how to pull individuals and communities who were isolated out of isolation.

'the programme is really geared towards our population which is parents and caregivers with children six months to six years old and are a variety of cultures and are generally newer to Canada, and/or are the hard to reach population which could be LGBTQ, Aboriginal, blind/low vision, teens... we would love to get more of those kinds of groups - so that is our population.' (Respondent C2)

Though the hard to reach was a gap identified, respondents were still unclear why. Some reasons given were that some communities were untrusting, fearful or wary, particularly when this was a service being offered by Public Health. This was reported to particularly be the case with the Indigenous community due in part to history, and with new immigrants who were not used to this type of government programming.

'The Aboriginal population. Jamaican/Caribbean is so hard. French Creole community. We had someone do a literature review and looked at this. I have read that trust is the big thing for the Aboriginals and for the Jamaicans it's criminality, they are a big target for this. It can be hard to get them to come out. There is a big African community that speaks French but it is tough. But I don't know why, the lit review we conducted did not show much. We do have someone who speaks French and is from Haiti but 80% of her work is English.' (Respondent C1)

The African Caribbean community, according to Respondent C4, despite being representative of herself, were hard to reach, due in her opinion to 'societal and cultural factors.' And that sometimes participants could feel that the programme was there for other reasons such as 'to identify child protection issues' (Respondent C3). Word of mouth and LCFA reputation was reported to be powerful at getting people out (Respondents C4, C5). There were also cultures that were felt to be more programme-oriented, such as the Asian community, 'for them, it is the networking and socialising' (Respondent C4).

'you don't have to coax them or beg them, they have a system where one tells the other and boom, you have a room full to capacity...and you have another culture where it's like pulling teeth' (Respondent C5)

For Case C, the first observation of programme delivery was located in a community hub 'working women centre' (aimed at immigrant women). All participants, except one, had immigrated to Canada in recent years (Observation 1C). This participant happened to be a teacher on maternity leave taking the programme for the second time. The second observation was based in a community centre amidst community housing, in a low-income area, with a group of newcomers who were all Arabic women (Observation 2C). The support site was in a social housing building (Observation 3C). All groups visited were culturally diverse (likely reflected in that the delivery was in English). All participants in the healthy workshops were women, with a few men (together with their wives) participating in the support sites. The support sites were reported to be inconvenient for some participants to travel to (Respondent C1). One LCFA pointed out that although they would get many of their target audience, some women did not come out to the programme because of logistical issues such as living in social housing buildings several floors high with no elevators, which was preventing them from coming because of the effort involved travelling up and down stairs with strollers, babies and small children (Respondent C4).

Additionally, there were comments on the issue of attendance, so although many people were waiting to get on to the education workshops, only some of those who were registered showed up. Respondent C3 commented that her recent list for the workshop series observed had 17 people registered, and only five showed up; and that a wait list was a barrier for people to access the programme because if the timing wasn't right they may miss out, for example, they may be returning to work by the time they were off the wait list. Yet, the wait list had to be there as they couldn't take that many people on at the same time.

All programmes reported beneficiaries to be both part of their target populations as well as expressing challenges with reaching the hard to reach. Many beneficiaries were not from the

target populations, but participating in the programmes because of want and interest rather than need.

5.8 Barriers and Drivers to Participation

Barriers and drivers to participation were explored and how or whether programmes were addressing them. This is mostly for programme beneficiaries but also covers LCFAs.

For Case A, funding for agencies did not seem to cover actual resources, handouts or food for the group participants. As a result, some agencies reported charging a small fee to participants 'just to cover the cost' or 'share the cost', the contribution ranging from \$3 to \$10 per participant (Respondents A1a, A2a, A2b, A5, A6). This was the only way agencies could make it work because they didn't have extra money internally to cover all those costs. This cost-sharing with participants was generally not seen as an issue either and the programme was reported to be 'cost-friendly' (Respondent A1a). They pointed out that the fee could easily be waived if it was an issue.

'We have many families living in poverty, and so if we have a family for the food bank and if they can't pay that fee, we can waive it...or we have a food cupboard here and they can access it.' (Respondent A2b)

'if anyone has an issue with paying, we can get around that and subsidise, it is interesting though because that is a buy-in, because if they pay a small amount and they show up... yes, and we can't do it otherwise, they take more ownership and responsibility that way' (Respondent A2a)

This small fee charged to participants sometimes enabled agencies to pay LCFAs more. Respondent A5 pointed out that she could be paid more because the agency she was employed by charged a small fee to those participants who could afford it.

A key barrier to accessing programmes was highlighted to be the cost of transportation. Respondent A2b described a young mothers' group that focused on cooking skills because they came without any of those skills and were a group often living in poverty. This group would get bus tickets, a bag of food from the food bank and a food voucher to enable access to the programme, however, most groups did not receive these items which depended on the site organisation or partner. Respondent A4 did comment that she had the flexibility to provide bus fare 'if it came down to the difference between someone being able to come or not.' Some respondents reported that many of the issues experienced by programme participants were the same - managing money, how to cook, how to prepare meals - regardless of being on social assistance, low-income or not, and that across the socio-economic scale people needed support (Respondents A3, A6).

Similarly, Case B's response to limited funding translated to Public Health units not covering some expenses such as mileage for LCFAs and expectations for community agencies to cover the food costs and other related costs of programme delivery 'because the service was free, however, Public Health would cover those costs for priority populations if needed' (Respondent B1). Respondent B2a reported that some of their LCFAs 'chose to cover the food costs themselves.' There were some thoughts in line with Programme A's, Respondent B5 suggesting that perhaps charging a small fee to participants might guarantee their attendance, '50 cents or one dollar, then they may be more committed to coming' (Respondent B5). Motivation, as mentioned earlier, was considered a key reason for participating or not participating (Respondent B1,B3).

For Programme C, participants received on-site childcare, vouchers for healthy food (to use at designated supermarkets), and transportation allowance. In previous years, the workshop component of the programme had a greater allowance for the supermarket vouchers but due to budget constraints had reduced this (from \$40 to \$20 value). The support sites linked to a good food box programme, whereby participants received vouchers to buy produce on a monthly basis that they ordered together as a group.

'You can only try so many different strategies to get people out - yes, come on there is an extra \$20. You can bribe them. But they have to want it.' (Respondent C3)

Running Programme C in different languages helped to increase access. The support sites were most commonly run in English because they had a wider population (taking in multiple groups from the workshops), although there were exceptions, such as a support site for the Chinese community which ran with languages of Mandarin and Cantonese. It was reported that once people had more years in Canada, they tended to be more open to do other things and were most likely to participate in the English-speaking, culturally mixed groups the programme offered (Respondent C3). It was felt by some that people wouldn't come out without an LCFA representing their culture (Respondent C4).

'Most people coming from different cultures, who have immigrated here, most of them don't choose mainstream agencies. They want someone from their own culture, they will trust and they will come. That information piece may be missing, and when you go somewhere, some agency where they use interpreters, they will tell you that message is not the same. People prefer not using interpreters. They say it is too much - this lady is talking, this lady is interpreting, and maybe something they are saying they are missing - so they say they just walk away, they just don't go.' (Respondent C3)

LCFAs for Case C commented on the limitations to what the programme could do, even if they wanted to give more resources.

'we have policies we need to follow and it is hard to bridge those policies because we are not the policy makers and so we work within the confines of the policy'
(Respondent C3)

Referrals to other resources such as food banks were common and were considered to have both advantages and disadvantages, but an option for participants who needed the extra help. Food banks were also described as a 'gap': the concern that the food was not enough, the food was not healthy or expired and that food was being given and people may not know what it was or how to use it; even if the food was not healthy, it was 'still food' (Respondent C2). Programmes were helping with this gap in some way. But it was also remarked on that this took some encouragement despite the need being there, as participants would say they often felt 'ashamed' using a food bank (Respondent C4). Some of these comments were echoed in Programme A.

'So maybe they have just lost a job and maybe are only just above the poverty line but you know there is a need there. So we buy food and gifts for them for Christmas. I had this guy say to me, 'I have been to the food bank and gotten things, and am grateful to have to provide for my son and myself'...He has had expired food, he has had food that was starting to rot. And he said 'you are already about as low as you can get, and you get that over top' and it's just such a deep cut'...I never really realised the impact. I had no idea. But he said it all had to do with that feeling of you being second best and that you don't deserve anything. He said he couldn't remember the last time he had fresh, good food.' (Respondent A1b)

Programmes were for the most part free to access with the exception of Case A whereby some community agencies charged a small fee to cover costs and get buy-in. There was provision of instrumental supports mostly reported for Case C but all programmes reported some level of scaling-back or limitations to their resource provision.

5.9 Programme Support and Supervision

Section 4.6 introduced the programme structure and support at strategic level. This section explores programme support and supervision at a practical level, particularly as applied to the LCFAs and the differences emerging through remuneration structure.

For Case A, the regional Public Health unit provided one level of support for the peer workers in terms of training and resources. The community organisations acted as the recruiter, employer and supervisors of the peer workers. It was reported that this aspect often caused confusion with the peer workers (Respondent A1a, A2a).

'Sometimes it is a grey area around who owns the programme. Because the training is done by Public Health depending on relationship with the community centre, some of the peers can think they are Public Health employees and they go directly to D at Public Health for questions instead of their site supervisors and that really should not be the case as really it should be the agency who they work for. If there is anything that has to go through it needs to go through the site supervisor first and I know with an LCFA in particular they always go over their supervisor and go to Public Health.' (Respondent, A1a)

Respondent A1a also reported there having been some issues between some agency supervisors and the peers, that could be exacerbated by a lack of clarity around role of agencies and Public Health. Respondent A2a reported working out ways in which to better this understanding, including peers being part of their staff meetings so they were recognised as internal staff. Respondent Aa recognised that role clarification was an important part of the process such as 'who did the recruiting and hiring' and Public Health's role with the broader programme. And at times this had been challenging due to Public Health's interaction with the peers through being the training provider and outlining the goals of the programme; so they had been working to keep that clear.

Overall, supervision was generally reported to be a positive experience; all supervisors who were interviewed were supportive of the programme and all LCFAs interviewed reported feeling well supported from their direct supervisors (community organisation site supervisors).

'what are the boundaries and what is proper coaching and mentoring and how do you guide that relationship so that it's not another barrier for the peer themselves'
(Respondent A3)

Respondent A5 stressed the important role of the supervisors 'supervisors can make or break the programme' (Respondent A5). Though, Respondent A6 commented that it could be difficult 'to get reliable support.'

'I don't have an exact budget and don't know exactly how much I can spend and different things like that I usually like to know...it's hard for me to perform the way they are expecting if I don't know what my expectations are...I think it's the atmosphere here but having other programmes before coming here have made it easier for me probably...I brought those expectations along from the other experiences'
but also
'I have lots of freedom here and even in other places...it's been very open...my supervisors have been very open, asking me what I want to do and have been very open to change.' (Respondent A6)

LCFAs reported and appreciated flexibility (mentioned previously) and trust from their supervisors enabling them to broaden their scope, and this was echoed by the supervisors.

'We can do a grocery store tour if we want to - both Public Health and my supervisor have said this is ok. You are not restricted to your kitchen which is kind of neat.'
(Respondent A6)

Though the cost-effectiveness was reported, the time for supporting the peers was also pointed out as having to be factored into the cost-savings (Respondents Aa, A2a, Report A1).

For Case B, LCFAs were supervised and supported by the programme coordinators (dietitians) in local Public Health units. Some health units such as that of Respondents B2a and B2b had a supervisor of volunteers as well. Some respondents described how the support for the LCFAs had dwindled over the years due to less staff time being allocated to the programme. One local coordinator stated that her position five years prior was three days a week and had since moved to one day a week to dedicate to the programme. She reported that this was directly related to how connected LCFAs were to the programme and the organisation, and impacted on the length of time they were able to maintain volunteers (Respondent B3). This was echoed by another local coordinator (Respondent B1). As well, the reduced support was recognised by the LCFAs interviewed (Respondents B4a, B5, B6). Supervision and support for the LCFAs was seen as different because they were volunteers and this was expressed to be challenging. Reconnecting LCFAs provincially so they could have wider engagement across the province was thought to be important (Respondent B3).

'You have to keep them motivated and engaged and it's hard when you don't have a lot of time and you have to work with them differently because their expectations are different between a volunteer and someone who is being paid... that ongoing commitment and relationship is always there.' (Respondent B3)

The programme was reported by another respondent to be more appropriate due to the LCFAs being volunteers rather than being in paid positions. Respondent B2b contended that there would always be a risk by not being employees and bound to the same level of obligation and commitment, but that they also offered 'checks and balances' throughout the programme.

'Over the years as I have worked on this programme, I wouldn't say that there is an issue with them not being paid, I think it is almost the opposite...rather than them feeling like they are employees fenced in by the rules and regulations of a programme they work for, I think they feel like they own the programme...I don't think it's a case of 'well, I am only going to give you your three presentations and you don't pay me', I never get that feeling, it's 'let me at it' ...their energy, if anything they would like more time to do this.' (Respondent B2b)

One LCFA pointed out the irony, that those volunteers who were 'good enough', wouldn't otherwise do it without being paid well.

'you can then have a bunch of highfalutin volunteers who you couldn't pay enough to do the job, but are willing to do it for free...I do think one of the benefits of being a volunteer is that I am not up on some kind of pedestal...I wouldn't do it if it wasn't a volunteer role, because you couldn't pay me enough, that's the funny thing, it's quite onerous' (Respondent B4a)

LCFAs commented that they were professional and treated their position seriously (Respondents B4a, B6). However, another LCFA commented that this was not always the case and that was because they were volunteers (Respondent B5). Respondent B6 pointed out what volunteering meant to her.

'I think volunteering comes from your heart and you do it to the best of your ability...I do it because I want to do it...not because it's my job and I can say no to this or that...I want to be here, this is my passion, it comes down to that.' (Respondent B6)

Respondents who were supervisors (local coordinators) all expressed that volunteer appreciation was important with some (Respondents B1 and B3) reporting recent challenges with being able to do this due to reduced funding with the programme. It was also felt by an LCFA that the model of relying on volunteers was 'unsustainable', that if she left the position it would be hard to replace her (Respondent B4a). However, the relationship was considered beneficial both ways.

'They are gaining something by volunteering with us but we are definitely gaining something by having them volunteering with us. So it is understanding them and why they are here with us and hopefully meeting that need because it is mutually beneficial.' (Respondent B2a)

LCFAs for Case C were supervised directly by the Public Health unit's programme-specific dietitians who had initial roles of mentors. Supervisors made sure that LCFAs were up-to-date on their information and were providing consistent and appropriate programming (Respondent C1). The dietitians were seen to provide the quality assurance piece. This was reinforced through observation of a programme meeting which included an education day and a team meeting (Observation 4C, 5C). The education meeting being held by the programme dietitians provided updates for programmes to ensure consistent messaging. It was also reinforced that the LCFAs were not there to be experts, but that it was important to be aware of broad issues because participants could ask questions. The team meeting observed was chaired by an LCFA, for which they took turns doing so. There was a discussion of trust and connections, and around the LCFA being important to be a gatekeeper to the community and activity, with that cultural linkage and understanding of culture. Both meetings had team building exercises, discussion and sharing. It was clear there was a comfortable relationship amongst LCFAs, supervisors and dietitians, where issues were openly discussed. Dietitians also supported the support-sites whereby they would conduct occasional workshops (as observed on the support site) and were connected with individual referrals.

LCFAs were mostly in full-time positions; there were some part-time LCFAs (three days a week) in order to spread out the languages. Supervisors and the manager expressed preference for LCFAs all being employed full-time and receiving full benefits. It was reported that the work

was difficult to do part-time but having regular hours was important as was a need to be flexible for providing programming (Respondent C1). LCFAs were unionised city employees and were reported to make 'good money...almost three times minimum wage' (Respondent C2). Respondent C spoke to her experience with the previous programme model (Programme B) and the reasons behind making changes to the programme.

'if you are trying to reach the marginalised group and you want true peers it's hard to expect and support them to volunteer their time when they are marginalised themselves, so I think that was part of the thinking around this programme... I know that at the time, I felt strongly that, it's great that we have these volunteers but the ones who last and really get good at it are basically the ones who have had the time and the money to do this...and the ones who really want to do it because they are peers, they do it because they really want to do it, but they do it for a year or two maybe but if they get a job they are going to take the job, which is good for them too but when you pay people you are going to have more stability and you value it in a different way...so the volunteer thing can be tricky...there are pluses and minuses to them both' (Respondent C)

By being paid staff, LCFAs could be supported and supervised differently and this was reflected in 'more commitment both ways' (Respondent C).

Across programmes, support for LCFAs varied with supervision ranging from dietitians as supervisors in Public Health to supervisors in community agencies. Generally, LCFAs reported to be well supported by their supervisors and agencies.

5.10 Summary

Chapter Five has explored the mechanism for programme delivery with RQ2. Findings revealed common themes around LCFAs acting as connectors, developing relationships and focusing on practical programme delivery. Tensions were raised around programme access and beneficiaries, limitations to coverage of areas and volunteer and paid models. Next, Chapter Six explores programme outcomes by addressing RQ3.

Chapter Six. Programme Outcomes

6.1 Introduction

This chapter sets out to answer RQ3: What are the programme outcomes at individual (for the LCFA and beneficiaries), organisational, community and policy level? What are their limitations and what are their opportunities? How do the different models compare? The chapter headings are laid out to answer this question, that is often unclear (linking to context and mechanism) and limited to individual behaviour outcomes. But first, this chapter explores the barriers identified around achieving healthy outcomes. Data drawn upon includes interviews, observation and programme documents. Respondents reported various outputs, outcomes and impacts all interpreted as short-term, medium-term and long-term outcomes.

6.2 Barriers to Healthy Outcomes

Section 5.8 identified barriers to participation of programmes. This section explores some of the barriers to healthy eating and good health outcomes. Specifically, what real life issues on the ground have been identified by respondents? Respondents were asked about the issues contributing to the problem of poor health and unhealthy eating.

For Case A, Respondent Aa described the problem being on individual and community level:

'the lack of knowledge and skills on an individual level and the lack of connections and supportive connections on a community level...that connectedness being the opportunity to then lead in to addressing the skills and knowledge' (Respondent Aa)

This description was consistent with many of respondents' comments, but the most common by far were lack of knowledge and lack of skills (Respondents A1a, A1b, A2a, A2b, A6). There were different views to what the issues were contributing to the problem across respondents.

- *'low-income/poverty or lack of money'* (Respondents A1a, A1b, A2a, A2b, A4, A6)
- *'food insecurity'* (Respondents A1a, A1b, A2a, A2b, A4, A6)
- *'time/ busy lifestyle'* (Respondents A1a, A1b, A2b, A6)
- *'motivation'* (Respondents A1a, A2b, A6)
- *'availability of unhealthy and processed foods (and lack of easily available and affordable healthy foods)'* (Respondents A1b, A2b, A4, A6)
- *'different family structures/family breakdown and less family meal time'* (Respondents A1a, A1b, A2a, A6)

'you can have a lot of knowledge and still not benefit from it, so skills is the biggest...and the wisdom and motivation to do it... people think they don't have the time but if people know how to do it, it's a motivation thing and organisation thing...it's a generation thing too...more women are working, there is more access to all these unhealthy foods, and that has been a big shift...many have never even learned those food skills and once it's lost it's hard to get back' (Respondent A6)

'It is so sad because a lot of this stuff they are buying that's processed, costs two times, four times as much as fresh. It's a lack of education and it cost them more.' (Respondent A1b)

A common comment was about lack of money, this could be a big issue and that people had to 'sometimes work with what was given to them such as food banks and had limited choices' (Respondent A6). Report 1A found that low-income rather than poor knowledge was a barrier to improving nutrition habits and highlighted the programme being 'only one component in improving the health of high risk groups.' Report 2A reiterated poverty being a major barrier to healthy eating and health. Respondent A3 pointed to the relationship between the programme and the system.

'As a small player and as an organisation that was trying to create community, more often than not, the formal systems that were supposed to be in place to make things better for families we were trying to achieve actually frustrated that goal...affordable housing for example - a lot of the Ontario housing wasn't really built with community, accessibility and transportation in mind.' (Respondent A3)

Most respondents of Case B pointed to different issues and that people weren't eating as well as they could for a number of reasons, identified as:

- *'food literacy' – 'although low awareness around it'* (Respondents B, B2b)
- *'obesity and health problems'* (Respondents B, B1, B2a, B4a)
- *'when it comes to food; home economics taken out of school curriculum creating a gap in knowledge for generations', 'lack of skills'* (Respondents B, B1, B5)
- *'parents working', 'loss of family meal time'* (Respondents B, B4a, B4b, B6)
- *'convenience'* (Respondents B, B2a, B4a, B5, B6)
- *'lack of finances', 'lack of resources'* (Respondents B, B1, B2a, B2b, B6)

Respondent B commented that health problems were driving a lot of the interest in healthy eating. Lack of money and the associated impact were reported.

'sometimes it is an issue of food security, of income...the SDH, they definitely have an impact on people's health, overall lifestyle and food choices' (Respondent B2a)

'it's certainly not access, we live in a green belt so food access is not an issue...some areas of the country, that is an issue and that would stop some people from eating healthy but that is not an issue here...in the Northern part of the province accessing food from a food availability perspective is an issue...but if you are looking at people having the personal resources to access healthy food, that is a different situation - this area unfortunately has one of the highest unemployment rates in the country and a lot of folks are struggling...in our area it is not necessarily a lack of fresh fruits and vegetables, it's a lack of knowledge and skills and understanding ...and even if folks have the knowledge, they just don't have the means' (Respondents B2a)

'in the last five years or so we have seen the recession, this region has suffered as much as any in Canada...folks often say they know how to pinch a dollar, they have the knowledge, what they don't have is the ability to purchase the foods and other living necessities with the household income they have' (Respondent B2b)

'if you can't pay your rent, well you are not going to be buying fresh fruits and vegetables and especially not if you don't live anywhere near that sells them - there are all kinds of issues there' (Respondent B)

Issues with children were reported as well.

