Aboriginal Food Skills Programming

Background and Key Informant Interviews Summary

November 2016

NUTRITION RESOURCE CENTRE

CENTRE DE RESSOURCES EN NUTRITION
Aboriginal Food Skills Programming: Background and Key Informant Interviews Summary

This report is produced as part of a series on the topic of food literacy in order to gain a better understanding of what works in community programs in Ontario.

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Background

Aboriginal peoples (Métis, Status and Non-Status Indians) live in urban, rural and remote areas throughout Ontario (see map of First Nations Communities). The term 'Aboriginal identity' refers to whether a person reports being First Nations (North American Indian), Métis or Inuk (Inuit) and/or being a Registered or Treaty Indian, and/or being a member of a First Nation or Indian band. Of those Canadians with an Aboriginal identity, 21.5% live in Ontario, while only 2.4% of Ontario’s total population is Aboriginal. This report deals with First Nations and Métis populations.

Cancer Care Ontario released their Path to Prevention report in 2016 outlining recommendations for reducing chronic disease in First Nations, Inuit and Métis (FNIM). They address the urgent need for action to prevent chronic disease, driven by rising rates of cancer, diabetes, heart disease and respiratory diseases among FNIM populations. Obesity, which predisposes individuals to chronic disease, is markedly increased in FNIM people compared to the general population. The report recognizes that “factors such as colonialism, racism, social exclusion, and self-determination have a profound effect on FNIM health and is responsible for the socio-economic and health inequities that exist between First Nations, Inuit and Métis peoples and the general Ontario population.”

The Path to Prevention report provides 4 specific healthy eating recommendations:

• Develop an Indigenous food and nutrition strategy
• Reduce barriers that prevent access to healthy foods for First Nations, Inuit and Métis
• Address environmental issues for Indigenous foods
• Develop traditional food and nutrition skills

The Path to Prevention report found that “participants in focus groups in First Nations, Inuit and Métis communities were aware of the link between being healthy and well, and access to healthy foods, knowledge and skills in making healthy choices and access to healthy food systems.” Food and culture are intrinsically linked; therefore, programming that aims to foster connection between food and tradition have benefits beyond providing good nutrition. These programs also contribute positively to self-esteem, Indigenous identity, connections with family, and social bonds. By engaging in the growing, harvesting, sharing and consumption of traditional foods, it enables Indigenous peoples to keep communities healthy, as well as maintain traditional cultural practices. Most of the communities surveyed in the report had either a community garden or family gardens where the respondents said they could gain control over their food supply and access food that is nutritious and safe, while also teaching traditional harvesting skills that may have been lost.
Background (cont’d)

A 2011 University of Ottawa First Nations Food, Nutrition and Environment study of 18 First Nations communities in Ontario provides details on health, food insecurity and food access issues facing this population. Here are some of the key findings:

• 34% of adults are overweight (29% of women and 42% of men) and 49% are obese (53% women and 43% men) based on measured and/or self-reported height and weight data. Further, 30% of adults stated that they had diabetes, and nearly half were smokers (49%).

• Food insecurity affects 29% of households; 21% of households experienced moderate food insecurity and 8% experienced severe food insecurity. Food insecurity at the household level was higher in northern communities (59%) compared to southern communities (18%).

• High food costs contribute to the increasing rates of food insecurity and hamper one’s ability to access a nutritious meal. A family of four spends between $175 per week on groceries in southern First Nations communities and $344 per week in northern First Nations Communities.

• First Nations adults in Ontario do not meet recommendations from Canada’s Food Guide. This group consumes more servings than recommended from the meat and alternatives food group, and less than recommended from the other three groups (milk and alternatives, vegetables and fruits, and grain products). Women, in particular, eat fewer servings of foods from these groups.

• Individuals are at risk for insufficient intake of many key nutrients that are required for health and disease prevention, particularly fibre, vitamin A, vitamin D, vitamin C, magnesium, calcium, and folate. Traditional foods are high in important nutrients, such as protein, iron, vitamin D, zinc and others. On days where traditional food was consumed, dietary quality was drastically improved. Conversely, on days when market food made up the diet, intakes of saturated fat, sugar and sodium were significantly higher than when traditional food makes up the majority of the diet.