'children have not been at a healthy weight the last few decades, it's not just food skills, it's activity, physical environment, the eating environment, there are a lot of reasons for poor health in children, and unhealthy weights is one of them... they have missed home economics, and there is no foundation to their learning if they didn't get that at home...so mothers used to stay at home and now they are all in the workplace...there is a generation of kids who have missed the opportunity to cook, we've got a societal problem' (Respondent B)

Case C respondents considered the issues to be ongoing, growing and interconnecting:

- *'unfamiliar foods for newcomers' and the 'healthy immigrant effect' and 'loss of support system' (Respondents C, C1, C2)*
- *'lack of trust', then 'becoming isolated' (Respondents C, C4)*
- *'income', 'lack of financial means', 'food access', 'food inequity' (Respondents C, C4, C5)*
- *'unhealthy eating environments' and 'modelling of food' (Respondents C1, C4)*
- *'access to unhealthy foods', 'processed, ready-made foods' (Respondents C1, C3, C4, C5)*
- *'lack of time' (Respondents C3, C4, C5)*

The struggles experienced by those groups who were new to Canada were repeatedly reported:

'as people grapple with getting work, some come with no education, all those things that make a person resilient are missing - education, language, some are coming and they are sick because they are coming from war-torn countries or whatever...all these people who really have never had a house where they cook their own food because they have lived in communal areas where everybody eats from the same pot and now they have their own place, and they have to figure out how to get meals going' (Respondent C5)

'people came here with good weights, healthy BMIs and then they come here and complain that they became fat and gained a lot of weight...they would say that they would go to the supermarket and see all these things, ready to go food, and they just jumped on that, but back home, home cooked food was the main component' (Respondent C2)

'So for many, they have come to Canada and find there is more food because you can walk into a supermarket and it is everywhere but when you think about food access or food inequity, we know that some people don't have the means which is financial means.' (Respondent C5)

'they are moving here, they are trying to get a job, they have now lost all their support and food may not be the primary concern...so for them, it's helping them get all those things that they will need to move forward through our current food system...so this is basic nutrition education, but information and resources, settlement and adjustment to Canada and understanding how food is different ...people have lost all familiarity with the food plus they get the pressure from their kids who grow up more Canadian and they come home and say they want hot dogs for dinner and they don't know what hot dogs are or whether it's something they should be feeding their kids or not so we have to help them make that transition into the country, into the city, give them that information' (Respondent C)

Respondents also spoke to layers of issues for people who were both Canadian-born and those who had immigrated, and that the problem of unhealthy diets and poor health was prevalent across the population; the issues were getting worse due to increasing food prices (Respondents C3, C5).

'Especially now we are going through this problem of food prices rising, I mean, it is actually through the roof right now, so how do we bridge that gap?' (Respondent C5)

Respondents talked about the knock-on effects of issues contributing to the problem.

'so we look at nutrition playing a vital role in growth and development and if they (children) don't start out right, poor health comes with it and then it causes a bigger problem for us' (Respondent C3)

'if parents eat poorly, their children will eat poorly, and then we have a society with more people with health issues' (Respondent C5)

'it is about anything and everything as we experience life...because it is life...it is not just food that affects our lives, it is also other components within our lives that affects the way in which we survive and thrive' (Respondent C5)

So, respondents across cases generally expressed that there were big issues and challenges to working to address the problem of unhealthy diets and poor health in the community. A knowledge and skills deficit around healthy eating was commonly reported across cases, but there were bigger issues presented by respondents that underscored the problem such as access occurring across the population due to different societal changes.

6.3 Programme Outcomes at Individual Level

This section explores individual level programme outcomes, including those for programme participants and LCFAs themselves. Keeping in mind, participants were not being directly asked questions.

At individual level, Programme A outcomes were reported to be (derived from Report 1A):

'increased individual capacity by providing LCFAs and programme participants with knowledge and skills around healthy eating and food skills through
-increased personal skills and knowledge of both LCFAs and participants
-strengthened supports and connections of both LCFAs and participants
-enhanced personal development of LCFAs and participants'

Respondents reported a number of individual outcomes (reinforced in programme documents), ranging from short to long-term outcomes for participants.

- *'getting a healthy meal during the programme'* (Respondent A2b)
- *'increased knowledge about healthy eating'* (Respondents Aa, A1a, A1b, A4, Report 4A)
- *'increased food skills'* (Respondents Aa, A1b, A2b, A4, Report 4A)
- *'healthier eating'* (Respondent A1a, A1b)
- *'increased awareness of local programmes and services, including links to basic needs support'* (Respondent Ab, Report 2A, Report 4A)
- *'increased confidence or leadership development'* (Respondents A1a, A2a, Report 2A, Report 4A)
- *'social connectedness, friendships and relationships' (including family)* (Respondents Aa, A1a, A2b, A4, A6, Report 2A, Report 4A)
- *'supporting mental health'* (Report 4A)
- *'broader reach/ increased capacity'* (Respondents Aa, Report 2A)
- *'they are more engaged'* (Respondent A1a)
- *'they are empowered'* (Respondents A1a, A2b)
- *'improved long-term health'* (Respondent A1a)

Outcomes for LCFAs were reported to be:

- *'building capacity in healthy eating and food skills'* (Respondents Aa, Ab)
- *'giving back to community and making a difference'* (Respondent A4)
- *'increased referrals and connections to community resources'* (Report 2A)
- *'increased leadership skills and/or programme development skills'* (Report 2A, Report 4A) *'relationships'* (Respondent A5)
- *'increased opportunities'* (Respondents A4, A5)

'This is two hours of relaxing and fun and meeting other people, two women from a six week session become friends, and this is a huge achievement for me... they would otherwise still be in home and now they support one another and do all sorts of things like look after each other's kids.' (Respondent A4)

Respondents spoke to the programme opening up the door to further opportunities, community services and programmes. Respondent A2b reported how they encouraged some participants to volunteer to get them out in the community and gain some experience and be a 'stepping stone' to something else.

'feeling better and then branching out to participate in other things like starting walking groups, taking up swimming together, reading programmes' (Respondent A1b, A2b)

'to build community and bring people together so that they feel part of the neighbourhood, part of the community and then when they come in here for a cooking class it may branch off and they do a fitness class; so it's not just the healthy eating, it becomes a healthier lifestyle and they come back and do other programmes - parenting, child programmes, we do a multitude of things' (Respondent A1a)

Reducing social isolation, increasing friendships and community connections were of the most predominant outcomes given by respondents, this being shared in interviews and programme reports. Many reported the benefits of sharing among participants in the group. And some noted they ran into participants of the programme many years on.

'when I meet people after so many years and run into them they tell me things they remember...one woman said that every time she goes into the grocery store and tries to buy something that's not healthy, she hears me say 'don't buy that'...another woman saw family she hadn't seen in a long time, they all complimented her on her skin and the only difference she had made was eating lots of vegetables because of the programme' (Respondent A4)

'one of the key outcomes is that a child has a little bit better diet because his mother learned some key skills and gained confidence in the kitchen' (Respondent A2b)

Programme A observation (Observation 1A, 2A, 3A, 4A) resulted in hearing about learnings and changes participants were actively making through increased knowledge, awareness and skills. This happened through both workshop and community kitchen sessions. Participants were trying new foods in the sessions as well as trying recipes with their families and reported making changes to their food purchasing practices.

There was recognition that this programme positively affected many people who would otherwise not be impacted on through Public Health (Respondent Aa).

'There are different steps to the whole process. There may not be specific patterns that people are following in order to change behaviour. First is awareness, then acceptance and things like that. Depending on where they are at on the spectrum, my hope is that they can get to the next step. And for people who have changed behaviours, I know their kids are getting healthy meals and that's the biggest thing because it's raising a generation of healthier people. I strongly believe that what happens at home is what influences a child the most.' (Respondent A6)

It was reported that changed behaviour resulted from participants coming consistently and over long periods of time. Some noted that coming for a six week session resulted in some changed behaviour (Respondent A4) whereas others felt that longer was needed and participants needed to be supported in making changes (Respondents A2b, A6). 'People do carry this forward, even if they take one thing, it makes a difference' (Respondent A4).

'Someone who comes for just five weeks, they are really just scratching the surface and you don't see as much changed behaviour long-term...there is a benefit to come to repeated sessions' (Respondent A6)

'really, it's what happens at home that is the biggest factor, if parents can take that home and influence their children, that is the biggest long-term effect' (Respondent A6)

And the benefits of employment opportunities through the programme were highlighted.

'But really the peer programme has allowed for a model to grab hold of and was a good fit for what the vision was and sustainability. And a way to train people in a credible way that gave the individuals skills and a way to sustain themselves because truly we have people who are not on social assistance because they have been able to come through this.'

(Respondent A3)

Programme B revealed some similar outcomes. Respondent B commented on the most obvious outcome being 'to try to get people to eat well.' Outcomes for both LCFAs and participants were:

- *'increased knowledge and developing personal skills'* (Respondent B2a)
- *'supporting one another, social and emotional support'* (Respondent B)
- *'increased access to food skills and educational opportunities'* (Respondent B1)
- *'increased awareness of other community resources'* (Respondent B1)
- *'increased awareness – the biggest thing'* (Respondent B2a)
- *assumptions around 'increased knowledge and/or skills'* (Respondents B, B1, B2a, B3)
- *'social cohesion'* (Respondents B2b, B6)

LCFAs were also considered leaders, as 'empowered' and that they 'were the ones who knew their public' (Respondent B2b).

'one of the interesting things that happens is that LCFAs are really passionate about the programme and there is no better engaged group than the LCFAs themselves; they themselves are really interested in systems change and policy work and so on...and they are leaders and champions in the community' (Respondent B2b)

It was acknowledged that food choice was complicated, and the programme couldn't be and wasn't the only influencer on health.

'it would be ignorant to think that the work we do is solely beneficial to the public...that this is what is only making a difference...and that there are so many other systems in place working together' (Respondent B2b)

'If our stats tell us anything, we still have similar issues in the community' (Respondent B2a)

Respondents did place high value on the LCFAs playing a role in connecting with individuals and with community groups, and this was seen as key in developing relationships and having more impact: 'if you don't have the community connections, it is very hard' (Respondent B2b).

Respondents expressed the difficulty with measuring and showing programme outcomes, in particular, behaviour change. The main challenges were that the programme delivery

structure was by way of 'one-offs' and they couldn't do follow-up. As such, there were many assumptions they had to make (Respondents B, B1, B3).

'But I would say one word is the biggest thing - awareness. And I might couple that with, although that is what I would want the audience to get out of that -awareness...so the outcome of knowing people's awareness and what is the outcome from that - is probably the most important outcome and is reasonable to think you can get that from presentations and demonstrations that are typically one-off.' (Respondent B2b)

There was recognition by respondents that funding was connected with outcomes.

'it is no longer that programmes can get funded these days without showing outcome indicators and I think that is one of the main problems with this programme, we can show impact in terms of our reach but we don't evaluate on a provincial level the impact it has on changing behaviours, whether it's increasing local food or increasing fruit and veg consumption or decreasing unhealthy eating...we don't have the data at provincial level to say the programme is meeting those and if we did, the programme would be in much better shape' (Respondent B)

Respondent B noted that the biggest impact was on individuals but they only had 'population data'. They played 'the numbers game' because this was what the ministry liked to see.

'We can show 21,000 individual beneficiaries in one year across the province. And with this extrapolate the numbers beyond, to households...where we really get tripped up is not having the data to support food literacy at the local level and having numbers to back it up' (Respondent B)

Respondent B had conducted a provincial review and found that 'very few programmes were able to capture behavioural change.' Respondents noted that it would be more effective and impactful to do series of sessions with evaluation (Respondents B1, B2b, B3). However, it was not known how many sessions would be the right number to have any kind of long-lasting impact.

'although we would like to have bigger reach, we have more impact on an individual and when you get to know a person on a personal level, there is that trust and they start to look to you and ask you questions they wouldn't ask other people...I would like to see more of that happening but the kinds of requests we are getting in the community are one-offs' (Respondent B3)

Respondent B voiced that the programme needed to be more strategic in how they implemented it in order to 'show health indicators' and were looking at how they could evaluate programmes to show outcomes such as individual behaviour change. This was reported to be a challenge without provincial coordination as programmes were 'now doing their own thing and responding to their own local priorities.'

'Theoretically someone's knowledge increased in something but their ability in not being able to do anything may actually disadvantage them because they have knowledge of what they should be eating and how they should be eating it because for whatever reason there may be barriers.' (Respondent B2b)

'we know that eating more fruits and vegetables can help reduce obesity but can we make a conclusion like that from a programme like this? Probably not' (Respondent B)

'How do you know it was us? How do you say that the LCFA demo that made all the difference, that that was the last thing they needed to make those changes? You can't. There are too many things that influence our behaviours.' (Respondent B3)

Respondent B3 commented that they did link with research that looked at food skills and connected it with the programme, as an important component in knowing how to help people to make changes. It was pointed out that 'peer education' had benefits beyond awareness and education, being able to connect with friends and the community through these groups meant there was a benefit to their mental health (Respondent B1, B2b), 'an enrichment for them socially' (Respondent B).

The programme logic model for Case C (Document 1C) had the primary short-term and long-term outcomes to be measured by number and percent of children meeting dietary guidelines and maintaining fruit and vegetable consumption. Secondary outcomes were measured by strong community partnerships, increased opportunity for community to access nutrition services, interdisciplinary collaborations and increased LCFA confidence, knowledge and skills as well as improved behaviour in participants.

Individual level outcomes, ranging from short to long-term, were reported to be:

- *'increasing awareness and knowledge'* (Respondents C, C1, C2, C3, C5)
- *'getting healthy snacks and vouchers to buy healthy food'* (Respondents C3, C4)
- *'increasing fruit and vegetable consumption is increasing healthy eating'* (Respondent C1)
- *'making healthy choices', 'behaviour change', 'keeping healthy habits'* (Respondents C, C2)
- *'the greatest benefit is that the mothers know how to feed their children healthy food'* (Respondent C5)
- *leadership opportunities ie. through taking lead of good food box programme* (Respondent C1)
- *'it's building capacity for the participants and hopefully they carry that on once they leave the support site'* (Respondent C1)
- *'healthy population' and 'reduced chronic disease'* (Respondents C, C1, C3)

Respondents all remarked about better long-term health outcomes for the population resulting from starting early.

'we are influencing the way children eat, so hopefully they will be eating healthier when they are older and their parents have learned some skills that affect them...so hopefully we are making an impact as far as their health, so we have their eating habits which leads to less chronic disease in the future' (Respondent C1)

'if you come to Canada new, what do you do? and so learning all these different things and so at the end of the day, we don't have that much in health care costs'
(Respondent C4)

'getting everyone to eat healthy so we have a healthy population...and people making healthier choices so they can reduce the risk of chronic illness' (Respondent C3)

The supplemental material supports were recognised as only short-term 'it is small, a short-term fix, but it is better than no fix' (Respondent C5). But this coupled with further referrals to the dietitian or food bank was making a difference in enabling healthier eating habits.

'it addresses inequalities in nutrition, because when they come to the programme we provide healthy snacks, tokens and vouchers...we can't do everything but we can do a portion' (Respondent C4)

'people tell me what the meal does for their family, the reaction is hugely positive...in the short-term they are making changes...and the longer term we have the support sites...because they have that extra year, twice a month, an opportunity to come out and talk about different things as it affects them and it is not just about food but health and wellness' (Respondent C5)

The leadership element with participants came out in the interviews. It was stated that throughout the programme, participants were given opportunities to learn and grow and to take ownership. For example, some participants would take the lead on organising and ordering the produce for the box schemes and helping to lead the exercises at the beginning of a session (observed too in Observation 3C), 'so teaching them to be leaders, we give them a leadership role and they run with it' (Respondent C3). Participants had used the programme to their benefit in order to find work too, by using the certificate of completion from the workshops to get jobs babysitting or setting up their own daycare, making healthy snacks in schools or childcare programmes or working in kitchens because 'the certificate showed they had food skills, food safety and knew how to provide healthy food for their children' (Respondent C4).

'I think when people come to the programme, they come with the knowledge somehow that if they do the food skills this can help get them a job...and if you are resilient you can, if you know how to sell what you have learned, you can...and I think some people have and some people are very smart and use that piece of paper to work for them...it is not a university certificate, it is just an acknowledgement that you have done something and they have used it and gotten jobs...and it works' (Respondent C5)

Positive outcomes were expressed to be not only for the participants but also for the LCFAs who all reported they were making a difference.

'at the end of the day when you finish the group and you hear a mother do a testimonial about what the six weeks has done for them, it makes you feel good too...it is not just the mother, but at the end when you know the result is astounding you know people appreciate what you do...we just keep on moving forward' (Respondent C5)

The second predominant outcome reported was the social aspect, community connections and reducing social isolation and the effects ranging from short-term to long-term.

- *'reducing social isolation - trying to get people out and comfortable going to the programme'* (Respondent C3)
- *'it's social, and hopefully everyone is leaving having a connection with someone'* (Respondent C1)
- *'having things in common, coming to a group breaks down isolation, particularly if new to the country'* (Respondent C)
- *'developing relationships, making friends'* (Respondent C3)
- *'they make friends, they socialise'* (Respondent C4)
- *'it is much easier to join a group of your peers and talk about food rather than a group for depression or about the stresses of moving to Canada although that is part of it'* (Respondent C1)
- *'social support'* (Respondent C5)
- *'a great impact is bringing people together in a community - isolated people and making them less isolated, connecting them with other programmes and supports in the community'* (Respondent C1)
- *'we give them that information about community resources and agencies and hopefully long-term they will use'* (Respondent C4)
- *'people go beyond the programme, after the programme, they continue building relationships, that is one of the things we do'* (Respondent C5)
- *'meeting people, and developing friendships on the workshops but particularly through the support sites, we find that different things happen for people there and they get to meet people from different communities'* (Respondent C)

Though respondents made assumptions about the outcomes, they also reported some evidence of these outcomes through informal contact in the community with past participants- 'long-term, after awhile you see them and they are still practicing healthy eating' (Respondent C4). All respondents who were LCFAs commented on this to some degree.

All programme observations revealed some participant outcomes of increased awareness (Observation 1B, 2B), making changes to their eating habits (Observation 2A, 2C) and trying new things (Observation 3A, 1C), and even saving money on grocery bills (Observation 1A). Across programmes, individual outcomes included improved awareness, knowledge and skills in the short-term, some behaviour change in the medium-term and improved health in the long-term for participants. The extent to which this was reported varied, with a few respondents reporting the most challenges with reaching these outcomes (particularly with Case B as the programme was structured) as well as with measuring them, of which outputs being the most measureable. LCFA development was broadly reported and social connections were also important outcomes of programmes beyond food.

6.4 Programme Outcomes at Organisational Level

This section explores organisational level outcomes mainly pointing to capacity increases, often reported by way of outputs.

For Case A, Respondents Aa and Ab reported that Public Health was able to increase its organisational capacity, and the programme strengthened Public Health's ability to reach its target population. Community agencies that were partners with Public Health on the programme reported a number of agency outcomes:

- *'funding from Public Health gives stability and sustainability'* (Respondent Ab)
- *'built organisational ability to outreach to specific populations, particularly vulnerable, at risk populations, ethno-cultural populations'* (Respondent Aa, Report A4)
- *'increased use of organisational programming and interconnections of site programmes', 'increased breadth of programming'* (Respondent Aa, Report 4A)
- *a 'value-added' benefit for agencies when offering LCFA programmes* (Respondent Aa, Report A2)

Respondent Ab pointed out the cost-effectiveness as another outcome: that this was 'more useful than if they turned the money into staff positions.'

'through all of this building knowledge and skills, reducing isolation and building connections -these connections are key to increasing knowledge and skills and this is the hook to get things to happen...doing what families, extended families and strong communities are meant to do anyway and have done in the past... that it is about supporting other people within your community, within your circle of connections and just going together through life and learning together, and that connectedness being that rock solid foundation' (Respondent Aa)

Despite recognition of this programme increasing capacity, respondents also reported limitations to how much they could do and how many people were utilising and accessing the programme: 'there is normally always a wait list and sometimes people don't show up' (Respondents A2b, A6). Report 4A pointed to capacity being limited due to high demand in the community for the programme and limited hours. As well, it was reported the limits to number of agencies that could be partnered with, despite demand there too (Respondent Aa).

Programme B also broadly reported organisational capacity increases, by filling the 'service gap' (Respondent B1). The LCFA programme enabled increased capacity of staff such as the dietitians to do other work. However, the reality for some was that even their positions had limited capacity (see Section 5.9).

'Over the years our internal programmes have promoted the LCFAs, there is potential that by engaging a group through our LCFA programme, you may interest more intensive programming in our department...so while the LCFAs do one-offs and awareness-raising, it could leverage into higher level strategy work and we have often promoted that.' (Respondent B2a)

The benefits of having provincial coordination enabled increased capacity and efficiency for the health units, resources could be put into developing programme materials at that level rather than each Public Health unit doing it, this has included training resources. The benefits of this model were that the training could be provided by the Public Health professionals and then have volunteers delivering the programme, extending it out to communities because there was a gap in terms of resource support; this enabled maximising on resources (Respondent B). Respondent B2b outlined how the programme met Public Health's mandate of 'need, impact, partnership and collaboration, and capacity':

- *'need - it is Public Health because there is a need both on LCFAs who respond to us in recruitment efforts and community responding to us*
- *impact - this being hard to measure but being within the health promotion model*
- *partnerships and collaboration - happening in the community*
- *capacity - this being a huge one because the programme extends capacity and hopefully building the public's capacity'*

The LCFA programme was reported to be able to meet a certain amount of community need, which then was able to open up the focus of the work, and scope at organisational level, allowing for multi-levels of work.

'because it was building the ground work for that, because it was meeting the community need which is very important, where it left off was where we wanted to leverage - so about environmental supports, community mobilisation and work towards policy...and to me that is of importance...and if we lose the LCFA programmes, the community need doesn't go away...community need doesn't exist because LCFA programmes exist, it's the other way around...so there will still be an unmet community need if the LCFA programmes disappear... and if we didn't have this, then how does Public Health work at the levels that we are mandated to work at: population level, policy development and systems change and things like that if there is this unmet need at the more immediate level... we are in a better position to work on the high level strategy, and I don't mean more valuable, but this is a result of the time and capacity to it because we are not diverted into the kinds of service the LCFA programme does'
(Respondent B2b)

Other respondents expressed that if the LCFA programme disappeared, then that ground work, service level piece would be lost. As well, Respondents B1 and B3 pointed out their reduced capacity over the years and frustration with being able to support LCFAs and the programme adequately. The LCFAs interviewed recognised this too. This impacted on partnerships and connections in the community, affecting reach and capacity (Respondent B3). Connecting with complementary programming was also seen as a way to increase capacity (Respondent B2a).

Programme C reported increased organisational capacity through:

- *'LCFAs in the community increasing Public Health's coverage of work'* (Respondent C3)

- *'increasing internal, interconnecting programme capacities'* (Respondent C1)
- *'sharing of resources created by the programme with the organisation such as infant and child feeding resources' (leaders on this)* (Respondent C1)
- *'helping the organisation to meet the OPHS'* (Respondent C2)
- *'helping the organisation to deliver on the strategic plan of supporting child health and deliver food education'* (Respondent C1)

So, Public Health was able to increase reach and diversity of reach in the community (to target/vulnerable groups) as an organisation and help with partner organisations increasing capacity, extending Public Health's service delivery of health promotion (Respondent C).

All cases reported increased organisational capacity while also recognising limitations to that increased capacity due to high demand for programmes.

6.5 Programme Outcomes at Community Level

This section explores programme outcomes at community level, some of which overlap with individual and organisational outcomes and may be more output related.

A number of community level outcomes were reported for Case A:

- *sharing beyond participants, with friends and families, 'extending into the community'* (Respondent A1b)
- *'community/ neighbourhood social cohesion'* (Respondent A3)
- *'nurturing community action'* (Report 4A)

As an example of depth and breadth of reach, Respondent Aa reported that in 2013 there were 202 programmes delivered in the community, 750 sessions and approximately 3500 participants (Report 2A). Recent statistics showed that the programme was enabling the Public Health unit to 'reach community targets they likely would not reach' - 46% of people on low-income, 77% parents, ESL and visible minorities' (Respondent Aa).

For Case B, community level outcomes were reported to be:

- *'increased reach and numbers in the community'* (Respondent B)
- *'meeting needs of community'* (Respondents B1, B2b, B4b)
- *'increased reach in community'* (Respondent B2a)
- *'increased reach of vulnerable populations'* (Respondent B1)
- *'networking, opportunity to reconnect with community'* (Respondent B)
- *'increased partnerships in the community'* (Respondent B1)

Respondents reported LCFAs transferring their knowledge and skills to individuals in the community, and those individuals sharing within groups, joint problem solving and taking their learnings home and transferring this to family and friends - that this went beyond just food but to life and its problems (Respondent B), as well as affecting other programming (Respondents B1, B2a, B3).

'For community, it is a great resource - I don't think there are many other services like this in the community - and nutrition is always a hot topic. There is always something in the news, always something people want to know more about. It is something that can't be filled, well it can probably be filled in other ways but at least we know it is credible. And it gives the public a credible source for basic nutrition as well.' (Respondent B3)

Engaging with partners meant they could do more such as connect with the food box programme providing subsidised or free fruit and vegetables or food banks, and then having the LCFAs teach the skills to prepare those items. Also suggested was that many agencies were doing their own thing and they could join this up better (Respondents B1, B3).

Respondents in general commented on the community need and demand for the programme and some challenges with adequately meeting that demand. Respondents reported that they tried to fill placement requests, which came from the community, as best they could but sometimes were unable to fill them due to LCFA availability and they didn't have the capacity to reach everyone (Respondent B1, B5).

'there is not enough of us and that I think ultimately there will be a mismatch just in general in the availability of competent volunteers who have the energy to do what is demanded of something like this and the amount of work there is that can be done' (Respondent B4a)

Though the programme was considered to be a small component of the Public Health unit, none of the community work would be getting done without the programme (Respondent B3). It was pointed out that programmes wanted to be as useful to the community as they could, and to keep the programme 'alive' it required being responsive to the community (Respondent B4a). Respondent B noted they were working on another proposal around capacity building and food literacy and how to get that built into the community; that this programme would support that.

Similar outcomes were reported for Programme C:

- *'the programme is not just a silo, it is reducing social isolation'* because of its group nature (Respondent C3)
- *'modelling healthy behaviour for all of us which can actually impact us all then'* (Respondent C)
- *'making friends and building networks, cascading messages and habits out to family and friends'* (Respondent C3)
- *'through partnerships, partnering with other community agencies to serve a community more effectively and efficiently'* (Respondent C1)
- *'the community engagement aspect is strong'* (Respondent C5)
- *'have experimented with different approaches in order to reach a wider base, increasing health promotion coverage in the community'* (Respondent C)

- *'this is a big opportunity to serve your community...you are serving your community when you go out, you meet the same people because it is a small community...when you go out, people see you and they say 'I learned so much from her' (Respondent C4)*

Although the programme enabled increased coverage of health promotion in the community, there were some challenges - 16 full time LCFAs, this was not thought to be a lot when taking into consideration the population size and different languages in the city (Respondent C1).

'we might have a wait list, but for English speaking clients, it's all over the city, so how do you run a workshop? And our challenge is matching the service with that, so for some -our Chinese speaking clients are all in one area and that is straight forward, we just put extra people there - but that is something we are always working towards' (Respondent C)

When the identified need was there, new LCFAs would be recruited. It was reported that there was a capacity issue with languages, this challenge was identified most by Programme C respondents.

'I think one of the biggest challenges we have is getting the people who speak the languages we need...and you can't have someone go out and deliver five or six workshops in one language for a very long time because you are going to exhaust, kids are going to age out, the demographics, the city will change' (Respondent C)

'we are missing the languages we don't speak, we can't meet all the language needs in the community...I will never have enough languages to serve our diverse population...so what I am trying to do now is to make it so that any LCFA can run any programme' (Respondent C1)

'But the programme is culturally and language specific. But we lost a lot of languages. We had a point where we had 33 languages. Today we have maybe 15. So for example, the Portuguese LCFA became a dietitian, the Vietnamese one retired, and others we have lost' (Respondent C3)

This was where 'cultural competence' came in when working with other cultures, how to prepare and be 'ready to work with a group so that there would be increased capacity' (Respondent C2).

Programmes all reported some level of increased community connection as outcomes of programmes. The programmes were important in enabling them to reach a wider population base, whether it be targeted or broad. However, challenges did exist across programmes of meeting community demand and need.

6.6 Programme Outcomes at Policy Level

This section explores the policy level outcomes of programmes, reported through respondents who were managers/supervisors or coordinators of programmes. Though there were a number of policy drivers (in Section 4.3) they were not necessarily reported as connected with outcomes. The Ontario Public Health Standards (OPHS, 2008) was the main policy referred to and that programmes were meeting their provincial requirements. All respondents across

programmes reported that the programmes enabled them to fulfil the OPHS (Respondents Aa, B1, C2).

Respondent Aa listed a number of the standards that they were meeting within the chronic disease and family health and child health programme standards (referring to a copy of the standards in the interview, and highlighted them for reference). Specific to the LCFA programme were:

'increasing capacity of community partners to coordinate and develop regional or local programmes and services...skill development in food skills and healthy eating practices for priority populations...increasing public awareness in healthy eating' (Respondent Aa)

Respondents A1a and A2a reported the programme enabling them to generally meet other ministry standards for their agencies.

Respondents B1 and B2b reported the programme enabling them to meet the OPHS. As was reported for Case A, Respondent B2b talked about them going beyond the food skills piece to cover a number of standards (although she didn't list them).

'when you look at the OPHS, that's our mandate and to me there is a lot of areas within that that would be really difficult to satisfy without having the volunteer programmes including the LCFAs...it really increases our reach, our capacity, community service and the requirements we have under the OPHS, now you could point to a particular one around food skills but in fact there are requirements throughout the OPHS that the LCFA programme satisfies...so we are mandated to do this anyway' (Respondent B2b)

However, according to Respondent B3, they were 'scrambling to cover the standards and to meet the need' but agreed that 'definitely if the LCFAs weren't here (they) would not be doing any of it, it would just be lost.'

In addition to meeting OPHS, Programme C reported meeting city policy priorities and that there were both internal and city-wide policies and policy initiatives that the programme would be invited to participate in and had some influence on. One example given was part of the priority directions and actions, which included integrating mental health promotion into services. The LCFA programme was considered innovative and was 'the first programme to do this' (Respondent C).

The question for interviewees around outcomes at policy level didn't elicit a great detail of responses, with the exception of Case A, however, it did bring out clear answers across programmes around meeting the provincial standards, whether the programme addressed the food skills mandate or addressed much more.

6.7 What works?

This section explores the key components that have made programmes work and helped them to achieve successful outcomes.

Key programme components of Case A were reported to be:

- *'central coordination'* (Respondents Aa, A1a, A2a, Report 1A)
- *'consistent and supportive supervisors for stability, knowledge, trust and relationships'* (Respondents Aa, A5, A6, Report 2A)
- *'active and involved steering committee'* (Respondent Ab, Report 3A)
- *'playing off the strengths of people (rather than their needs), focusing on peer skills'* (Respondents Aa, A1a, A2a, Report 1A)
- *'broad nature of the programme and flexibility'* (Respondents Aa, A1a, A2a, A2b)
- *'group/ neighbourhood/ community aspect of programme'* (Respondents Aa, Ab, A2b, A4)
- *'good communication and making it fun for participants'* (Respondents A1a, A1b, A4)
- *'support (funding, training, resources) from Public Health'* (Respondents A1a, A2a, A3, A6)
- *'comfortable, willing and committed participants'* (Respondents A4, A6)

Report 1A highlighted the quality control, monitoring, credibility and reliability of the programme. Respondent Aa noted that because the programme was broad enough, 'it made sense enough', and carried on because it worked well. In addition, a core group of organisations still found value in the programme. Respondent Ab reiterated this.

'I have worked in Public Health for 15 years and have seen programmes start with all kinds of excitement and then leaderships changes, staff changes, community groups even. Key leaders who were part of the programme in 1990, I couldn't see a single name still leading it. So there is something that keeps it ticking. If you don't have the same value or outcome or impact at community level and so many people keep changing, you lose it. If one or two people were driving this programme, it would be dead in the water. But somehow the programme keeps getting new people on to the steering committee and it keeps going, the energy in it is amazing.' (Respondent Ab)

Respondent Aa developed, with input from the steering committee, core 'non-negotiables' – 'what was unique and compelling about the programme' and when ideas or changes to the programme were suggested, they would refer to the non-negotiables to decide whether they would 'strengthen or erode the programme.' He noted that the 'focus, the vision, the means through those connections and the structure all made it keep going and be effective.'

This meant:

- *the focus: 'the vision of the programme is life transformation through increasing skills and knowledge and building relationships'*
- *the means: 'the vision is accomplished through effective peer learning and through unique peer connections'*

- *the structure: 'the structure that makes the programme work is a decentralised approach and a partnership model'*

It was commented on that although Programme A had the strength of 'multiple benefits', it could also be a weakness because of it being 'less focused and therefore difficult to measure and provide training for.' But the strength was the 'ability to be flexible as goals changed, as language changed, as funding changed' and to take advantage of emerging needs and opportunities (Respondents Aa and Ab). Programmes were considered complementary and valuable as a core Public Health and community agency offering.

Reported important components of Programme B's 'design' were (Report 2B):

- *'peer education*
- *the experiential, practical and skill-based training*
- *assessing community readiness and matching to community messaging*
- *'prescriptive' approach to training of LCFAs combined with the 'non-prescribed' approach for community*
- *LCFA recruitment to be from the community broadly, rather than from certain segments of the population*
- *intention to build community capacity'*

Respondents of Case B pointed to the following key programme components:

- *'provincial coordination so can be more strategic' (Respondent B)*
- *quality of training programme for LCFAs (Respondents B1, B2b)*
- *'knowledge transfer - from coordinator/dietitian to LCFAs to community' (Respondent B)*
- *'having adequate number and committed volunteers' (Respondent B1)*
- *'accessible and up-to-date resources' (Respondent B1)*
- *'targeted messaging' (Respondent B)*
- *'volunteer engagement is important and key to the success' (Respondent B2a)*
- *'the group (LCFAs) is cohesive' (Respondent B3)*
- *'having strong support from the organisation locally' (Respondent B3)*
- *'continued education' (Respondent B3)*
- *'a good local coordinator running the programme is necessary' (Respondent B4a)*
- *'collaborative working' (Respondents B2b, B4a)*

The importance of working together to address health problems was highlighted.

'It's the proverbial piece of the puzzle, could you do comprehensive health promotion without policy? Yeah, but it would be lacking. Could you do it without capacity building? Yeah, but it would be lacking. And the same thing applies to education, skill building, awareness raising. Where people tend to roll their eyes a bit around that is that years ago, even in Public Health, that was all we did - nutrition education. And then we realised that wait a minute, dietitians could do more than that...they have a lot of expertise, and are surrounded by others with different job descriptions but by working together there are other strategies so that we can come at health problems more comprehensively... so there was a move away from this but never was it said that it was an important and integral piece of the puzzle.' (Respondent B2b)

So, there were many components of Programme B itself that made it successful, as well as it being considered part of a much bigger programme of health promotion work.

Respondents of Case C reported that the main reason for the programme being received so well and being well supported was the cultural and linguistic aspect, of which every respondent pointed to, and the emphasis was evident throughout. Key programme components were reported to be:

- 'organisational support' (Respondents C1, C2, C3)
- 'LCFA having good facilitation skills then clients will come back' (Respondent C1)
- 'incentives' (Respondent C1) - *healthy snacks, gift certificates (\$20 for the six weeks of workshops and \$10 a month at the support site), child care, fruit and vegetable box*
- 'the cultural component is huge' (Respondent C1)
- *peer nature of programme 'we are peers and we treat them as peers so you are respectful'* (Respondent C5)
- *LCFAs reflecting the community* (Respondents C, C1, C2)
- 'diversity' (Respondent C2, C3)
- 'outreach' (Respondent C3)
- 'food being an international language' (Respondent C5)

'I think the fact that we hire peers, so the person gets what the other person is going through as much as they can...within all those groups there is a lot of diversity but it makes a difference...keeping the focus on key messages around nutrition and what we are trying to achieve...and then there is a homogenous group because they all have kids which breaks down isolation...and I am not sure if it would be the same if we had professionals doing this... it would be difficult to hire all those languages and we don't need them providing that depth of information' (Respondent C)

'for every programme to succeed you have to have people who believe in it...I think one of the reasons it is so successful is because we believe in what we do...we are parents, there is a large representation of what the world looks like in terms of where people are coming from so each person comes with their own knowledge and skills...so when they meet people coming from their parts they can actually address some of the issues that they experience and help them to look at how they can make changes...and these are very important components...we work hard at making sure we show empathy and respect when it comes down to it, it is because we care about people and this is genuine' (Respondent C5)

The importance of some level of community representation of the LCFA was reported amongst all respondents of Case C, in order to better understand the issues and be more effective in practice.

'Diversity. I think if it was an English programme for zero to six years old, they started in 2001 to fulfill OPHS. But if you look back they do have other programmes in Public Health who fulfill the same nutrition component like LLB but I don't think if it was just an English programme zero to six. The difference is that it is peer, it is culturally and language specific aspect that you have for the diversity in this city. That makes it successful.' (Respondent C3)

Many respondents across programmes reported the peer aspect of the LCFA being an important component that made programmes work so well; that community representation of the LCFA was key. Organisational support, including resources, was commonly reported across all three programmes as was some level of coordination and collaboration.

6.8 What does documented evidence show?

Programme reports and evaluations were reviewed to draw on documented evidence. Document review was built into the previous sections; however, this section focuses on documented evidence that can further illuminate findings as related to outcomes, with some input from interviewees. Overall, programme reports and evaluations were limited.

For Case A, three reports were available for review with Report 2A carrying limited information. Respondent Aa commented that evaluations have generally been reported to show the value in the peer programme. Integrating LCFA activities within existing community structures found benefits to participants, the LCFAs and the organisation (Report 1A). Key results showed:

- *'over 50% of participants reported the programme resulted in improved nutrition knowledge and cooking habits (but was not evident on the food frequency questionnaire utilised)*
- *most participants reported consuming less fat and more fruits and vegetables*
- *participating community groups reported the programme to be effective at integrating nutrition and food skills within the target population*
- *the practical approach was well received and preferred over a 'nutrition information dissemination' approach'*

Report 3A was an evaluation piloted in some neighbourhood sites specifically in response to increasing poverty rates. Findings showed that this approach enabled participants to view their lives from a positive and holistic perspective, by focusing on their strengths and assets, as well as recognising their vulnerabilities. The tool 'helped support people to work to strengthen their assets and eliminate or minimise vulnerabilities.' Respondent Ab noted that this approach did not take off beyond the pilot phase, however, some community capacity to do so was built in the process and they continued to utilise an 'asset-based approach to community development.'

For Case B, three reports were available to review. Report 1B was a process evaluation from the first year of the programme, with three pilot sites. The report showed key findings:

- *strong commitment to the programme from Public Health units*
- *increased confidence in knowledge and skills of LCFAs after training*
- *high level of confidence of trainers in LCFAs' knowledge and skills*

The report included recommendations that OMAFRA maintained its role as provincial sponsor of the programme and for there to be continued monitoring and evaluation (which had since been dismantled). A main finding of Report 2B was that 'the continuum of awareness, skill-building and behaviour change was not agreed upon' and questioned whether the programme could achieve behavioural change among participants. In light of this, it questioned whether it could realistically be responsible for it. This concern was made evident in interviews, as expressed previously.

Report 3B assessed the transfer of food skills to LCFAs. It found LCFA knowledge in nutrition to be 'moderate' and the need to further develop conceptual skills of the LCFAs during training, and identified a need to further skills in 'safe food handling, recipe modification and meal planning.' It also revealed that more than the average general population, LCFAs reported following Canada's Food Guide, so they were essentially reinforcing their messaging in practice in their own lives.

For Case C, one report was made available, despite requests made for other internal documents. Key relevant findings of the programme report considered still current by the programme manager (Report 1C), reinforced the findings of this field work:

- *'the linguistic and cultural fit of the LCFA created a more conducive learning environment and this carried over into the support groups*
- *the mixed team approach for delivery was effective in combining peer language, cultural competence and experience with content and specialised support of professionals and enabled quality assurance*
- *programme participants felt safe, comfortable and trusted the LCFA through the cultural and experiential similarities which lead to increased sense of self-esteem and efficacy*
- *that trust then leads to programme participants accessing further resources and services in Public Health and in the community*
- *participants valued the reduction of social isolation, community engagement and skills development of the programme almost just as much as the nutrition education aspect*
- *the role and potential of food in providing a non-threatening and culturally acceptable way of accessing community services and resources*
- *that, despite most participants being well educated, many were living in poverty, and food access and insecurity were predominant issues they were dealing with'*

Recommendations emerged from Report 1C:

- *'to develop more effective strategies to deal with household and community food insecurity issues'*
- *'to apply the programme model to different programmes with low participation of diverse communities, on a national scale'*

At the time of interviews, there was a pilot study being initiated to measure for changes in fruit and vegetable consumption for participants. Participants at the beginning of the education

workshop series were asked to complete a survey, again at the end of the workshops and then three months later the survey would be sent to their home for completion. Although it was too early to know the results of that evaluation, Respondent C4 reported participants of her group sharing their answers to some of the questions, which were increased fruit and vegetable consumption and feeding their children more healthy foods.

Overall, there were limited programme reports to draw upon for outcomes. Nevertheless, those referred to provided some evidence of outcomes.

6.9 What are the gaps?

This section focuses on emerging gaps in programmes. This is mostly reported through interviews as this was the most up-to-date information that could be obtained honestly and was a question posed to interviewees.

Respondents of Case A reported programmes were in one way well supported and in another way had gaps when looking at the big picture.

'I feel like the fish Nemo, we are unsung heroes, little fish, I just keep swimming...the centres are good and the coordinator of the programme is awesome but the larger picture, these programmes are kind of like low profile' (Respondent A4)

'if we didn't have that, there would be a lot more angst about responding to just part of the problem...because you have to deal with individual stuff, you can't just completely ignore that but we know there is a huge impact from that policy, broader level, supportive environments change... and the programme allows us to specialise those efforts a little more...although at face value the programme is very much an individual focus...because it is set within a group and neighbourhood context, that is the thing that impacts the broader systems and environments and does that effectively' (Respondent Aa)

'but if the whole world was just addressing problems with the programme, we would be missing that broader community advocacy, provincial level, federal level stuff...so it has to be in complement to that...so it doesn't address those broader things but complements them...so there are lots of policy gaps it complements rather than addressing directly' (Respondent Ab)

As reported previously, many interviewees identified that generally there were not enough resources (funding, hours for LCFAs) to do what they could be doing, including advocacy work and more collaboration. However, all respondents reported continued investment in the programme and the general desire to 'do more' but had limited hours allocated to the LCFA positions in Case A.

A key gap emerging from Case B was the diminished support for the programmes. A challenge expressed by all respondents was some level of frustration with the changes to the provincial piece of the programme and withdrawal of government support.

'it's unfortunate that associated ministries, in particular, OMHLTC, haven't recognised the value to a comprehensive health promotion approach of this programme...it's not a be-all-and-end-all programme in itself by any means but it's an integral piece both in what it can achieve and by the void that would be there if it weren't in place'
(Respondent B2b)

Similarly, all respondents recognised the value of keeping the programme going and their commitment to it in the community, but that it could only be part of the solution to addressing the problem of unhealthy eating and poor health.

'Organisationally, it fits a community need and our department remains committed to that - even in the face of the lack of provincial support. It also helps us to meet our mandate in terms of the OPHS. Provincially, well, I already mentioned that I think they are short-sighted around the value of the programme and that it probably should have been a mandatory programme across the province just allowing local interpretation. But instead, it is now floundering.' (Respondent B2a)

As reported already, the programme as a whole (on a provincial scale) was decreasing in size - fewer Public Health units were continuing their commitment to the LCFA programme.

Respondent B3 pointed out that time should be freed up to work on policy pieces but this was still limited. And the dietitians were involved in policy for example, the Nutritious Food Basket, which involved advocating for increased social assistance rates through the board of health (Respondent B1).

'So it's hard to say whether it's freed up time...during the economic down turn we lost quite a few positions at that time in the health unit and we are not seeing it come back - it is coming back in other positions but not in nutrition...things are coming out about issues with nutrition and they are saying you've got to deal with this now and it's hard when it is a small component of the health unit.'

A number of respondents reported the demand for programme activities in the community. As well, a lack of understanding as to the wider role.

'There are always requests - and we get calls and then if we can't meet requests people ask what do you do? I think there is not that understanding of health promotion and policy and advocacy piece that doesn't carry any weight with them, they don't know what that means. What they know is if you come to my brownie troop and talk about nutrition - well, isn't that what you are supposed to be doing? There isn't necessarily an understanding in the community as to what we do.' (Respondent B3)

This challenge of community need and demand was expressed by all the respondents of Case C who were LCFAs was that they were working to full capacity and there was still more work. They reported they had responsibilities organisationally (with meetings, training, supervision) as well as in the community planning and delivering their own programming (workshops, support sites, presentations) as well as supporting other programmes and partnerships. This was felt to be a reflection of community need, demand and job requirements, with no signs of slowing down (Respondents C3, C4, C5).

'I think we are overwhelmed in terms of workload, we are over-extended even as full-timers. I have groups, workshops, presentations, meetings etc. Demand is coming from everywhere. This is a programme that we deliver but on top of it we are supporting other programmes and accommodating partners. I can't even find the time to call up the participants to register them and we have programmes daily...it is hard to pace yourself. And we have paperwork which is a total job by itself. Every token, voucher we give we are accountable.' (Respondent C5)

Even with Case C, some organisational tension was reported, that despite the programme being well supported and respondents feeling this way, one of the supervisors expressed the challenge of the programme sitting within a Public Health unit which was reported to be 'nursing heavy', dominated by the nursing field and that the nutrition pieces played a back seat role' (Respondent C1). There was also a general scaling back of resources that was expressed in observed programme meetings (Observation 4C).

Across cases, there was reported demand for programmes that was challenging to fulfil - whether it was coming from the community or from the organisation and this was partially reported to be due to community need but also due to lack of recognition and investment in the programmes and more broadly, nutrition. As well, all programmes reported some limitation or reduction of resource supports.

6.10 Summary

Enhanced individual, community and organisational capacity was frequently reported across programmes. All programmes reported increases in personal capacity (for participants and LCFA's): around knowledge and skills, and around resources. Increased social and community connections were frequently reported as well. Respondents reported being able to deliver on organisational and policy requirements as a result of programmes. Outcomes beyond outputs were reported to be difficult to measure for all programmes and as findings show, there was heavy focus on reporting individual outcomes of programmes. Challenges were expressed across cases around support for programmes and meeting community demand and need. Learnings from a collation of the diverse data sources have enabled corroboration and illumination of these findings.

PART FOUR DISCUSSION

Chapter Seven. Discussion

This chapter and section weaves back the findings in Chapters Four, Five and Six to the problems outlined in Chapters One and Two. This chapter discusses key themes that have emerged through the findings as linked with the literature and food and health policy areas.

7.1 Introduction - Consolidation of Findings

The research has confirmed the overarching aim of programmes, identified through interviews, observations and documents, as being to address healthy eating behaviours through health promotion thereby contributing to positive health outcomes in the population. LCFAs had clear roles in this but how they worked played out differently. This chapter discusses key themes that have emerged. These themes include aspects of programmes that present both challenges and opportunities in progressing them towards addressing food and health policy issues. What are the structures and mechanisms of programme delivery important for outcomes? What are the differences across programme models? What are the implications for food and health policy?

Consolidation of findings is presented at first through a policy framework lens, with the policy analysis done in two stages: descriptive and explanatory. The Health Policy Triangle (Figure 7.1) is utilised here to introduce and organise findings within a policy perspective. It is applied to show how it relates to the different LCFA programme models by looking at areas of: actors (key players), context (social, cultural, economic), content (the what, key areas of work) and process (the how).

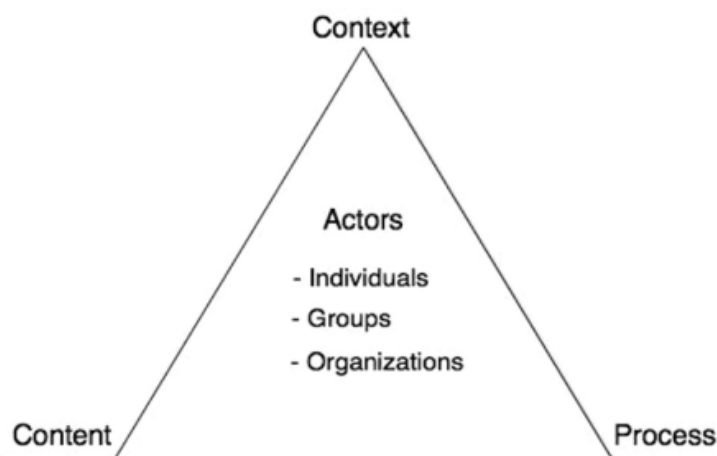


Figure 7.1 Health Policy Triangle (Walt and Gilson, 1994)

Table 7.1 shows a summary of programme components as related to the Health Policy Triangle (Walt and Gilson, 1994).

Table 7.1 Health Policy Framework as related to Programmes

	Case A	Case B	Case C
Actors	-Community agencies - OMHLTC (indirect) -Regional Public Health Unit (plus three municipalities) -Coordinator (with Public Health) -Supervisors (with community agencies) -LCFAs -Programme participants	-OMAFRA -OMHLTC (indirect) -Local participating Public Health Units -Supervisors (dietitians with participating Public Health units) -LCFAs -Programme participants -Community agencies	-OMHLTC (indirect) -Municipal Public Health Unit -Programme manager and supervisors (with Public Health unit) -Programme dietitians -LCFAs -Programme participants -Community agencies
Context	-Need for practical knowledge and skills development; learning within the community, social and economic context; community-building	-To fill gap in nutritional services and response to community need resulting from fiscal-cuts and loss of home economists	-Response to high-needs, under-served communities -And supportive child development and parenting programming
Content	-Increasing capacity -Increasing knowledge and skills around healthy eating	-Promotion of food literacy/food skills and food safety	-Enhancing nutritional status of children in early years with diverse, ethno-cultural communities through healthy eating education and skills
Process	-Community-driven (idea came from community agencies), and joining with regional Public Health as a shared programme (bottom-up) -medium intensity programming	-Driven by provincial government initially then only by local Public Health units (top-down) -low intensity programming	-First driven by provincial government (as a Case B programme) then became driven by municipal Public Health units -high intensity programming

Actors

The work of these programmes has required engagement with multiple players at different levels, with partnerships being important to the programmes. Though the federal government plays an overarching role in public health (including health promotion), it was not a reported player. The health ministry, OMHLTC, which supports Public Health units and mandates the OPHS (2008) was the highest level reported actor. Programme B differed in that OMAFRA originated and co-developed it. All programmes were supported through the local Public Health units and fed into meeting the provincial Public Health standards (OPHS) yet with no explicit government support at federal or provincial level [being recently pulled from Programme B at provincial level (by OMAFRA)]. Local boards of health (governing bodies) set strategic plans for which programme support fit into or not. This level of support through Public Health varied and was found to be limited particularly in Case B. Support for these programmes was voluntary so it was up to each Public Health unit to decide whether to or how to support. So, there was still provincial funding in all cases through the OMHLTC but this was less direct as the money was not earmarked; the province funds Public Health units to meet OPHS but how they do this, LCFA programme or not, makes programmes vulnerable and competing for resources. Lack of higher level support from key players has translated to uncertainty, diminishing programme offerings and capacity issues. In some cases this meant programmes being completely lost by Public Health units (such as with Case B), few hours for LCFAs and fewer agency partners (Case A), and cutting back on incentives for participants (Case C). LCFA programmes create an access point in both directions for varying actors to connect ie. Public Health, grassroots activists, community agencies, citizens and/or city officials. But this needs to be within a participatory model rather than a top-down delivery of programmes.

Context

Canada has had an international reputation for health promotion (Lalonde, 1974; WHO, 1986) and a long tradition of supportive health promotion with initiatives such as LCFA programmes. Case examples show programmes have long been established and have somewhat become institutionalised at organisational level. However, these programmes are the exception rather than the rule. Over the years, there has been de-investment in programmes, particularly in health promotion federally and provincially, with government favouring a 'deficit-reducing environment' over a 'health-promoting environment' (O'Neill et al, 2000). Despite most influencers on health stemming from outside of health care, concentration of funding and budgets remains on health care and its competing priorities (Malik, 2013; Kirk et al, 2014).

However, programmes can be framed in such a way to speak to their ability to achieving health goals (Respondent Aa). Canada has a complex structure of multi-level government with Public Health units having complex funding models ie. money from a federal department, different provincial ministries, the cities and/or counties to which they belong and community partners; this complexity can make it difficult to identify where responsibility and accountability lies (Nathanson, 2007). Programmes sat within provincial, regional and municipal structures. It was clear there was limited support for programmes at provincial level and there was a range of support at the local level. When resource support, primarily by way of funding, is only local, it can be more difficult to sustain programmes. This can be a problem with community as a setting. Community focus and localising responsibility for health can forget that problems are bigger than the community; poverty, food insecurity or lack of food skills are not unique to one area (Boutilier et al, 2000). But the community aspect remains important as Kennedy et al (2010) found, that by being locally driven and valued, has sustained them. All three case studies have reinforced the sustainability of programmes through local support and the need to have more than one actor at play. Both Programmes A and C, which were more localised, had grown, whereas Programme B hadn't.

The context to which Programme B came about fit with OMAFRA's elimination of home economists in the community and schools (though home economists still work privately), and children were no longer growing up learning to cook, this creating a generational problem. At the same time, dietitians and nutritionists were pulling away from their work in the community. Programmes began as a way to engage with community, and extend Public Health's ability to fill the gap in nutrition services. The creation of programmes were driven based on needing to meet the needs of under-served communities; in particular, with the growth in inequalities and highly diverse communities. Respondents reported to varying degrees, a need in the community and general population in addressing healthy eating, food skills and knowledge. The link between diet and health had become widely recognised at the inception of programmes; this coincided with a general deskilling of the population over time for a combination of reasons including, and according to respondents, increased access to and availability of unhealthy, processed foods. The social aspect of programmes was also important context, reported in different ways, in particular the need to address social isolation and building social networks.

Content

The key areas of work for LCFA programmes focused around increasing knowledge of healthy eating and food skills for individuals in communities; and building community capacity. As

programmes were set within Public Health, their focus was to deliver on Public Health policy priorities, namely health promotion. Competing priorities in Public Health often show attempts to balance individual and collective, immediate and long-term responses. And in practice this may translate to some support for programmes, but this is often lifestyle-focused and limited. Programmes, particularly Case B, did have a focus on food safety (and directed by OMAFRA) so public safety and health in the immediate can take precedence over the long-term health as food safety, though important too, is clearer in terms of measuring indicators and outcomes (cause and effect relationships). Content involved little around education on the food system and/or how to influence it.

Process

Milio's (1987) framework for healthy public policy helps to understand how the development of programmes came about by considering: initiation, action, implementation and re-formulation.

All programmes developed around the same time, late 1980s to early 1990s, but the inception of the programmes was distinctly different. Case A was a bottom-up approach, with the community driving it and harnessing support from Public Health; Case B was top-down, with the provincial government (OMAFRA) creating and driving it; Case C began as a programme under the Case B model, and evolved from there. Case A and B reported heavy influence of The Ottawa Charter in the early stages of development (WHO, 1986). Health in All policies were influential, reported through respondents of Case C and this fitting with the 'healthy city for all' mandate and championing health equity (WHO, 2010a). There was a concerted effort to promote the Programme B model across Ontario as a provincial programme, and OMAFRA originally providing provincial level training when it was piloted and being rolled out. This was the most widespread programme model with Case A and Case C being unique (despite Case C originating as a Programme B model). Public Health, as a partner for Programme A, was able to provide coordination, resources and training, and this was an important feature in the successful implementation of this model. Although remaining consistent with goals, programmes all changed over time, in response to the changing community and to fitting policy priorities: Case C moving towards a more cultural and linguistic model of LCFAs, Case B moving to the promotion of local food and Case A reporting that being broad and flexible was important. With Case B and the withdrawal of intentional government supports, it was reported to be primarily due to funding priorities being diverted elsewhere, despite individual programmes in Case B focusing on local food in line with OMAFRA's priorities. So, despite programmes re-formulating, this did not necessarily result in more support. The discussion

will continue with the next sections on key themes emerging from the findings connected with RQs, before applying a further policy lens for analysis.

7.2 Community-based or Community Development Models

This section incorporates discussion of all three RQs. In particular, RQ1 and how the strategic aspects of programme design impacts delivery and outcomes. Cases have shown how community development can occur within LCFA programmes in Ontario.

Findings have shown that programmes were community-based models, which are considered effective and supported by policy initiatives to increase health coverage and as one way to tackle the SDH (Jay, 1938; Hancock, 2009; WHO, 2010b; Kaczorowski et al, 2011). But there is some concern that this only downloads responsibilities for health that is not taken up and supported on a higher level (Boutilier et al, 2000; WHO, 2010b). Community-based initiatives may be lacking in consistency and coverage, thus creating a patchwork of programming. This would be different if programmes were mandated across all communities (though there are challenges with defining community and its boundaries), but this is not the case. Furthermore, community-based initiatives may be lacking in community participation, be top-down and not in reality create shifts in power (WHO, 1978; Pederson et al, 1994; Laverack and Labonte, 2000; Carey and Braunack-Mayer, 2009). Initiatives are not bottom-up if healthy eating activities are done 'to' them (Wallerstein and Bernstein, 1988; Terris, 1992; Wallerstein, 1993; Boutilier et al, 2000). Many respondents did report that programmes were done 'with' community. This wasn't clear in some cases, an issue raised by Kennedy et al (2008) and Kennedy (2010). Programmes have generally been first deciding community needs ie. healthy eating, and relying on the community who expresses 'want' to come forward with two main exceptions: the origin of Case A (driven by community), and Case C's support site focus on broader SDH (topics determined by participants). This points to a need for upstream listening (by policy makers and funders) to these voices: that it seems participative encounters could be more by way of being imposed (and within boundaries) on the community. However, participant and community empowerment was reported by many respondents, but it wasn't clear to what extent this empowerment occurred. Findings mostly relate to reports of material and psychosocial dimensions of empowerment ie. increases in personal capacity and community resources and were least likely to be political (WHO, 2007), this could occur for both LCFAs and programme participants.

Programmes emerged as either more community-based or more community development in their models, as seen in Figure 7.2. Case A emerged with more of an intentionally community development aspect: through its inception and through recruitment of leaders identified by

community agencies. Case C was a clear example of a programme providing employment opportunities for immigrants because of its multicultural focus (although, was not exclusive to this). Programmes A and C were opportunities for community members who may otherwise be living on low-incomes to gain experience and paid employment. In these cases, LCFAs were more likely to be 'peer-like', in that they were reflective of the community, but didn't necessarily work within the same community they lived, as some of the literature has pointed to (Cook and Wills, 2011; Yoeli and Cattan, 2017). However, even one respondent from Case A acknowledged needing to strike a balance between peer fit and strong programming, which didn't always go hand in hand (Respondent Aa).

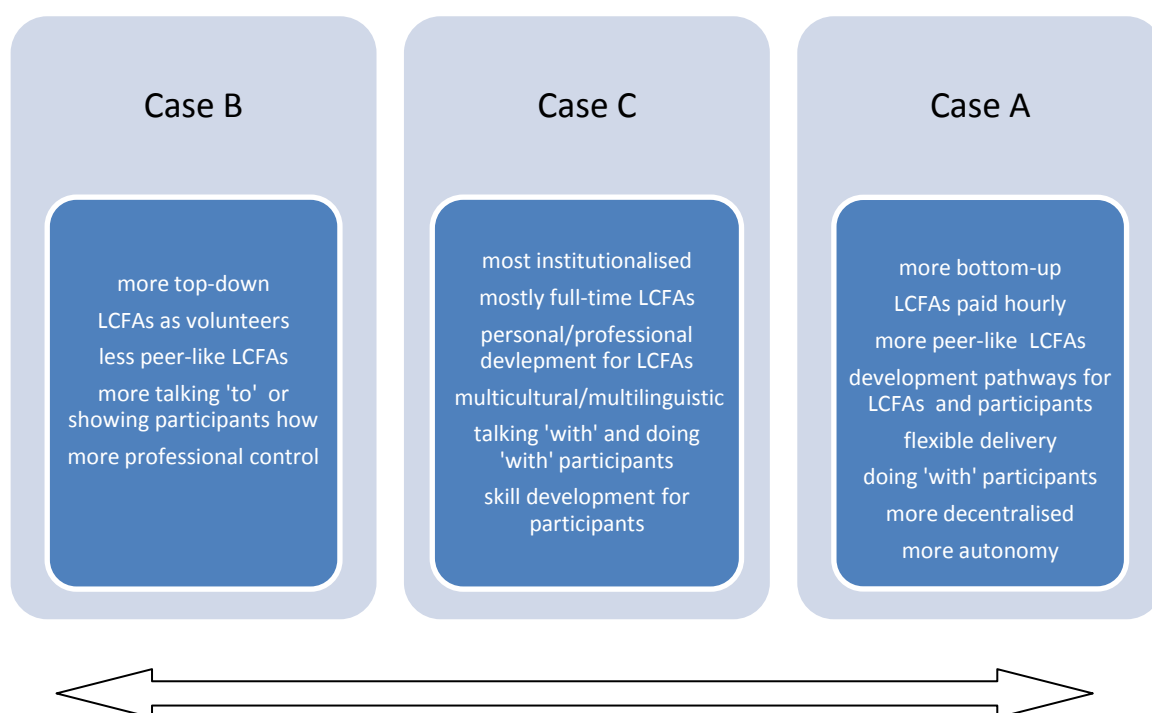


Figure 7.2 LCFA Programme Community Development/ Lay Helping Spectrum

Important consideration is that programmes ranged from a model of full-time paid workers, to paid hourly to volunteer in their structure. Depending on this aspect, programmes could be limited in their ability to lift people out of poverty: Case A provided limited hours for LCFAs which were likened to a volunteer position; community agencies expressed that they could not afford to ensure enough hours and benefits for LCFAs to constitute this, however, peer workers were able to work in more than one agency and as one respondent pointed out, some peers were able to get off social assistance as a result of the programme (Respondent A3) and

many of Case A LCFAs moved on and up for reasons attributable to the experience gained as an LCFA and the opportunities that came out of it (within agencies) while there were also those just moving on to get other jobs. Case B couldn't achieve it with LCFA positions being volunteer-based and this reflected the demographics of those who were LCFAs. Case C, with a stronger remuneration structure showed this ability and made a concerted effort to pay a living salaried wage. So though a programme such as Case C had LCFAs with higher levels of education and qualifications, many were immigrants and could have been experiencing poor job prospects as a result. The implication is that programmes provide a much needed model of opportunity, considering inequalities and inequities that continue to be a problem in Canada, and allow for progression in socio-economic position which can translate to improved health (Mikkonen and Raphael, 2010; Hassen et al, 2017; Block, 2017).

The community development aspect of some of the programmes wasn't as strong as others. Case B has shown that formerly well paid professional roles ie. that of the home economist, have been downgraded to a volunteer model. This was reported to mostly be due to budget constraints and limited funding allocated to programmes. There was also some indication of limited tangible support for food literacy. All programmes however presented opportunities for example, in leadership: whether for participants of programmes or LCFAs. Participation ideally includes all stages of programmes (Baum, 1998; Stead et al, 2012). In reality, this seemed to occur mainly at the implementation stage. Observation however did shine light on some exception to this: Case A involved some of the LCFAs (who were more experienced and acted as mentors) in their steering meetings who actively participated in some of the decision making. Participants were observed and reported to help shape the programme delivery, which was seen with the community kitchens. This aspect also occurred for Case C's support sites but the difference was that Case A allowed for more participant-led opportunity, and Case C allowed for this in addition to the LCFA and/or a professional-led aspect. Case A also incorporated existing peers in their training for new workers. The literature points to programmes being limited in training and support, including employment and development opportunities (Leaman et al, 1997; McGlone et al, 1999; Coufopoulos et al, 2010; South et al, 2011). The training models of programmes (including ongoing training and support) can have different focus (South et al, 2013a). Case B was focused on service delivery (content determined by the professional), Case A and Case C on both service delivery and personal development. Case A dominated more in its personal development of LCFAs emphasising empowerment and ownership and LCFAs had individual learning plans for Case C. These differences of focus translated to more or less opportunities for community development.

All programmes were reported to result in positive health outcomes, more likely to occur with community participation (Rifkin et al, 1988; Garcia and Henry, 2000; Lawn et al, 2008; South et al, 2010; O'Mara-Eves et al, 2015). But levels of participation and the strength of outcomes did vary, with those programmes further along the community development spectrum reporting stronger outcomes. Programmes that built in asset-based approaches were more effective in this capacity, particularly when incorporated into recruitment strategies for the LCFA, ideally with community representation (NICE, 2008; Torres et al, 2014; McCollum et al, 2016). This level of participation must consider issues of inclusivity (or exclusivity), power and privilege that are part of programme, community and organisational structures (Rayner and Lang, 2012; Rifkin, 2014).

Community development also extends to social change, and there remains further opportunity with its role in the food system, through participatory and collaborative approaches, and engaging in diversity in the community; programmes being a key linkage between Public Health and community (Gutierrez, 1995; Allen, 2010; O'Mara-Eves et al, 2013; Appavoo, 2014; Blay-Palmer and Knezvic, 2015). Though limited, there was some action here, and further potential identified. Programme A, for example, reports an outcome of nurturing community action (Report 4A). Programmes may provide mutual support but may fall short on community action, depending on its interpretation.

Community-based initiatives can often be interpreted as community development when this may not always be the case. There can be professionals working in the community and be community-based, and having lay people working in the community does not necessarily translate to community development or better engagement with the community. These case examples have shown ways in which programmes can move themselves further along to be more community development focused rather than merely community-based. Community engagement strategies have been questioned whether they go far enough to allow for empowerment and health improvement; in part explained by different interpretations and lack of clarity around strategies that work (Geoghegan and Powell, 2005; Popay, 2006; Cornwall, 2008; Carey and Braunack-Mayer, 2009; Milton et al, 2012; McCollum et al, 2016). Crucially, the LCFA programmes had different categories of engagement and demonstrated participation differently through: community agencies and partnerships (having community agencies with ownership of programmes shows more community and decentralised decision making processes); opportunities for community members to develop; and programmes utilising an asset-based approach is a more empowering model than a deficiency model of community need (Kretzmann and McKnight, 1996; IACD, 2009).

7.3 Lay Helping

Following on from community development and interconnections with lay helping (Figure 7.2), this section uncovers further issues and distinctions emerging between programmes in relation to lay helping, mostly incorporating discussion of RQ2 around the role and function of the LCFA.

'Peer' was the most common term used to describe LCFAs across all programmes, both in interviews and in documents. Peer support strategies have been getting evermore interest by organisations and government with the most adapted model in LCFA programmes being the peer as a volunteer approach (as with Case B); likely due to the recognised value of the peer approach as well as being a financially favourable option, with volunteerism being widely supported in Canada, however, this is most common among those who are Canadian-born and of higher socio-economic status (Vezina and Crompton, 2012; Sinha, 2015), of which findings confirmed.

How does the role of the LCFA fit, is it a natural helper or are these roles just adding another layer of professional or semi-professional? Some roles are clearly filling in for what the home economist or dietitian/nutritionist was doing in the community in the past and are considered an extension of existing services as Kennedy et al (2008) found. This can be seen as task-shifting (WHO, 2006a) but with boundaries. There were some identified tensions with acceptance of the LCFA by the dietetic profession (Case B) and ways of controlling their scope (quality assurance, checks and balances) but this was seen more clearly with models more controlled by Public Health (Case B, C) as LCFAs were reported by informants to have a wide scope of practice in Case A. Findings reinforced that LCFAs seemed to be more accepted by professionals when there were clear boundaries placed on the role (Dugdill et al, 2009; Dworatzek and Stier, 2016; Williams et al, 2016). But there was a range of what was accepted practice by the professionals (reported by respondents). Most limitations were reported to be from dietitians and not others, such as direct supervisors who were more open to a broader scope. These roles may have caused discomfort for some, and been viewed as threats without imposing clear boundaries, as the literature has shown, a way to exert control by the professional in the hierarchy as Kennedy et al's (2008) model demonstrates. However, clear roles and functions could be helpful in mitigating the threat (Haines et al, 2007; Currie et al, 2012; Dworatzek and Stier, 2016). Many views were that the role did indeed enhance their work as a team. So level of acceptance and confidence in the LCFAs ranged. The undervaluing of knowledge and skills of LCFAs can be restrictive (Minore et al, 2009; South et al, 2013b; Ahmad et al, 2017), this was most utilised in Case A. Some tension was raised with

respondents in Case B around how LCFAs, although valued as volunteers, were not always valued as communicators of healthy eating messaging due to limited knowledge, thus impacting on their scope of practice (though scope of practice was intentionally limited).

In practice, some tension could occur in part due to LCFAs representing Public Health within Cases B and C and in the delivery - as a teacher or a facilitator, as a professional or natural helper, and this was an important distinction: that sharing of power between the LCFA and community members to bridge the gap. LCFAs being regarded by the community because they were part of Public Health was seen as both positive for credibility (Respondent B2b) and negative (Respondent B1) because it could mean they were 'policing' the community. Overall, LCFAs being seen as peers, rather than professionals, translated to more power-sharing roles with the community and well positioned them as liaisons between community and Public Health (Respondents C, C2), this could help in making health more achievable because they could be seen as more equal and communicate on a more appropriate level (Giblin, 1989; Kennedy, 1999; Simoni et al, 2011; McCollum et al, 2016).

Programmes may favour professionalised skills over natural helper qualities. For example, in Case B and increasingly more in Case C, which has shown that those coming into the role may meet both professional and natural helper qualities; a sign of the economic reality of a changing workforce, higher educated immigrants (than previous generations), and the broad interpretation of 'peer'. Indeed, there are blurred lines between peer and paraprofessional. Does it matter? Many respondents spoke to the effectiveness of LCFAs rather than this distinction being an issue. It may not be the defining feature to have something so specific in common, such as culture or language or living locally, but to be seen as non-professional. Findings on the whole showed that LCFAs were valued for their experiential and embodied knowledge (Illich, 1970; Coufopoulos et al, 2010; South et al, 2011; Gilkey et al, 2011). This was seen too with Programme A incorporating LCFAs into the training, which is recommended (Kennedy et al, 1998; Yoeli and Cattani, 2017). LCFAs were generally seen as non-experts, and collectively there being benefit in sharing of experiences and learning in a group. This aspect can reduce the power imbalance but only if the LCFA is perceived this way (though they could still be seen as experts of Canada's Food Guide for example, as was reported). If an LCFA has the desired qualities and is effective at facilitating change, at individual, community and/or policy level, than so what? As Payne et al (2001, p.145) emphasise, for people living in poverty, relationships are key, so not as necessary to have a common background but that relationships and trust can trump this. Respondents reinforced that relationships and trust were highly important amongst the community, key for community engagement (NCCDH,

2013). Thus, professionalisation of roles may not be as much of an issue if this aspect can be preserved through the informal nature of the role if working within a non-professional, non-expert capacity which can create less of a power differential (Simoni et al, 2011). In some cases though, they were merely acting as semi-professionals delivering food and nutrition programming: this could be either a step-down from the level they may have worked at before (evidence of this through Case B and C) or a step-up (most seen with Case A).

Food activities were the avenue for which to decrease social isolation, build relationships and community. Respondents spoke to the community building aspect, though it was evident there were different meanings, and this could translate to community cohesiveness or community action, or both. LCFA programmes may provide a deeper level of community engagement on food issues than that with which professional models can due to their relationships with the community, understanding and local knowledge, bridging the linkages (with credibility both ways) and advocacy work, as some respondents reported and/or alluded to (Respondents Aa, B2b, C).

Power and privilege dynamics can occur, mainly for the Case B model with some LCFA mentality of a limited understanding of poverty and the conditions shaping lifestyle behaviour; this may in part be a consequence to having volunteer LCFAs and the resulting demographics of LCFAs as well as in how Programme B originated, as a top-down programme.

Understanding participants, their behaviours and the reasons for those behaviours are important as a function of the LCFA to provide support and facilitate change. The traditional role of the LCFA as a natural helper, of being closely aligned with the values and understanding of the community with whom they work has evolved and some of these qualities may no longer exist, having been replaced by other qualities such as presentation or facilitation skills (recognising they are not mutually exclusive). Findings, in some cases, revealing a disconnect in understanding but only to a certain extent. That non-judgemental quality so valued of LHAs (Simoni et al, 2011; South et al, 2013b) is both confirmed and contradicted here, which may be explained by the lack of 'peer-ness' of some of the LCFAs in Case B, for example, and lack of understanding of people's situations (Respondents B4a and B6). Those LCFAs who were more reflective of the population with whom they were working (for the most part) seemed to have that contextual understanding of barriers and drivers to healthy eating. These case studies have shown a variation between those arriving into position with these desired skills. So LCFAs may fit anywhere along the natural helper - paraprofessional continuum (Eng et al, 1997); LCFAs can be both insiders and outsiders as some of the literature has found, and this can provide some advantage (Cook and Wills, 2011; South et al, 2011; Yoeli and Cattan, 2017).

This was echoed by Respondent Aa for example. Privilege can work in favour alongside as allies and influencers of policy, as is the model of community food centres (Saul and Curtis, 2013) and Payne et al's (2001) work, as a way to bring to the table people of different socio-economic positions to make change happen.

Though the cultural and linguistic aspect of matching LCFA's with the community was a component it was not always deemed most important, as has tension been raised around whether they can work with a broad spectrum of people in the community or only certain communities. Even with Case C being most culturally and linguistically matched, they too were more diverse in delivering programmes within mixed groups. This is reflective of communities, that people making them up are not homogenous, and are from a variety of cultural, racial and ethnic backgrounds, face different issues (more broadly and in relation to food); and neighbourhoods and communities change (Boutilier et al, 2000; Jablonski et al, 2016). Cultural tensions can exist within cultures and class differences; indeed, some participants would rather share and be part of a group that doesn't include others from the same culture or have their situation, if living in poverty for example, exposed. Being so specific to one group or one culture may enable tailoring messaging more effectively but providing programmes for mixed groups in the community may mean being more inclusive, promote community cohesiveness and ultimately healthy communities; this too is in line with Canada's Multiculturalism Act (CIC, 2015). Multicultural competence (and humility) is confirmed as a more valued quality of the LCFA (Eng et al, 1997; Torres et al, 2014). Programmes able to outreach successfully to low-income or isolated communities would be another important feature as is being representative in some way of that community (Torres et al, 2013). Cases A and C showed they more closely aligned with the community due to their recruitment strategies. Findings did reinforce there to be a number of LCFA characteristics that are valued as has been reported in the literature (Nittoli and Golith, 1998; Kennedy et al, 2008; Rosenthal et al, 2010; Glenton et al, 2013; South et al, 2013b).

There is contention between paid and unpaid models of LHAs/LCFA's and no consensus as to which model is best (South et al, 2014). Roles are often considered cost-effective but this needs to take into account resource impacts such as supervision, support and attrition (Nkonki et al, 2011; Daniels et al, 2014) and other ways in which different models translate (Adebayo, 1995; Leaman et al, 1997; South et al, 2014). Findings confirmed that these considerations were needed, with some respondents pointing to the cost-effectiveness as well as the resource-intensive aspect of programmes; this was reported in Case B even as a volunteer model. Payment models were able to support people in earning a living wage (Case C), get

them off social assistance (Case A) or move them along to better paid positions and may be a more accessible point for employment. Though Cherrington et al (2010) report volunteers to be more peer-like, this was not found to be the case with the models explored in this study (Figure 7.2). Indeed, the model with LCFAs as volunteers was more likely to be less peer-like (Case B), despite one interviewee's comments (Respondent B2a). These comments have been found in the field, the view that just by being a volunteer, this made someone a peer. Case A is a good example of a stepping stone, this model seeing movement from participants to LCFAs to further roles such as supervisors at community agencies. Professionalisation of roles needs to be cautioned as getting in the way of community development and where allegiance lies, the community or the organisation (WHO, 1989; Lehmann and Sanders, 2007; Cherrington et al, 2010; Fitzsimons, 2010). Findings show in all cases to some extent, it remained strong with the community. Case C could be more seen as a career development model, but not necessarily at the expense of community benefit.

Programme design and LCFA style could translate to more or less formal ways of programme delivery. This isn't always clear; roles are perhaps meant to be more informal ways of helping (over the professional) and are not considered the professional ie. they are not a Registered Dietitian in Canada. But they could still be professional, and formal in practice and this makes supervision and programme delivery easier as Respondent Aa commented on. Some models have shown to be more formalised than others particularly if people are coming into the role from professional backgrounds or higher levels of training. But does formalising the role exclude the very people for whom this role has been intended? Yes, in some way. But there is a difference - roles were not necessarily for people with no education, but rather with no formal nutrition and dietetics qualifications. Case B was the only programme too that provided certification (although this was not transferable – as something such as a national or provincial college may do), which may have made the model more formalised or indeed influence those recruited. Findings show that remuneration by way of pay does not necessarily translate to formal delivery in practice, nor does not being paid translate to informal delivery. Though on the whole, programmes were mostly informal in the community. This aspect of being in volunteer or paid roles for LCFAs seems to reflect different ideologies and result in different socio-economic positions of these roles. Respondent C was clear in her view, that paying people (in full-time positions) will likely lead to more peer-ness/ community representation.

Case examples have shown that there is a hierarchal nature of these roles, and that some are further along the professional spectrum (Eng et al, 1997) due to incoming professional

qualities, career development and remuneration aspects. Those LCFA positions integrated into the health organisation (Case C) were more formalised and more professionalised but this did not necessarily mean they were more professional in practice. As observed, all LCFAs across programmes were informal in programme delivery with the community but the professional aspects came through. For example, LCFAs in Case B demonstrated strong presentation skills (Observation 1B, 2B) and this was reflected in an interview with an LCFA stating she treated this as a professional, though not everyone did (Respondent B5). And Case B and C came across less formally, but this depended on programme activity. Workshops that were education based were more formal than the community kitchens, with the food demonstrations (Case B) coming across more formally. This could in part be the result of delivery types encouraging different styles, more likely translating to: talking-to (food demonstrations), talking-with (workshops), and doing-with (community kitchens).

Does being a volunteer more closely align an LCFA with the community as Cherrington et al (2010) suggest? Not necessarily. That volunteer aspect of the role can change the demographics of those who come in to the role which in turn can affect the dynamics with the community ie. that they may be less of a natural helper because they don't know or understand the community. But programme examples also show exceptions to this. It was reported that some LCFAs came into position driven by altruistic tendencies and this can be seen more with Programme B, coinciding with qualities of volunteerism, implicit volunteer mentality and explicit in reflecting demographics. Though, as one LCFA commented, that some people would only do it as a volunteer as they couldn't be paid enough, speaking to both level of work and perhaps some privileged aspect of volunteering - volunteering being a luxury option for which many cannot afford to do (Sinha, 2015; Ahmad et al, 2017); or are not in position to do, confirmed by Respondents B1 and B3.

As well, issues of recruitment and retention were more predominant in Case B and with Case A, reported by some respondents to be partially related to the volunteer or near-volunteer nature of programmes (or the role being secondary to other priorities in life) and differing demographics of LCFAs; this being a risk of volunteer roles; they could be an opportunity but also a barrier for the very communities of which LCFA representation may be desired. Having LCFAs as volunteers, doing few spread out hours and not considered employees resulted for some in a limited role in participatory programme development and delivery, as with Case B. Evidence of supportive and inclusive teams within programme structures (such as with Case A and C), is more likely to be good for LCFA self-care and reflective practice (Kubiak and Sandberg, 2011; Jackson, 2014).

Findings reiterate the literature in that there is added value of these roles, but there can be tensions: between the LCFA and the community, the LCFA and the professional. Findings show that they are likely seen differently by different people and some may confuse them for professionals. Programme structure, LCFA demographics, how they saw themselves and what they wanted ie. career development and how this translated in practice, could mean more alignment with community or not. A mixed remuneration model for programmes (paid and volunteer LCFAs working in different capacities), such as suggested by Cherrington et al (2010) and Singh et al (2015) may only add to more confusion of their role and boundaries, but may allow for expansion of the role too. These cases have shown that within Ontario (and across Canada there would be greater diversity here), this is what is happening – different regions and cities in the province have sustained operating under different models.

7.4 Food Literacy

This section discusses aspects of all three RQs. Food literacy is a dominant concept in relation to LCFA programmes emerging through findings, but raise issues about how food literacy is interpreted.

Food literacy was the most common focus of programmes, though mostly recognised as food skills and education, but came through with a broader understanding of the concept in interviews and was promoted across programmes. Some respondents preferred using the more emerging term food literacy as it was more comprehensive than food skills.

LCFA programmes were highlighted as a necessary means to address food literacy in the community in findings. Programmes aimed to improve aspects of food literacy differently amidst a nutrition transition and culinary transition (Lang and Caraher, 2001). A deskilling of the population (this issue has emerged through all programmes) was a leading factor and reflected a key focus on food skills. Despite being a predominant focus of Programme B, this was most limited, both in style of delivery (one-offs), approach (mostly food demonstrations) and in that some participants already had cooking skills. These issues were recognised by certain respondents, with some intention to address them where possible. As well, the nutrition transition of lifestyle changes such as more sedentary lifestyles and convenience of foods were issues across programmes.

Programmes have demonstrated the ability and potential to address various components of food literacy. This was more apparent in Case A and C with more intense programming; this interrelated knowledge, skills and behaviour required to plan, manage, select, prepare and eat food would take time: the more domains present, the stronger the relationship with food (Vidgen and Gallegos, 2014). Issues of food literacy that were identified by respondents did

not just include lack of knowledge and skills, but time, time management and planning meals, as well as reading labels, food choice/ selection and purchasing, and any of these could be challenging for individuals and households. All these issues with participants were apparent in the observations of programme delivery. For those who were participating, the practical aspect of programmes was evident and this increased the ability for programmes to work across domains. For some, the nature of sitting around a table and discussing amongst peers how they did things: trying, sharing, even take home activities in some cases. And in the community kitchens, focused on the preparing of food with some groups planning and deciding of dishes and discussion of implementation at home, with sharing from week to week. It seemed that the more intensity of programming and opportunities for consolidation, the greater the chance of increased food literacy.

It was expressed that by LCFAs being peers allowed for more effective messaging (socially and culturally relevant) in addition to increased knowledge through Canada's Food Guide (HC, 2007a), and shared learning taking place at a practical level. This shared learning element provided more richness and depth to food literacy development of participants. Participants were generally reported to go through a series of changes: in the short-term awareness could be increased, with the intention of increased knowledge and skills following and behaviour in the medium-term. And with resilience, having money enables resilience such as buffering increased food costs, so too can knowledge and skills if people have a greater repertoire of food preparation and knowledge to draw upon (Harrop et al, 2009; Smith et al, 2010; Vesnaver et al, 2012).

One respondent spoke about food literacy as a SDH, and needing to know the language first before being able to do anything (Respondent C2). This point draws attention to language and literacy skills, and LCFAs did act as connectors here: through their own linguistic similarities (and this was important opportunity for access), cultural connections to foods, through others in the group speaking the same language, learning the English names of foods, and connections in some cases to English classes which increased competency in the language so as to read food labels for example. Though, it was also a challenge to always have cultural and linguistic matches.

Due to a lack of transference of knowledge and skills across generations, the food literacy piece for children kept emerging as a focus area either to develop (with all programmes whether there was existing focus on children's skills or not), and to build on some of the work already being done in schools (Case B), or as additional activities within programming for parents (Case C). This is in line with some push for food literacy to be further embedded into

systems such as Public Health and schools in Ontario - emphasised by respondents of Case B, and highlighted by the advocacy work provincially (alPHa, 2016). However, food literacy cannot be solely focused here (as much attention in Canada is) as children need to have a conducive environment for healthy eating; the home and family structures need to allow for food literacy to flourish.

Local food was a key area dominating food literacy in recent years. This has been seen on a national and provincial level, with respondents commenting on, such as relating food literacy to local food (Respondent B), of which the Local Food Act doesn't do (GoO, 2013; Sustain 2013b; Sustain, 2014). The promotion of local food or gardening in part intending to support the local economy, agriculture and the environment. Programme B emphasised local food the most (and wanted to do more), with promotion of Foodland Ontario (2015) resources and supporting people in how to buy local for their family, but respondents from the same programme recognised the difficulty with this messaging (Respondent B2b, B3). And as Respondent B2b pointed to, having food literacy without the means, can actually make it harder for them: knowing what they should be eating, knowing how to prepare it, but not being able to afford to do so; diet quality being affected by more than food literacy (within a knowledge and skills frame) and too much attention here can miss the mark (Ruel and Alderman, 2013; Barosh et al, 2014; Durao, 2015; Jablonski et al, 2016; Monteiro et al, 2017; Steele et al, 2017). Attention was also seen on food safety, partly because unsafe consumption of food can have immediate and devastating consequences, and as a reflection of issues in the food system - the complexities of where and how food is sourced and the number of stages at which food safety is a concern. A food safety approach on programmes translated mostly to that of personal responsibility and food skills (though important) rather than addressing issues in the food system.

Food literacy was considered an issue across the socio-economic scale. Examples were also given of LCFAs showing people what they could do with what they had or eating on a budget, however, this can make assumptions that being poor means a lack of food skills or poor management of resources. Indeed, there were mixed views among respondents on this being the case. Some assumptions were made about food literacy, in particular around food skills, that those who had come from other countries most often were highly skilled in food preparation, and the focus was this transition from their home country and cultural food availability to that within Canada, which required support (cultural transition). Reported across programmes in some way, and dominant in Case C, was the 'healthy immigrant effect' (Vang et al, 2015), with efforts to support people in continuing to eat healthy and adapt to

changes of lifestyle in Canada. So this was not so much around skills but helping people to keep their habits through access, for example, by connecting them with sources of food such as produce they were familiar with and learning about new dishes and foods that were abundant so as to increase their ability to prepare healthy meals. Conversely, many people of Canadian origin were indeed considered less food literate, particularly in relation to food skills, which has been a generational shift. However, this is more generalised to the population as opposed to participants of programmes. An added benefit is that this food literacy piece could be transferred from LCFAs and participants to their social networks. Respondents did report programmes were empowering individuals, families and communities through improved food literacy, in particular, the education and skills aspect and being group and community oriented, and that generally participants were better equipped in some way to eat healthy as a result of programme activities. Programmes played a role in increasing confidence or self-efficacy in cooking and thus a role in reversing the culinary transition of food deskilling. This is likely due to the practical aspects of programmes (Hanula et al, 2010; Krummel et al, 2017).

Though working on food literacy may have had the effect of diverting attention from some underlying systemic issues, programme objectives were largely food literacy focused, highlighted through the provincial standards (OPHS, 2008). And food, the nature of food and being able to focus attention on food literacy, was felt to allow for work across class and cultural barriers with its universal relevance.

Regardless of how it was interpreted, food literacy was reported to be important and necessary by all respondents to achieve good health. However, claims of the benefits of food skills and their relationship with health outcomes can go too far. They are important, and can make a difference (programmes playing a key role here); home cooking often being difficult to achieve in the ideal sense particularly for those low-income households (Caraher, 2016, pp.123-127). And how much can food literacy win out over big food, as Desjardins (pc, 2009) expresses, for which it is hardly necessary to have food literacy in the modern world? Or indeed, food skills? But for eating well they do, and this locates the LCFA in an ideal situation to support people in doing so.

Though food literacy has been gaining increasing attention in Canada (as well as other countries), it for the most part remains narrowly viewed and is still unclear whether or how it can take on a wider context (Slater, 2013; Cullen et al, 2015; Krause et al, 2016). This includes food systems literacy (Widener and Karides, 2014; Sumner, 2015; Palumbo et al, 2017). Education on the food system and food environment is part of food literacy (WCRF, 2015; Weiler et al, 2015). Some interviewees did report food literacy carrying a lot of meaning, going

beyond the individual and encompassing the food system. Local food was a key focus area of programmes and food systems and the food environment was reported as an emerging area, coinciding with increasing attention and recognition that the food system and food environment are influencers on healthy food and dietary outcomes (Caspi et al, 2012; HC, 2017b). Some ways of dealing with local food access were at a community garden level and accessing good food boxes, and there was a cultural component to this (Case C). Programme B promoted the messaging with Foodland Ontario recipes. Though the tension of promoting local food was identified, it is a key policy driver in Ontario (GoO, 2013) despite the challenges of doing so in Canada's climate (Simmons, 2011). Though the connection between eating local and being healthier might be a bit far fetched, Respondent B did say just that.

Respondent B1 commented that their board of health endorsed food strategies (and was on a healthy food systems team) and local food programming but that agendas were set locally. Similarly, Respondent C2 commented on the work of a food strategy group looking at food systems. Here, there is opportunity for programmes to participate in local food as a movement (to make more accessible) and engage in collaborative strategies (Allen, 2010; Werkheiser and Noll, 2014). For the most part, LCFA's were removed from taking part in food systems work, this being often seen as the dietitian's/nutritionist's role but not the LCFA's, however, some indication was there for potential of LCFA engagement on food policy issues, such as with local food policy councils which exist throughout Canadian cities, to ensure voices are heard and to include a broader representation and relevance to community issues. This can enable modern food literacy to capture the individual in relation to a wider context within the food system and environment.

Findings have shown that food literacy often remains as an individual and household level issue but can be broader to include community and beyond; programme models varied in how this was being identified and addressed. If food literacy is viewed too narrowly, it neglects the underlying determinants of food behaviour and if programmes only focus here, they may be of least benefit to those worst off (Palumbo et al, 2017). These aspects are further discussed in Sections 7.5 and 7.6.

7.5 Food Behaviour

This section discusses parts of each of the RQs as they cross-cut with issues of food behaviours, in particular, with findings raising some tensions around underpinning theories and approaches.

On an individual level, respondents recognised that knowledge and even skills may not be enough to make healthy choices. Programme theory on one level seemed to be that if people

were taught about healthy eating and were given knowledge and skills then healthy behaviour would follow and people would be healthier. On another level it was understood by some respondents to be more complex and that this was too simplistic, as reported by Contento (2008). Notably empowerment, education and disease-prevention were all approaches used; with some differences in interpretation and operational aspects. Some respondents focused on empowerment through education, and some pointed to empowerment and education approaches. According to Naidoo and Wills (2000, p.97-98) the empowerment approach to health promotion uses a facilitator approach, as some respondents pointed to (particularly in Case C), but it also means people identifying their own problems and solutions; these types of programmes for the most part are identifying the problem as people eating unhealthily but it could also be that participants themselves have identified that as a problem and seek out programmes. Observations showed that participants were merely guided in identifying solutions. An educational approach aims to enable informed choice but this assumes choice is the result of acquiring knowledge and choice is not complicated by other factors. All programmes incorporated an education approach, but this was intended as facilitative rather than expert-led. The strong educational approach was apparent in observations but done so in practical and responsive ways with the groups. Some programme delivery was observed to be more hands-off from an educator perspective such as through community kitchens observed in Case A, which were the most facilitative in a 'learning through doing together' approach that could be participant-led.

Underpinning models reported were predominantly behaviour focused with The Stages of Change model (Prochaska and DiClemente, 1983) whereby participants would be expected to progress through a series of stages. It was reported by some of the respondents of Case B to be stuck at the awareness stage in part because of length and style of delivery (low intensity). Other respondents, mainly from Case A and C reported that participants were able to make sustainable changes as a result of participation on the programmes. Programme C in particular, was structured so as to provide support in making changes over a longer period of time (higher intensity).

Health lifestyle behaviour and behaviour change occurs within social, economic, environmental and structural contexts. There was evidence of awareness within these programmes of wider factors that affect lifestyle choice. Even though Canada's Food Guide was central to the delivery of healthy eating messages, importantly it was being delivered within the social and community context with the function of the LCFA more closely aligning with understanding of the SDH (more prevalent in Case C as well as Case A). There were some

elements of the Food Access Model (Dowler and Dobson, 1997), if taking into account food choice and factors beyond the individual control. Increased awareness, knowledge and skills through education are important for behaviour change and behaviour change is influenced by individual and collective factors. Thus, programmes going beyond the immediate environment will more likely lead to sustainable and equitable outcomes (Raine, 2005; WHO, 2007; Jepson et al, 2010; Gore and Kothari, 2013). This is in line with recognition that the concept of health promotion means more than health education (Tones and Tilford, 1994; WHO 2004a and 2015).

Further theoretical concepts emerged from cases. Social Learning Theory (Bandura, 1977 and 1986) too was noted by respondents in Case A and B. Still a persuasive model focused on the individual as with the Stages of Change model, importantly this model takes into account the learning within one's social context, as respondents noted. And self-efficacy as a key variable to change behaviour (Bandura, 1997). Participant empowerment, a more widely used term, intertwined (and blurred) with self-efficacy, was noted across programmes. There is some evidence of participants (and LCFAs) making changes in their lives with reports of individual empowerment, and their beliefs and confidence in their ability to change (as expressed by some respondents and participants in programme observations). As Empowerment Education suggests, participatory and community-oriented efforts lead to people having increased control over their lives (Freire, 1972; Wallerstein and Bernstein, 1988). Though programmes have a role here, individual empowerment can be limited by external factors beyond one's control. It wasn't clear how much empowerment came into play and to what extent, or whether education was merely the focus in some cases. However, this was not being measured in this study.

Though internal factors such as knowledge and skills affect self-efficacy, so too do external factors such as time and money, which respondents spoke to as barriers to healthy eating (and a broader food literacy approach can build in). The social environment playing a role too and the social aspect of programmes emerged repeatedly, as key in enabling supportive environments; understanding that individual behaviour is shaped by the wider context (Bronfenbrenner, 1977); the interconnecting nature of cognitions, behaviour and environment are important. As social networks influence behaviour, programmes are an example of how interrelationships between the LCFAs, participants and organisations exchange information and provide linkages. This is reflective of a social health promotion model being more suited to programmes and their response; however, the tension remains around health promotion's practice still being individualised. As Seedhouse (2004, p.5) argues, health promotion is

prejudiced and riddled with deep theoretical tensions; and in this regard, is health promotion in itself, though well intentioned, inherently flawed? From a pure imparting of knowledge onto others (transfer of knowledge), of information that is the best advice based on the most current 'evidence', what little is known from a limited viewpoint, then most likely. But if LCFA programmes are more than this, as focused on personal skills and on community development and social capital, then here they carry a much higher value and may increase likelihood of long-term health behaviours. Personal skills and social capital promotes resiliency in individuals and strengthens communities (Harrop et al, 2009; Smith et al, 2010; NICE, 2007). This connects with the philosophy of Healthy Communities (OHCC, 2014).

LCFA programmes may help to bridge the 'intention to action' gap to achieve behavioural change through motivational social support and encouragement, and helping to address targeted issues with community groups (Contento, 2008). For example, if access to healthy food is an issue, then working to improve this barrier or if strong beliefs interfere with healthy decisions, then the LCFA could be better placed to influence and alter these attitudes and beliefs. Motivation is key here, those most motivated may benefit the most (Besharov and Germanis, 1999; Johnson et al, 2008).

Conducive environments for healthy behaviours are necessary (Raine, 2005; Story et al, 2008; Scrinis and Parker, 2016). A healthy food environment was reported by some respondents (Respondents B1, C1), this could include provision of healthy food during programmes (as observed) though limited, and engaging with people (though this aspect wasn't clear). This could be interpreted as working within and challenging environments. Ultimately individual behaviours remain important but 'thinking in terms of settings and conditions rather than behaviours' is necessary (NCCDH, 2013). There is a back and forth between behaviour, settings and the conditions which shape it, so though programme emphasis was on behaviour, it was generally understood that there needs to be a focus beyond it to achieve good health. Emphasised by respondents, programmes went beyond promoting healthy behaviours (as individually framed), they promoted healthy settings with the social aspect and peer support; contributing to improved social and mental health involved a more holistic view of what health means. But the wider setting, such as the environment for which food choices were being made, was where programmes were not focusing as much. Expanding their role more into these settings is an opportunity for programmes.

7.6 Food Security

The field work raises interesting points about household and community food security (but not about national or global food security). This section discusses aspects of RQ1, RQ2 and RQ3

particularly focused on RQ2 and the reality of how programmes were able to address healthy eating for those who were food insecure.

Respondents across cases spoke to issues of food insecurity, emerging in programme reports as well (Report 1A, 1C). Low-income rather than poor knowledge was the most identified barrier to improving nutrition habits and reinforced by interviewee comments. LCFA programmes saw participants from a range of socio-economic backgrounds. Though some participants were considered food insecure, others were not. Of interest, one programme delivery (observation) took place in a food bank location and yet this was all women with means, described as more likely to be food bank donors than users (Respondent A4). Though not all those who were accessing programmes were on low-income, respondents reported that the need existed regardless of people's income levels and issues were consistent across the income spectrum - time, managing money (rather than having it or not having it), the ability to prepare meals and food skills (Respondent A6). This goes back to food literacy being considered a universal issue. As with Case A, where SDH was an underpinning strategy, and low-income populations were identified as a target population, it was difficult to identify whether someone was low-income or not (Respondent A1b).

Strategies such as LCFA programmes by way of healthy eating workshops, community kitchens and gardens are not on the emergency end of the spectrum (such as food assistance programmes). Though, community gardens in Case C for example, experienced varying degrees of success - some being regularly busy with entire families participating, and others having few participants. There was expressed desire by respondents of Programme C to expand the community gardens and outreach further, as a way to also utilise existing underused space in the city, and this could fill a need for some of the population on low-income. However, this may be an unfair expectation and could be interpreted as those who are poor having to work for their healthy food when everyone else can just buy it. Community gardens could be seen for other benefits, and although it's unlikely people could grow their way out of poverty, this could help to buffer their situation, at least in the short to medium-term for those participating. And that is the catch too, as Loopstra and Tarasuk (2013) and Rocarolo et al (2015) have found in Canada, and respondents have reinforced, there can be limited participation, particularly from those on low-income, and those less food insecure are more likely to engage in these activities.

All programmes however spoke to participants in programmes who were of less means. There was recognition that supporting this latter group was more challenging for the programmes. LCFA programmes have been shown to be further along the 'community food security

continuum' (MacRae, 1994; FSP, 2005) with participatory programming and capacity building strategies. Despite recognition of the limits to food assistance programmes by respondents and intentions for example of 'showing alternatives to being funnelled into the culture of food banks' (Report 1C), all programmes were referring participants or linking to food banks which was going backwards rather than forwards to system-change strategies (OPHA, 2002; Caraher and Coveney, 2003), demonstrating it was easier to look for more 'ameliorative' rather than 'transformative' solutions (Ledwith, 2011, p.11). That said, LCFA programmes may contribute to improved food security through increasing accessibility, nutrition, and acceptability. These programmes may still be an example of a more empowering response to food insecurity and poverty (as opposed to a charitable model of only giving handouts) (McCullum et al, 2005). Programmes contribute most to community food security as a capacity building strategy.

Many LCFA roles have been focused on supporting people to eat healthier (through knowledge and food skills acquisition) working within the context of their lives (Leaman et al, 1997; Hopp et al, 1998; Dewolfe and Greaves, 2003; Kennedy et al, 2008; Health Canada, 2010). Support that is relevant and tailored is likely to be more effective (Kobetz et al, 2005; Sahay et al, 2006; Eyles and Mhurchu, 2009; Winters et al, 2010). Though targeting those on low-income, this was not necessarily reflective in take-up of programmes. LCFAs can do more than merely information dissemination (as informational campaigns, such as Foodland or EatRight Ontario do); and helping people to eat healthier may be able to buffer differences in health between socio-economic status. But is this true given the differential take-up and ability to adhere to healthier diets (Jepson et al, 2010; McGill et al, 2015; Bonaccio et al, 2017)? Programme participation - access, utilisation and ability to make changes - can differ, and this was reported to be mixed. Overall however, LCFA programmes are more likely, than their professional counterpart, to get engagement of communities lower down the socio-economic scale. Increasing food skills and gardening has not been shown to effectively improve household food insecurity, pointing to the necessity of addressing underlying health determinants (Loopstra and Tarasuk, 2013; Tarasuk, 2013; Huisken et al, 2017). It also needs to be cautioned that gardening is a seasonal activity and can be limited depending on where people live in Canada. Community initiatives on the whole may however offer a more immediate avenue for which to increase access to healthy food and community connections in addition and complementary to policy intervention, and may help strengthen the local food system and environment (Blay-Palmer and Knezvic, 2015).

There were some tensions with emergency versus non-emergency approaches to food

insecurity and programmes could be caught in the reactive mode - not often being the best to meet community need beyond the immediate. Both Public Health and community agencies were involved with emergency food and programmes heavily focused on showing people how to work within their means ie. showing what people could do with a food bank hamper and were found to highlight how Canada's emphasis on food charity rather than food rights can threaten systemic policy strategies and people's ability to achieve household food security (Rideout et al, 2007; Riches, 2011; Riches and Silvasti, 2014; Seed et al, 2014). And yet there was widespread recognition that food assistance (such as food banks) was insufficient in terms of quality and quantity of food provided. This strategy being disempowering and working against the philosophy of health promotion (Poppendieck, 1999; Saul and Curtis, 2013; Lambie-Mumford et al, 2014). Even the internal incentives (vouchers, good food box scheme) provided by Case C were recognised as not a long-term solution, as has been critiqued in the literature (D'Souza, 2006; Black et al, 2012; Miewald et al, 2012). Programmes play a role here in supporting people to improve their immediate situations but also to push and challenge the causes of these situations.

Community need has been defined differently, mostly by having a lack of food skills and lack of knowledge to being more complex to include food insecurity, poverty and other systemic issues. How and by whom is identifying community need and within what boundaries? It may not be those who 'need' it most who are identifying it or who are being identified, as some respondents expressed (and certainly those who are taking part). Programming in response to community need might be misaligned (Loopstra and Tarasuk, 2013). This issue of food security reveals some tension between universal and targeted programming discussed in the next section.

7.7 Population Health and Health Equity

This section discusses RQ2 and RQ3. Findings have raised questions around the role of LCFA programmes for population health and health equity, which are key health policy areas. Respondents (supervisors/managers) reported to be working from a population health approach, but were generally challenged with showing outcomes beyond outputs, typical of health promotion programmes.

Universality is a theme for health care access and public health in Canada. And, the problem of unhealthy diets and poor health is prevalent across the population, as reported by respondents and supported by the literature, but as poor health disproportionately affects those on low-income the most, there are arguments in support of both universal programmes

and targeted interventions (Jepson et al, 2010; Marmot, 2010). This research has shown LCFA programmes to be both universal and targeted in their approach, with both approaches revealing the limits of programmes on their own. Being universally accessible avoids the possible stigmatising effect as is the case with food assistance programmes of taking part in programming for the poor. This is practical, not only from a political acceptance perspective but in reality, how can programmes distinguish whether a person is low-income or not unless they self-identify? Or programmes set more rigorous criteria, a concern raised by some interviewees. The issue begs the question of who is accessing and benefitting from programmes?

In practice, a population health approach²¹ may be out of kilter - that despite the model meaning action on multiple health determinants (the 'what'), this may not be happening due to continued emphasis on personal responsibility. Problems need to be seen as bigger than the individual (Hancock, 2011; Rayner and Lang, 2012; Kirk et al, 2014). However, they do show broad potential here. LCFAs ideally work within an ecological framework (Balcazar et al, 2012); programmes can work at different levels (the 'who'), with the extent to which they do so varying, but it may be the system and wider societal level to which they are most limited. Being part of a system that takes action on multiple levels will be most effective, and they are actors in the system (Golden and Earp, 2012). Programmes have shown 'how' action can be taken through this model by (WHO, 1986; PHAC, 2014): reorienting health services through a community-oriented health promotion delivery model (rather than in a clinical setting) and delivery by trained lay people rather than health professionals; building personal skills through focus on food skills, knowledge of healthy eating, and wider access to information and connections to resources; creating supportive environments through the social and community aspect of programmes making it a source for health, building of networks and community connections; the 'peer-ness' of the LCFA and of the group enabled greater levels of comfort and trust to develop relationships, support and social capital; building healthy public policy whereby LCFAs could identify areas that impact on the health of communities and play a role as advocates (not clearly in all cases); the policy and advocacy piece opened up for the dietitian/nutritionist role through the (theoretically) redirection of their positions within Public Health; strengthening community action through bringing communities together and providing networking and community development - utilising skills of the community, creating leadership, linkages and opportunities whereby the community can identify issues and have a voice, leading to community empowerment. All these areas speak louder than the

²¹ See Figure 2.3 Population Health Promotion Model for framing of the 'what', 'who' and 'how' for action on population health.

programmes, such as building personal skills and creating supportive environments, which can require more intervention than an LCFA programme; 'health in all' requiring being embedded in policy everywhere, with diverse and complementary approaches.

Public Health's emphasis on population health meant that in some ways they were moving away from individualised service. But this didn't for the most part translate to a model which addresses underpinning systemic issues. And though a population health approach may have been the intent, in practice programmes focused more on intermediate rather than structural determinants of health. Furthermore, a population health approach can be confusing, it may lead to assumptions that whole of populations are being reached when programmes are examples of showing this not to be the case. Programmes had targeted approaches: through being responsive to identified need, tailoring their delivery, being neighbourhood/community-based and prioritising sub-population groups. This didn't necessarily translate to certain sub-populations being engaged with effectively for various reasons and assumptions: trust (some may come from oppressive, untrusting governments), programmes not being a fit as certain cultures were reported to be more responsive to coming out to groups and that not every area within an area (city or region) could be reached equally. It was clear that not everyone was engaging in the programmes and this was a challenge, even with being universally accessible; access and utilisation are different. Access needs to consider geographical (urban, rural) and socio-economic issues in addition to recognising interest in health and how it is viewed (Wardle and Steptoe, 2003; Seedhouse, 2004; Guthman, 2011). As well, programmes often run in the daytime, and this means not everyone can participate.

Some respondents reinforced concerns over health promotion programming and its differential take-up. Programmes that focus on food skills and community engagement rather than poverty and food insecurity may result in those with greater means accessing programmes (Frohlich and Potvin, 2008; Jepson et al, 2010; McIntyre, 2011; Goodall et al, 2014). Programmes were targeting low-income communities generally by promoting or basing themselves in these neighbourhoods. It was argued that participants could come from a variety of backgrounds and indeed this was encouraged by some to build connections within groups and communities which could lead to strengthened communities (this didn't necessarily mean changing the context or food system), while acknowledging there was a 'balance to be had' with participants (Respondent Aa). There are some arguments however against this approach including the ability to focus programming and some concern that those who are poor being less likely to participate in programming as highlighted earlier. Tarasuk (2015), for example, argues for the need to be more deliberate at focusing resources for

people at the 'bottom end of the spectrum.' So though programmes reported that they were taking a population approach through directing their work at sub-populations and not individuals, whole sub-populations were identified as challenging to reach, despite some effort, yet, concerted action with priority populations is necessary for addressing health inequities, which continues to be a major challenge in Canada (Hassen et al, 2017).

Community representation of the LHA can promote greater equity in service provision (Torres et al, 2013; McCollum et al, 2016). The peer aspect of the LCFA, if meant the LCFA was reflective of that group or had something in common through lived experience (only if this is identified) or meant the approach was less professionalised/top-down was a useful outreach strategy. Respondents from different programmes made points about the ability of LCFAs to reach certain groups more effectively as peers, and some reported this could be both a strength and a weakness ie. through only reaching those with whom they had something in common. Interviewees from Case B expressed the most challenge with reaching the hard to reach communities, and this coincided with how Case C evolved to a model felt to reach more under-served communities. However, Programme C concentrated their reach to the early years population and was thus more targeted. All programmes, though some did better than others, reported challenges with reaching certain groups, reiterating some concerns in the literature (Price and Lester, 2012; Attree et al, 2012; Goodall et al, 2014).

Women were the most predominant group accessing programmes. Groups were also observed to be most racially and/or ethnically diverse in Programmes A and C (likely a result of the demographics of LCFAs). Children were being reached across programmes, either directly or indirectly through their parents. These are all sub-populations most adversely affected by health inequalities and inequities. Seniors, in particular, were accessing Programme B (both men and women) and this is a population most affected too by poor health as a result of issues such as social isolation (Cornwell and Waite, 2009). This is in line with NICE (2008) recommendations and that people are more likely to seek health and make changes to health behaviour at key life stages.

Importantly, certain communities may be more isolated particularly with the migrant population or those with language barriers, with respondents speaking to a loss of support system for new immigrants. People in the community without immigration status could access programmes and could perhaps still be reached for services who may otherwise not be reached or not qualify for other social and health programmes. These programmes are one avenue to engage with this sub-population which could be more isolated, thereby increasing their access to services, social supports and networks. Reducing isolation, increasing

community connectedness and social networks were key objectives and valuable outcomes of programmes on their own. Programmes are of value in reaching under-served communities and can be one equitable way to increase health goals. For example, respondents who spoke to the 'healthy immigrant effect' expressed that the deterioration of health of immigrants over time in Canada had to do with adaptation to an unhealthy 'westernised diet' and also on other stressors and life changes, including loss of social supports. Indeed, country policies are shaped to encourage immigrants with high human capital and their ability to contribute to the economy and society, and would be of interest to them to support initiatives that promote the maintenance of their good health, thus reducing impact on health care and other costs in the long-term (Vang et al, 2015). The reach was ultimately greater than merely that of programme participants as families, friends and wider social networks could be influenced in some way by programmes through the sharing of healthy eating messages and practices. Indeed, Case C respondents reported a diversity of immigrants (with some being refugees) – some who were highly educated with English proficiency who were connected and resourceful and others who were not. Many participants of programmes were educated immigrants and may have been experiencing situational difficulties such as poverty.

LCFA programmes support Public Health in reducing disparities within a health equity framework through: (1) some, though limited, advocacy work through the organisations and the dietitian/ nutritionist being able to focus some effort on advocacy (food access, income), and advocacy through LCFAs (of community issues) (2) reporting of programmes being effective strategies in reaching communities (3) tailoring programmes with an understanding of the unique needs of populations that experience marginalisation (4) engaging in the community and multi-sectoral collaboration (other government and community organisations) to identify ways to address health needs and improve health outcomes (Kouri, 2012; NCCDH, 2013a; Torres et al, 2014).

Gaps remain over who is targeted and who is reached for community programmes as can be the disconnect between fit of programmes, gap in understanding of issues between those working to address them and for those living with issues such as food insecurity which draws attention to the importance of programmes with lay workers and their understanding of the community. Findings reinforced that LCFAs and those in similar roles, were in all cases considered more accessible to the community, as Ball and Nasr (2010) indicate. Still, there is no one size fits all approach.

7.8 Programme Autonomy and Agents of Change

This section discusses RQ1 and RQ2. The findings raised interesting points around issues of autonomy and collaboration, centralised and decentralised models further to earlier discussion with aspects illustrated in Figure 7.2. This is of importance as to how programme structure can influence programme operation and the scope of programmes.

Programmes received various levels of support from government (provincial and municipal) and community agencies. LCFA models studied can be considered integrated within the health system in some way (with none acting independently), making them more formal models as they were structured, according to Torres (2013). Formal in structure does not necessarily translate to formal in operation. Case A was a co-opted model, that seemed more connected to rather than integrated within Public Health, this resulted in Case A having more autonomy from Public Health and being most informal in operation.

The interplay between agency and structure looked different, whereby programmes most integrated (Cases B and C) resulted in more power being held with Public Health. The structure of these LCFA models reinforce where professional involvement and control come into play (Eng et al, 1997; Kennedy et al, 2008; South et al, 2013a). Power imbalances can occur if ownership and power still lies with Public Health (Pederson et al, 1994; Frolich and Potvin, 2008). All programmes had elements of shared power in the community. Case A has shown an example of shared power between community agencies and Public Health, this can also mean shared resources; however, Public Health held the funding and for all respondents funding was an issue and can tip the balance between who really holds power. This was not expressed by respondents that Public Health was exerting power, as the funding issue was beyond programme level. LCFAs as employees of Public Health (Case C) seemed to carry more power than LCFAs as volunteers with Public Health (Case B).

Programmes are well placed within the structures of Public Health to support improved health, as through employing different strategies: advocacy, mediation and enabling (WHO, 1986; Kickbusch, 1995). Many respondents highlighted the importance of partnerships, collaboration and the multi-factorial aspect of healthy cities and communities; effective partnerships being a key feature for successful programmes (Bourgeault and Mulvale, 2006; Lehmann and Saunders, 2007; South et al, 2011). Programmes being part of Public Health can increase their legitimacy with top-down support that is flexible but they can also be bottom-up. Being connected with Public Health can enable a politicised approach to addressing issues; programmes could be more collaborative in tackling food and health issues (WHO, 2010b). Programmes have shown they don't work so much in isolation, this being seen across

programmes but more clearly among Case A and Case C structures, whereby they interconnected with other programmes and services, set within organisational structures.

Increasingly health services and programming is suggested to place emphasis on the SDH (O'Neill et al, 2000; OPHA, 2008; OMHLTC, 2010; Schrecker, 2013; Kirk et al, 2014).

Programmes can leverage internal and external stakeholders and collaborative partnerships; Public Health is a key avenue for bridging civil society and government. LCFA programmes could also influence organisational priorities such as through connections with community issues and advocacy for strategies to address them. This is not to say LCFA programmes be solely responsible, but with joined-up thinking and a coordinated approach, they can be part of the menu of action to address issues, as an 'integral piece of the puzzle' (Respondent B2b). Engaging with a broad coalition of actors can mean greater scope and more participatory practices (Meister and Guernsey de Zapien, 2005; Hill et al, 2007; Anderson et al, 2015; Simonsen et al, 2017). This does not need to take away from LCFA autonomy.

Programmes ranged from centralised to decentralised models: with varying levels of Public Health control (as described by respondents). The more decentralised, the more autonomy of programmes and LCFAs to do what they wanted and therefore having more scope to respond to the community's wants and needs or to be agents of change. The extent of autonomy can vary, and it did (South et al, 2013a). Those models more attached to Public Health seemed to be more directed from health professionals. The most decentralised model, Case A, was found to have more autonomy among partner agencies creating more of an equality with partners with less power to Public Health, and LCFAs reported feeling most autonomous in their practice with support from supervisors. Case B was decentralised in one regard - with ownership of the programme to individual Public Health units; the programme was centralised with provincial coordination of resources, training and delivery content. LCFAs of Case B reported more rigidity with their delivery content; however, this was reported to be shifting since some dismantling of the provincial piece. The programme continued to be owned and controlled by individual Public Health units though, and this translated to more boundaries on LCFA scope of practice, which was also likely to be due to the volunteer nature of positions, placing LCFAs lower down the institutional hierarchy. Case C was centralised with a municipal Public Health unit that allowed for Public Health control but at a local level. This control seemed to be the tightest due to the localised aspect and ownership with the Public Health unit as well as designated professional involvement (programme dietitians). Programme autonomy was connected with how the role of the LCFA was seen and utilised.

The findings reinforced concerns that although these roles are important in filling human resource gaps, they are often not recognised and are undervalued, issues raised by Torres et al (2013; 2014) and Najafizada et al (2015) in Canada. Though, the potential of these roles as change agents is identified (NICE, 2008; Plescia et al, 2008). Findings have also highlighted the limitations in these roles acting as change agents, as the literature has pointed to (Riessman, 1984; Nittoli and Giloth, 1998; Kennedy et al, 2008; Ingram et al, 2012). LCFA roles were more likely to focus on acting as individual behaviour change agents but may have potential to act as system change agents, the latter of which would have greater impact on healthy outcomes; but LCFAs were mostly working within the system rather than challenging the system.

Opportunities for a range of activities identified of LCFAs have both been confirmed and limited (WHO, 2004b; APHA, 2009; Richmond and Ross, 2009). What was most limiting was that LCFAs could have a clear identified role in advocacy and some respondents recognised this. Although LCFAs did not have a direct role in advocacy, they were reported to be necessary to help create healthy environments by engaging people (Respondent B1) or to only be limited by a lack of training and capacity (Respondent Aa). LCFA programmes can play a role in different types of advocacy, and on a whole can shift the emphasis from that of only representational advocacy (Smith and Stewart, 2017). LCFAs can play a facilitative role in helping citizens advocate for their communities, for example, in identifying problems and solutions, in improving the local food environment as well as facilitating change beyond this (Schwartz et al, 1995). LCFAs may be uniquely positioned to act as enablers of policy change by drawing attention to issues with 'emotions and values' (Cullerton et al, 2016). Relationships and trust harness the advantage of LHA/LCFA roles, which allows for opportunity for greater change. LCFA programmes play a unique role in increasing community cohesiveness and in acting as connectors, bridging issues with Public Health and facilitating community participation and action, building on strengths and enabling community voices. Is there a place for more upstream advocacy with healthy public policy? Being situated within institutional structures and the community could be a powerful way to mediate between the two, if a programme model allows for it.

7.9 Downstream, Midstream and Upstream aspects of Programmes

This section highlights dimensions of programmes and discusses gaps and opportunities identified in relation to the RQs in working across different levels. This is interpreted through the role of programmes at service-level (downstream), intermediary-level (midstream) and structural-level (upstream).

A criticism of public health and health promotion programmes is that efforts are too downstream (Whitehead and Popay, 2010). Upstream interventions are more likely to reduce inequalities (Dorfman and Wallack, 2007; McGill et al, 2015); if programmes are able to work across all aspects - downstream, midstream and upstream - they may be effective at contributing to achieving better health outcomes across the socio-economic spectrum.

Programmes look to be one-dimensional but should be viewed and operate as multi-dimensional - more than the surface of working to increase knowledge and skills of healthy eating. So, though there is a need for immediate level work, focus needs to move beyond personal responsibility (Raine, 2005; Wallack and Lawrence, 2005; Dorfman and Wallack, 2007; Ledwith, 2011). These case studies have demonstrated that LCFA programmes can do so through the lens of individual environments but are bigger than the individual. Set within a group and community environment, they can shape cultural and social norms, and contribute to evidence that social support and social capital can improve health behaviours (Putnam, 1995; Lomas, 1998; Dennis, 2003; McElmurry et al, 2003; Cook and Wills, 2011; Simoni et al, 2011; South et al, 2011; Harris and Haines, 2012; South et al, 2012; O'Mara-Eves et al, 2013; Taylor, 2015).

The interconnecting and multidisciplinary nature of food and impacts of the food system have become increasingly understood and recognised with the need to be more holistic in approaches. Respondents from all programmes spoke to recent awareness and drive towards whole food systems approaches within organisations and programmes. This coincides with the literature pointing to a need to join-up efforts and work at all levels (Caraher and Coveney, 2003; Caraher and Dowler, 2007; Robinson, 2010; Capacci et al, 2012; Cullerton et al, 2015). Though programmes were often downstream, there was a midstream aspect to them, creating broader support and connections for individuals, families and groups that can cascade out and create healthier environments. So too, is upstream level activity needed and programmes can contribute to change through efforts such as advocacy. Advocacy can be at multiple levels including work at local level connecting with organisational and city strategies that can create change across communities; and provincial and national strategies that can have wider impacts.

It is important that all programmes, as many interviewees expressed, understand and function in a way that does not ignore the importance of upstream activity. Still, a tension remains among policy-makers around who is responsible, between personal responsibility and the social, environment and economic factors (OPC, 2006; NCCDH, 2014). The lack of (or limited) upstream advocacy to change systems, from a health promotion and food policy perspective,

could be a missed opportunity. These case studies have shown some effort in working within a SDH frame, though most of the effort was focused on environmental (intermediate) determinants. Programmes cannot cure poverty (nor do they claim to) and in some cases, this is the main cause of poor diet and health; their existence too could be an excuse for not addressing root issues. They do not and cannot do what, for example, a guaranteed basic income can do, but can do something in the meantime to help promote food security (even if in the short-term), and support general healthy eating which is an issue across the income scale. Programmes varied in their intentions and aims to work with those of low resources, and focused more so on the symptoms and coping strategies rather than causes of poverty and food insecurity - intermediate rather than structural determinants of health. This being necessary too, but there needs to be a shift from individual and household level to system level responses and challenging the current system ie. charitable responses to hunger rather than human rights. Health promotion includes not just coping with the environment but changing it too (WHO, 1986).

Programmes may seem to still be focused on personal responsibility because they are limited in what they can achieve if working within the confines of Public Health and programmes. As Raphael (2000) points out, targeted efforts that focus only on programme delivery will not adequately address SDH. Many respondents expressed that focusing on individual knowledge or skills alone was not enough to enable people to eat healthier. LCFAs have already been shown to help people work within their means (Leaman et al, 1997; Hopp et al, 1998; Dewolfe and Greaves, 2003; HC, 2010). Though education cannot be a catch-all solution, education and learning can be empowering, as respondents have noted. And though the 'self-help' aspect (alone) can undermine systemic work (and systemic issues can undermine self-help), if there are factors within people's lives they can change that are within their control, are affordable and practical, even small changes can make big differences to health.

Programmes may be able to contribute to changes in the local food system and environment. Programmes may also change the socio-economic status of individuals by providing opportunities (for both LCFAs and participants), especially for those experiencing systemic barriers such as class, race, ethnicity and gender (Cases A and C showing examples of how this could be achieved). Programmes may thus be able to change the resources or opportunities available to participants and influence underlying structures which work against good health outcomes (Winne, 2008; Jepson et al, 2010; Rayner and Lang, 2012; Gore and Kothari, 2013; Roberto, 2015) - enabling work across downstream, midstream and upstream contexts; this could be strengthened with more intentional programme design.

7.10 Food Policy Implications

Implications for programmes and food policy are explored here through further policy analysis, complementary to the introduction in this chapter and as a consolidation of the discussion. The Multiple Streams Framework (Kingdon, 1995) is applied to show that though timely to look at this framework, as there is heightened attention from a problem, policy and political perspective, the three streams are not being well integrated. Programmes on one hand are supported and on another they are not; there is policy in their favour, and policy working against them, all seemingly competing and contradictory. On a local level, LCFA programmes have a key role in contributing to policy priorities at various levels. It may also be that their role at local level is key to informing wider policy issues. However, their level of support remains a question. Are programmes a way to merely be seen as doing something - they are visible - but are they effective and are they enough to address the problem? Figure 7.3 shows the Multiple Streams Framework as three streams, overlapping and interdependent.

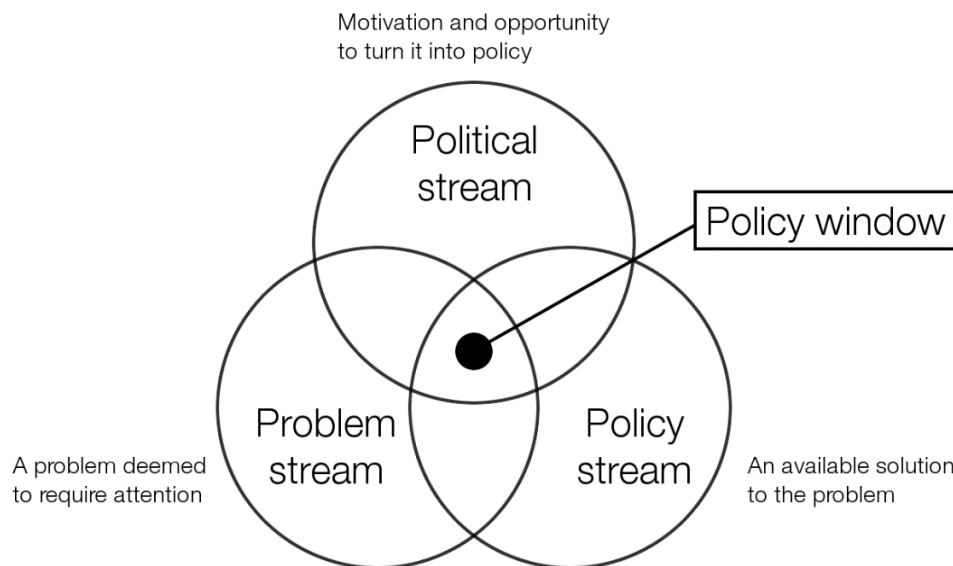


Figure 7.3 Multiple Streams Framework (Kingdon, 1995)

Problem

The thesis has framed the overarching and growing problem as food-related ill health and health inequalities due to the complex determinants of food choice and health (Popkin, 2002; PHAC, 2010a; WHO, 2013a; HC, 2017b), and that the traditional top-down approaches to promote health have had limited success in the community. This includes the problems of the food system as discussed in Section 2.6. A big difference to identifying solutions to the problem are how it is framed (including influences of the media) and perceived: is it merely a problem of personal responsibility and consumption (Roberto, 2015)? From a food policy

perspective, it is much broader than this (Hawkes, 2004; Pettoello-Mantovani, 2005; Clapp and Scrinis, 2016). Canada has consistently had limited commitment to health promotion - despite the growing high cost of unhealthy behaviours and inequalities (Manuel et al, 2016). The problem has continued to be framed as that of individual choice, despite recognising the SDH (Labonte, 1993; O'Neill et al, 2000; Raphael, 2000; Hancock, 2011; Malik, 2013; Schrecker, 2013; Kirk et al, 2014).

Findings from this research show that the problem varied in how it was being framed: from individual to societal to policy level. The recognition was that the problem was complex, and though programmes were recognised as playing an important role, it was also recognised that a broader policy response was necessary. The biggest challenge was being able to attribute outcomes as a result of the programmes, which is not uncommon (Brug et al, 2005).

Establishing a comprehensive effect of programmes was difficult due to the complexity of the problem but this also speaks to the importance of the programmes' context with which they play out contributing to the outcomes.

Health promotion is about the interplay of health, politics and power. The time programmes were developed saw heightened policy attention to health promotion, followed by reduced political will perhaps because of the enormity of the problem and its framing, complexity of Canada's political structure, competing powers and policy influencers. While it may be agreed that the problem (however it is framed) require attention, the action required may not be agreed upon nor considered immediate.

Policy

LCFA programmes can be one policy choice; even within this choice, there are different models. If the problem is identified, as often is, as that of personal responsibility and consumption, an obvious policy response is one that focuses on food behaviour. Tackling a problem from this perspective can be a more do-able solution; policy that can be seen as doing something is better than nothing. LCFA programmes can tick that box as a local policy option. But findings show programmes have not been considered as a serious strategy, coinciding with how health promotion has been viewed in Canada (Jackson and Riley, 2007). Government rhetoric in Canada abounds around the necessity of addressing the SDH, for which LHA strategies have been identified in playing a key role in (Freeman, 2016), but there remains little in practice to support this approach as it has not played out with tangible supportive policies (Raphael and Sayani, 2017). Programmes have likely maintained a level of support because they have been seen to be focused on lifestyle and behaviour; freeing government of responsibility and making it easier for some stakeholders. Personal responsibility ways of addressing issues by focusing on education, skills and local food depoliticises problems of

poverty, food insecurity, inequalities, social justice and the food system (Guthman, 2011; Weiler et al, 2015, Caraher, 2016). Policy responses also depend on how the problem is perceived (McIntyre et al, 2016). Furthermore, a problem identified as that of food illiteracy (by way of lack of knowledge and skills) is politically favourable to address as a whole of population approach, whereas a problem of food insecurity can only be addressed with targeted action, benefitting a section of the population. If there is not agreement on the problem, there may not be agreement on the solution.

Alternatives to LCFA programmes are plenty and include those discussed earlier in Section 2.6; from individual to population-wide responses. Solutions are often unclear and the reality is that the problem is complex and thus solutions must be comprehensive: short, medium and long-term (Rock, 2006; Capacci et al, 2012; Cullerton et al, 2015; Segal and Opie, 2015).

But recent national and provincial policy attention functions alongside as well as connects to programmes and includes (Figure 2.4): the development of Canada's food policy, a Healthy Eating Strategy, the revamping of Canada's Food Guide, the Healthy Menu Choices Act, the Local Food Act, Ontario's Food and Nutrition Strategy and changes to provincial public health standards (OPHS), Foodland Ontario and EatRight Ontario, which all highlight the potential and confusing nature of Canada's and Ontario's policies. Ontario's Food and Nutrition Strategy (Sustain, 2013b) has key priorities that directly relate to LCFA programmes, including specific attention to areas of food literacy and food security and as 'supporting public health and community-based healthy eating programmes in community settings.' This is an example of how strategies do not necessarily translate into action and it is surprising that programmes are not better supported in this light. However, respondents reported this strategy as a policy driver.

Canada's new food policy (GoO, 2017) is an opportunity to engage with a wide variety of stakeholders and create a comprehensive food policy document, however, the details, emphasis and how this is to be implemented remain unclear. There should be a trickle down to policies at local level as well as a conduit for voices including those engaged in LCFA programmes. Canada's Food Guide to Healthy Eating (HC, 2007a) has played a supportive role in LCFA programmes, and likely will continue to in its redevelopment with indication that this is favouring health over other powerful influencers (HC, 2017a). Policy action is needed to promote less processed and more plant-based foods (Monteiro et al, 2017); it is promising so far that the new food guide may fall more in line here and this can join in with the role of LCFA programmes in delivery of this messaging. But the new OPHS (2017) have watered down key pieces relevant to food and health policy that conflict with the Food and Nutrition Strategy,

both at provincial level. There was a move, as mentioned by some of the respondents in this research, towards building in food environment and the food system influences on behaviour (in the early stages). Food system issues have become somewhat more recognised, and as respondents have noted, programmes have begun to play a role in this connection ie. via the Local Food Act (GoO, 2013), food strategies and Public Health in general (provincially and locally); programmes already intertwined through growing food and food procurement, and this seemed to be expanding. Programmes provide some opportunity for people on low-income to participate in local food, though limited. However, not only have food skills and healthy eating been removed from the OPHS, the standards also fail to recognise wider influences on health including food systems and environments and place emphasis on individualised approaches. The Local Food Act too contradicts with the Food and Nutrition Strategy, lacking attention to food literacy and access (Sustain, 2013b; GoO, 2013; Sustain, 2014). As findings have shown, local food needs to be considered more broadly so that it works for everyone.

Removal of the food security measurement tool in Ontario reaffirms the lack of priority food security is. The Nutritious Food Basket tool (GoO, 2010) continues to be used, which may seem sufficient enough to measure affordability of a healthy diet at a local level, but there remains little action as to what to do with the results. As a supportive tool that dietitians use for advocacy, this could provide opportunity for LCFA advocacy work too. Foodland Ontario (2015) seems to be more about supporting agriculture; EatRight Ontario (2016) is driven by expert advice and focuses on areas such as 'food choices when money is tight.' Both Foodland and EatRight Ontario do emphasise disseminating information to populations and were frequently used by LCFAs to support their messaging, but they only help people to work within their means. The recent announcement of funding cuts to EatRight (2018) reinforce the concern (as expressed by some respondents) of the lack of sufficient attention to nutrition and implies that people should make healthy choices on their own. The Healthy Menu Choices Act (GoO, 2015) downloads responsibility to the consumer to make informed choices about the foods they choose to eat when out rather than regulating the ingredients that are known to have serious health consequences. This fits well with government not wanting to be seen to control what people eat. Those standing to benefit will most likely be those who can afford to make healthier, informed choices at more expensive restaurants, not the fast food, ultra-processed ones. The effect most likely to result in people feeling worse about their unhealthy 'choices'. Some regulation has come into effect as part of the Healthy Eating Strategy, but on a voluntary basis which is an inadequate response (HC, 2018b). But part of the role of LCFAs is to help people make informed choices. As it was pointed out, that showing people how to

make adjustments within their situations can go a long way for some.

Further indication of the confusing nature of policy is that LCFA programmes were once a provincial strategy (with Case B model the example) and this provincial support (OMAFRA) has been removed. Those that have survived have been supported locally for many years, being recognised locally as a key strategy to address the problem.

Politics

The unwillingness to tackle the enormity of food and health problems but at the same time being seen to be doing something, favours options that are softer such as that of food skills and education. Though there remains lack of sufficient attention to the impact of food to health, when taking a food policy perspective (Hawkes, 2004; Roberts, 2010, pc; Caraher et al, 2013; Clapp and Scrinis, 2016), there are some indicators of progress in Canada and potentially a policy window (but the three streams are not clearly being merged).

Though Public Health traditionally has not been radical, there have been signs of change - with food strategies and food policy councils building and some increased focus on community development and advocacy in Public Health. There is momentum and it is a timely opportunity to draw attention to these programmes - what they do, what they can do (and can't) and drive for further change ie. through health social movements. The current climate of recognition in civil society calling for healthy food for all and food politics emerging is seeing some political shift and makes programmes more relevant. There has been a groundswell in Canada from the health community, in part coming from Public Health and the growing realisation and understanding of undesirable health outcomes despite a system that includes universal health care. Food behaviour (that focuses on skills and education) is not enough of a policy response. Government intervention and other sectors with different actors and approaches is required to tackle food and health (Caraher and Coveney, 2003; Capacci et al, 2012; WCRF, 2015; Lang, pc 2017).

Though the response to uneven and inequitable health by one sector has been inadequate, there are many actors playing a role, thus strengthening potential impact. LCFA programmes in themselves have shown multiple actors playing a part. Still, there are opposing forces with food and industry influence ie. through its lobbying power, advertising and marketing to consumers. Programme issues have partially been due to a lack of will to act, but a lack of capacity to do more, and influenced by differing ideologies in community health promotion (Boutilier et al, 2000; Raphael et al, 2014). Regardless, they cannot replace other social and health programmes and are limited on their own without supportive policies; they cannot

hope to influence the context without the support and active listening of policy makers. Still, society has not sufficiently held government accountable for issues of hunger, food insecurity, poverty and inequalities. There is potential for increased collaboration between civil society (including community agencies, NGOs) and Public Health. There is strength in the collective voice, and collective action for change (Gutierrez, 1995; Brown and Zavestoski, 2004). But there needs to be more public awareness of the problems of the food system (local, big food) and charitable responses to food insecurity and poverty. It has emerged that food literacy as linked with health literacy and the WHO's definition for health promotion can often be viewed just this way, within an individual frame.²² As well, food policy may be merely translated to food literacy (narrowly framed). This individualised responsibility for health can divert attention from addressing systemic barriers to health.

Though solving food and public health problems cannot be limited to food literacy, nor limited to one programme, programmes can meet on multiple policy objectives in relation to food and public health. There was recognition that barriers to health still existed and programmes had to fit into a broader, more comprehensive strategy. Respondents argued that taking away the programmes would leave a deficit of health promotion work in the community, and that resources could not solely be placed at policy level (and working to address systemic barriers to health) because the need was present and had to be addressed at situational level, and that the programmes' existence allowed for multiple levels of work and the potential for positive health outcomes in the short to long-term. Though Public Health involved programmes are more likely to be supporting policies rather than working against them, programmes and organisations have identified a role here, and more scope for this to happen. Thus, Public Health, including LCFA programmes, can be part of being both policy keepers and policy influencers (Milio, 1987; Lee, 2006; Simonsen et al, 2017). The latter piece being more possible through capacity building not only within the organisational structure but in the community too, leveraging the interdependent relationships within community engagement (Kretzmann and McKnight, 1996). Programmes can be one strategy and take on a wider context to food behaviour. Programmes have shown that, as part of Public Health, they can incorporate a broader strategy that contributes to addressing health. More action is needed by policy entrepreneurs to create committed change; existing LCFA programmes can play a role in drawing attention to programmes as a policy response and to addressing the problem more comprehensively.

²² Health Literacy is defined in section 2.6; Health Promotion is defined in section 2.4

The RQs have been addressed and shown both confirmation and confliction with the literature, particularly when looking at remuneration models. Key findings for RQ1 are their localised support and collaboration contributing to their function at strategic level. RQ2 has shown that the universal and targeted aspects of programming as well as the food literacy versus food security focus could create some tension around take-up of programmes (concerns raised in the literature). Findings for RQ3 have shown positive programme outcomes at all levels, but were heavily reported at individual/community level. This reflects the focus on programmes often being at this level, but can neglect their bigger opportunity.

In summary, good practice includes a programme model which reduces barriers to access for participants, valuing community relationships and representation, greater intensity of programming, targeted and universal considerations - in both a geographical sense (priority neighbourhoods) and focus: food literacy (across the population) and food security (targeted) and going beyond the individualised, personal responsibility focus to ensure that programmes are contributing to reducing inequalities. Programme models can be effective at outreach and building community capacity; this will have the most impact within a supportive and flexible structure (at programme, organisational and policy level) and set within work addressing the wider context that includes the LCFA as a more participatory actor.

PART FIVE – CONCLUSIONS

Chapter Eight. Conclusions, Reflections, Recommendations

8.1 Contribution to Knowledge

Though literature abounds on lay health roles, this thesis has shone a light on programmes that are relatively unknown particularly in Canada, and it locates the debates within a food policy one (Lang et al, 2009; Lang, pc, 2017). Food literacy is often viewed from a food skills and nutrition education perspective and falls short of drawing attention to its broader potential, to which this thesis contributes. It also adds to literature on community engagement and its role in contributing to health and food policy outcomes. Furthermore, the literature points to a lack of long-term strategies within health promotion initiatives due to lack of commitment and long-term vision. The LCFA programmes studied were long established and supported through Public Health, successful in their own right and chosen in part because they stood the test of time. Similarities and differences were found across programme models, allowing for greater insight into the role programmes played at improving health. Including the perspectives of LCFAs themselves has been of value, and has been limited in the peer literature. Health promotion is often seen in practice within an individualised rather than socio-ecological frame, these case studies showing that programmes have the potential of both, to work at intermediary and structural levels but reinforce the need for initiatives to be part of a broader strategy. For food policy, this adds to understanding the complex nature of how food behaviour is shaped and ways to address it.

Due to the case study being context-dependent, making generalisations – to the population and to other settings – should be cautioned. However, general conclusions can be drawn, through the strengthening of findings from three cases within an overall 'big picture', triangulation of data and relating findings to existing literature (Diefenbach, 2009; Yin, 2009; Crowe et al, 2011); the value of case study being the contextual aspect (Miles and Huberman, 1994; Stake, 1995; Baxter and Jack, 2008; Creswell, 2011). A great deal can be learned here, real-life context being necessary for advancing understanding (Flyvbjerg, 2006). The validity of findings was supported by contrasting and comparing programme models. Considering the RQs allowed for looking at programmes and their evolution. The learnings may be most limited for long-term outcomes due to the research design, however, findings did provide interesting answers to contribute to the deficit of literature around strategic, mechanistic, and outcome aspects of LHA/LCFA initiatives.

8.2 Lessons for Programmes and Policy Makers

LCFA programmes warrant support, amidst a policy environment receiving heightened attention to diet, lifestyle and the conditions shaping it. Programmes have sustained mostly local support over the years in part because of Canada's long time recognition of health promotion programming, and have been a way to demonstrate local commitment and join-up community and government priorities. Their value-added benefit is clear. Though programmes are an important policy response that includes nutrition education and food skills, the danger is that programmes become food policy by default, when food policy is not adequately being addressed. Though programmes may be a supportive way to nudge people towards a healthier lifestyle (Williams et al, 2016), this may not be enough; they are necessary but not sufficient. Programmes may be underpinned by recognition of the SDH, but may be limited in addressing them and may be still more individualised than socio-ecological in their approach due to the entrenched biomedical and behavioural models in Public Health (Kennedy et al, 2010; Kirk et al, 2014; Mathers et al, 2014). Programme models have also shown they can incorporate a wider approach.

Programmes are one policy response to the problem, this research showing there are multiple models within this choice. But they are an optional choice, which have seen reduced support over the years. What if they were mandated? Programmes have been limited in contributing to health outcomes through being localised, lacking overarching leadership and policy action, showing they are highly dependent on local ideological and organisational commitment (Raphael et al, 2014). This coincides with responsibility of diet and health being downloaded to communities and individuals, which should not be the case. Programmes would benefit from top-down support, based on good practice, in order to ensure consistency, greater reach and access; essentially a scaling-up, while still allowing for localisation.

Community involvement means opportunity for LCFAs to be recognised as change agents at different levels. Programmes have the potential to contribute to improved overall health in the community and reach under-served and disadvantaged populations; changes in diet can make big changes to public health. Their greatest impact comes from coordinated effort that includes focusing on environmental and structural determinants, and cannot be without macro level responses to the problem. Importantly, programmes are paired with systemic work, allowing for one arm of delivery of policy and further policy work at Public Health and community level.

Recommendations for Policy and Practice

These summaries will be provided to the programmes taking part in this research process.

They are organised by downstream, midstream and upstream recommendations in Table 8.1.

Table 8.1 Recommendations for Policy and Practice

Downstream	1. LCFA programmes should be recognised by policies as an important strategy to promote food literacy and healthy eating in the population 2. Find ways to build in effective evaluation and cross-sharing of programme models to demonstrate what works, to increase evidence-base and contribute to the knowledge of best practice, and thus increase likelihood of gaining sustained support through increased capacity and core funding 3. Consider a national or provincial framework in line with national priorities and/or provincial public health standards for the role and function of LCFAs so that there is consistency, clarity and recognition of the role and how it connects with addressing food and health policy priorities 4. Consider mandated rather than voluntary support for programmes more broadly
Midstream	5. Ensure that barriers to access and participation of programmes are being addressed at organisational level and provide support (or connections to support) for intermediary or material barriers to health (some examples of good practice have been shown) 6. Consideration should be given to how a programme model of LCFAs as volunteers or paid reflects recruitment, retention, community engagement and SDH aspects, the impacts on public health and for whom 7. Programmes may benefit from a more comprehensive focus on food literacy rather than food skills and education and include a broader food systems approach (some of which has begun to happen); context and framework of focus needs to be not only on behaviour but on the conditions shaping behaviour; as well as food systems and the environment
Upstream	8. Provide opportunity for LCFAs to represent and facilitate community voices and change; consider LCFAs as part of a wider coalition of actors working to improve public health 9. Programmes should maintain a wider role in advocacy and join-up efforts that include support for policies addressing intermediary and structural determinants of health 10. Attention to programmes should not divert from attention to other upstream work; Public Health should harness its power to especially benefit those experiencing the greatest inequalities and inequities in health and ensure a politicised approach to the problem

It is important to align programme goals with global, national, provincial and local priorities; this alignment with higher policy means potential for support and overarching leadership at provincial and national level to meet policy priorities (such as that of CPNPs across Canada); and needs to coincide with greater attention to and investment in public health and health promotion activity; with consideration for the voluntary aspect of programmes in Public Health units and implications. Programmes could go some way in reaching groups disproportionately at risk for poor health and lead to reducing the gap in inequalities but require greater consideration to who accesses programmes and how, and whether this contributes to widening inequalities. A combination of strategies, universal and targeted, are needed for health promotion and health equity to reach those most hard to reach; 'peer' level representation being important. With this in mind, LCFAs can serve as a bridge, bring together social and cultural 'norms', join-up civil society and Public Health. Action is needed across a wide range of stakeholders and sectors, creating more bridges and connections for health improvement; opportunity can be provided for LCFAs to play a role.

Public Health can be a power struggle politically and in the community (tensions with health care and health promotion priorities, collaborating with community partners), but there is still a power advantage for collaboratively facilitating and driving policy action and change. Programmes can be effective and go some way at contributing to addressing public health, but need to be utilised as part of a broader, coordinated strategy that addresses intermediary and structural factors that can lead to long-term health outcomes. Though programmes have been able to sustain policy and community changes over the years, the findings as viewed through a policy analysis lens have revealed there are both opportunities and challenges to their benefits and sustainability.

For certain, the current pathway of increasing diet-related illness and inequalities means doing nothing is not an option, and something may not be enough. The problem persists, suggesting that programmes come nowhere near addressing the complexities of the problem on their own and can therefore only be one strategy; the scale of the problem is so big that there is not enough coverage of programmes and investment in and of themselves; and questions whether food literacy alone (especially skills and education) is enough to meet a food policy agenda. The problem cannot merely be framed as individual or community. Systemic responses must be more assertive, including the food system's contribution to the problem and shifting the paradigm of thinking from focus on personal responsibility.

8.3 Reflections on the PhD Process

What first began as thinking within an individual frame and viewing programmes as teaching people to eat healthy evolved into a greater appreciation of the effects of social, environmental and economic barriers to health and how health is framed. Perspective has moved from placing importance on the basic concepts of food literacy to being wider, and a broader understanding for the 'community' aspect of programmes in contributing to health outcomes.

The framework of the thesis involved big concepts to explore and, particularly with an inductive format, both these aspects were purposeful (to see where things would go) but made it challenging nevertheless. There are a number of ways in which the research design could have been different and could have included different data for example, that of interviews or focus groups with programme beneficiaries themselves. The research could have included more cases, such as some less developed LCFA models to explore the challenges and to provide a different comparison. More interviews could have been done, and questions could have gone deeper into the food policy domain. But more isn't necessarily better. The inclusion of elite policy interviews if had been undertaken could have added more depth to contextualising the policy environment and it was disappointing there were no relevant interviewees for this part. Though a different researcher may have tackled the process differently, with a completely different focus, this was grounded not only in researcher experience and perspective, but the results generated from the findings. High value was placed on the views and results of interviews to gain those different perspectives. Because the research process has paralleled work experience in a number of environments, this has shaped interpretation of findings and analysis. Experience of LCFA programmes and a wider experience of health promotion has been both advantageous and challenging at times, in particular, having an intrinsic understanding of the messiness of community programmes. Personal involvement in the field helped to increase validity of the research. While recognising researcher bias and both subjectivity and objectivity playing a role, through being open to learning throughout the process, and observing new concepts and angles, this has led to further insights and understandings, and ultimately a richer experience.

For consideration, the field work took place at one point of time - a snapshot between 2014 and 2015 - in an ever changing policy domain. Applying complementary frameworks of the Health Policy (Walt and Gilson, 1994) and Multiple Streams (Kingdon, 1995) illuminated policy alignment and tensions through findings, but these dynamics are likely to continue. Though some time has passed and some details may have changed, this research remains relevant.

8.4 Future Research

Further research is needed in looking into LCFA programme models addressing public health from a SDH perspective, delving deeper into programme roles in food security, the advocacy potential of LCFAs and empowerment of beneficiaries. As well, to specifically look at the targeted and universal nature and impacts on programme design, delivery and outcomes as related to individuals and communities across the socio-economic scale, particularly for those on the lower end of the spectrum. This research could be applied to exploring other LCFA programme models, in different provinces across Canada to provide more context to the situation nationally or specifically to other regions, such as in Northern parts of Canada where food access is a much bigger problem.

Specifically related to policies in Canada, it would be a timely opportunity to explore programmes in the coming years, in their connection with Canada's emerging National Food Policy, as this research was taking place only at the consultation phase of the policy, and the new Healthy Eating Strategy. As well, Ontario's Food and Nutrition Strategy was in its infancy. Canada's Food Guide will soon be changed and the public health standards have recently been revised; the impact of these changes could be reviewed.

Around food literacy, of interest would be more in depth exploration about the wider role of different types of programmes considering food literacy as a broader concept that is limited but emerging in the current literature (Slater, 2013; Cullen et al, 2015; Sumner, 2015; Vidgen, 2016).

Broadly, the literature on lay helping in public health in Canada has been limited and this research could be applied to looking at other initiatives in health, of relevance due to the need for cost-effectiveness, increasing capacity and responding to a diverse population in the current economic climate (Najafizada et al, 2015). Efforts to move beyond short-term outcomes and exploring those long-term outcomes would be worthy of study.

There is potential to explore LCFA roles in different forms of advocacy, specifically around their facilitational role as this is a gap remaining in the health field (Smith and Stewart, 2017). International comparisons of programme models would be of value, particularly when looking at similar systems of health, such as those that provide universal health care and have similar problems of health inequalities, poverty and food insecurity and are experiencing challenges with solutions to these problems.

APPENDICES

Appendix A - Descriptors related to LHAs/LCFAs

PEER = broad overarching term	Peer is often the terminology used in the field (ie. many positions may be labelled as peer positions) vs. lay Often used for mental health and addiction roles (but also issues with stigma as peer can translate to self-disclosure ie. of previous drug problems, living in poverty) Having something in common with the community: life stage (youth to youth, mother to mother, senior to senior) or by shared identity or lived experience ie. race, culture, ethnicity, newcomer status, age, gender, sexual identity, disability, homelessness, substance use, mental illness But shared identity may not be enough to make a peer Considered to be less of a power differential between those with whom they are working; 'Peer' in the literature is often assuming more of a direct association: ie. student to student, mature adult to mature adult, mother to mother Peers most likely in informal roles and can be in paid or unpaid positions
LAY HELPER = broad overarching term	Not requiring any formal qualification to enter into the role 'Lay' is often the terminology used outside of the field, in research for example, to distinguish from a professional (being non-professional) but does not necessarily mean individuals in lay roles have lived experience or closely match those with whom they are working (ie. are not necessarily a peer) Roles can be paid or unpaid This is not necessarily interchangeable with 'natural helper' but does overlap
NATURAL HELPER	Most likely a local or insider This is seen as a role more closely aligning with the community, having no or limited training, and informal in practice but understanding instinctively the issues with the community and how to work with them Roles most likely to be unpaid
PARAPROFESSIONAL	Most likely an outsider or incomer More hierarchal than natural helper and considered more professionalised than the natural helper, implies a level of training specific to the job and/or tertiary level training but is lower on the professional ladder This position would be a paid position
PROFESSIONAL	Certain credentials and qualifications often associated with tertiary-level education (and not connected with lived experience) Assumes expert level knowledge and/or skills acquired through formal channels of education, training and/or certification A different power balance between the professional and the individuals with whom they work Formal in practice

Appendix B - Field Work and Participant Information

Letter of Introduction (to Programmes)

Dear (insert manager /supervisor name),

I am a doctoral student conducting research on Lay Community Food Advisor Programs. Ethical approval has been received from City University, London to conduct this research.

The purpose of the research is to study different Lay Community Food Advisor (LCFA) models in Ontario and explore their role in public health at different levels; to contribute to and inform evidence-based policy as applied to public health. Key overarching themes of the research are food literacy, social determinants of health and community engagement.

A scoping exercise has identified many models in operation or under development. However, the focus will be on three established, well developed and different programs using a case study approach. I would like to use the (insert program) program as one of the case studies.

The following are proposed research activities dependent on access to the program:

(1) Key informant interviews: for the purpose of understanding the bigger picture, policy connections and perspectives with decision-makers/ program managers/ supervisors/ LCFAs. Interviews will be recorded only at consent of each interviewee.

(2) Observations: for the purpose of observing interactions and to gain insight into the operational context and function of programs. Observations will not be recorded nor will notes be taken and will only proceed if all participants of the group agree.

Overt participant observation is planned to include the following:

- LCFA meetings (strategic and operational planning, interactions between managers and LCFAs)

- Program delivery in the community to a group of participants (interactions between facilitators and participants through workshops, cooking sessions, food demonstrations etc).

(3) Document review (ie. available reports, evaluations, policy papers, websites, program newsletters)

In terms of time commitment, I would aim to keep interviews to one to two hours and the same for observation. I have attached a general participant information sheet which provides more detail.

The research is intended to be non-invasive and I will strive to be as flexible as possible. All participation is voluntary and autonomous, and information shared will be kept confidential. Participation in this research by staff or community members will have no negative impact on their relationship with Public Health.

Please let me know if this would be of interest and I can provide further details. Your cooperation and participation would be greatly appreciated.

Field Work - Observation Checklist

	OBSERVATION	COMMENTS
1.	Activity ie. community kitchen	
2.	Aim/ objectives of activity	
3.	Geographic base	
4.	Type of group - single workshop, series of sessions, drop-in	
5.	Focus - food skills, nutrition knowledge, food security, food safety?	
6.	Approach of LCFA	
7.	What are participants doing? How are they doing?	
8.	How does learning take place? How are messages transferred? ie. sharing of knowledge and experience	
9.	Interactions between LCFA and participants, amongst participants	
10.	General sharing of other information, participant comments	

KEY INFORMANT INTERVIEWS**MANAGER/ SUPERVISOR**

1. What is the rationale/ theoretical basis for the program? How has program evolved?
2. What is the overall problem the program aims to address? What are the contributors to the problem (actors, policies, behaviours etc)? Has this changed over the years?
3. What policy supports the program - nationally, provincially, regionally, locally? What policy might work against it?
4. What is the focus and approach?
5. Who are the key players/ actors? What do they do?
6. What is the role and function of LCFAs? What training and support do they receive?
7. Target population? Who are you reaching? How are they being reached? Who is not being reached?
8. What are effective approaches/ the key components of the program? How/ why do programs keep going?
9. What is the underlying theory of change/ logic model?
10. What can/does program achieve at individual, community, organisational and policy level?
11. How does program address public health? How does it work within the framework of: food literacy, determinants of health and community engagement?
12. Challenges/ tensions (community/ organisational)? Opportunities?
13. What is the wider impact of programs? How does this relate to policy?
14. How does program differ from other programs? What other programs/ initiatives complement it?
15. Program and policy gaps – what can they do, what can't they do? Is anything missing from programs/from policy? Emerging needs?

KEY INFORMANT INTERVIEWS**Lay Community Food Advisors**

1. What training and support do you receive as an LCFA? Scope of your role?
2. What are the focus of the program? What are the issues program aims to address?
3. What are effective approaches/ the key components of the program?
4. Who is the target population? Who are you reaching? Who are you not?
5. What are the outcome objectives for the delivery of the program and are they being met (indicators)?
6. What are the intended and unintended outcomes and impacts (both positive and negative) at individual and community level? How do programs take into account the factors which work against positive outcomes (barriers)?
7. How do programs address public health?
8. What other programs/ initiatives complement this program ie. part of multi-faceted strategy/ partnerships?
9. What are the limitations of the program? Are there any gaps ie. is program addressing the problem or other solutions needed?
10. Issues, tensions, challenges (ie. community/ organisational)? Opportunities?



Title of Study: Lay Community Food Advisor Programs. How they contribute to public health policy priorities: A Canadian Perspective.

Interview Consent		Please initial box
1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • be interviewed by the researcher • allow the interview to be recorded • make myself available to answer further questions should that be required for clarity	
2.	This information will be held and processed for the following purpose(s): I understand that any information provided is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published: the results of the research are intended for this current thesis only, with a possibility of publication and I will have complete anonymity in every case. The identifiable data will not be shared with any other organisation. Data will only be accessible to the researcher and primary supervisor.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way, and that I am free to share comments without reprisal from Toronto Public Health.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Participant

Signature

Date



Title of Study: Lay Community Food Advisor Programs. How they contribute to public health policy priorities: A Canadian Perspective.

Observation Consent

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being observed as part of a group by the researcher • the researcher may talk to me as a participant • I can choose how much to contribute to the research during the observation	
2.	This information will be held and processed for the following purpose(s): I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. No identifiable personal data will be published: the results of the research are intended for this current thesis only, with a possibility of publication and I will have complete anonymity in every case. The identifiable data will not be shared with any other organisation. Data will only be accessible to the researcher and primary supervisor.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Participant

Signature

Date



Title of study Lay Community Food Advisor programs: How they contribute to public health policy priorities: A Canadian Perspective

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

Lay Community Food Advisor (LCFA) programs may be effective in increasing coverage of health promotion, empowering individuals and communities, help to reduce social exclusion and address the gap in nutritional inequalities. Having members within communities as 'peer educators' or 'natural helpers' may ensure good understanding of local health issues and better delivery of relevant nutritional messages. Evidence suggests LCFAs may increase awareness of healthy eating and help people translate advice into practice thereby positively influencing patterns of behaviour.

This research aims to explore the opportunities and limitations that exist with LCFA programs and how they relate to policy priorities. The use of qualitative approaches include key informant interviews to gain varying perspectives and direct observation for insight into programs. The focus will be three case studies on different models in Ontario. The purpose is to study different Lay Community Food Advisor models in Ontario and explore their role in public health at different levels; to contribute to and inform evidence-based policy as applied to public health.

Why have I been invited?

An initial scoping exercise has identified three main programs operating in Ontario. These programs have been chosen to study as they have been established for some time. You are invited to participate due to your level of involvement with the program.

Do I have to take part?

Your participation in this project is voluntary and you can choose not to participate in part or all of the project. If you choose to participate you may withdraw at any time or refuse to answer any question (if being interviewed).

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

One to two hours of your time will be required. This will be in the form of semi-structured interviews and/or program observation. The research will be taking place within the program environment. It is anticipated that this will only be required one time, but there may be a request to answer further questions at a later date (for interviews only).

What do I have to do?

For interviews, some questions in relation to the program will be asked and you can choose whether to answer them. You can decide how much you want to be involved. For program observation, you do not have to do anything different.

What are the possible disadvantages and risks of taking part?

There are no known risks associated with your participation in this research.

What are the possible benefits of taking part?

Although there may be no direct or immediate benefits to you for participating in this project, you are making a contribution to knowledge and awareness in this field to which the wider community can benefit from in the future through program and policy development.

What will happen when the research study stops?

If the project is stopped at any time, all data will be destroyed and deleted from files.

Will my taking part in the study be kept confidential?

All information will be confidential. Your name will not be attached to your interview notes (for interviews), nor will any personal information that identifies you be written in any reports that come out of this research. Only myself the researcher and my primary supervisor will have access to any information. No identifying information such as names, places, or dates will be mentioned in any reporting. Records will be stored in a locked filing cabinet. When research is complete, all records will be destroyed using a shredder. Any audio records will be deleted (observations will not be recorded). The information you provide will not be used for any future project.

What will happen to results of the research study?

The results of the research are intended for this current thesis only, with a possibility of publication. You will have complete anonymity in every case.

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time and this will have no bearing on your involvement with the program.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to the researcher. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone (011) 20 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is:

LAY COMMUNITY FOOD ADVISOR PROGRAMS: HOW THEY CONTRIBUTE TO PUBLIC HEALTH PRIORITIES: A CANADIAN PERSPECTIVE

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [REDACTED]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London Research Ethics Committee

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