• Almost all First Nations adults (93%) consume traditional foods to some extent. During the year, over 100 different traditional foods are harvested, with specific types and varieties varying across communities. The majority of adults reported consuming fish (73%), game (68%) and wild berries or nuts (60%). Wild birds were popular among one third of the population (39%), and wild plants were enjoyed by 32% of adults. One in five (21%) used foods from trees, such as cedar tea and maple syrup. The traditional foods eaten most frequently were walleye, moose and blueberries.
Background (cont’d)

• Ontario First Nations adults consume an average of 43 grams of traditional food daily, although heavy consumers eat up to 205 grams per day. Traditional foods are consumed in larger quantities in northern communities. Nearly three quarters of adults report that they would like to consume more traditional foods in their diets; however, barriers to increased consumption include lack of a hunter in the family, lack of equipment or transportation and lack of time for harvesting.

• In the Boreal Shield/Subarctic area, nearly 30% of First Nations women of childbearing age exceed the Health Canada hair mercury guideline. Communication of the risk is required to advise women of childbearing age in this region to consume aquatic animals that are a lower position on the food chain and therefore are likely to contain lower levels of heavy metals. This would involve consuming, for example, whitefish more often, and eating fewer predatory fish, such as walleye, in order to lower their mercury intake.

The Nutritional Habits of Métis Children and Youth study carried out as part of the 2006 Aboriginal Peoples Survey (APS) by the Métis Centre of National Aboriginal Health Organization examined children between the ages of six and fourteen. This survey targets Aboriginal people living off-reserve, including those who identify as Métis. Métis account for 33% of the total Aboriginal population in Canada. Almost half (43%) are under the age of 25, while one quarter (25%) are aged 14 and under. Below are some highlights from this study:

• Nearly half (52%) of Métis children and youth had consumed vegetables other than potatoes and salad daily in the week prior to the survey; 10% reported that they consumed green salad daily.

• Almost two thirds of Métis children and youth (61%) consumed fruit (excluding juice) every day in the week preceding the survey. A further 51% drank 100% fruit juice daily.

• More than three quarters of Métis children and youth (79%) reported daily milk consumption, with 59% consuming other dairy products on a daily basis.

• 30% of Métis children and youth consumed store-bought meat (including beef, poultry, pork or lamb) daily. 20% consumed it 5-6 days per week, and 30% consumed meat on three or four days out of the week.

• 18% of Métis children and youth had consumed wild meat (moose or caribou) one or two days during the week.

• 18% of Métis children and youth ate processed meat three or four days per week, with 8% consuming it daily. A further 19% consumed potato chips or French fries three or four days per week, 5% consuming them daily. Almost one quarter of Métis children and youth (24%) consumed foods that contained refined sugars 3-4 days per week, and 19% consumed refined sugar every day.
What is Food Literacy?

Food skills is part of a larger construct of food literacy. Desjardins & Azevedo provided the following food literacy definition that is generally accepted and used by public health professionals in Ontario:

• “Food literacy is a set of skills and attributes that help people sustain the daily preparation of healthy, tasty, affordable meals for themselves and their families”5

• “Food literacy builds resilience, because it includes food skills (techniques, knowledge and planning ability), the confidence to improvise and problem-solve and the ability to access and share information”5

• Food literacy requires external support with healthy food access and living conditions, broad learning opportunities and positive socio-cultural environments”5

Healthy Eating and Food Literacy

According to Canadian community health surveys carried out by Statistics Canada, less than half of Ontarians (39%) consume at least 5 servings of fruits and vegetables per day.6 Adults in Ontario have the lowest prevalence of vegetable and fruit consumption (37%) compared to youth (43%) and older adults (44%). Females report significantly higher consumption of fruits and vegetables (45%) compared to their male counterparts (32%). There was no difference in Aboriginal vs. non-Aboriginal populations in terms of vegetable and fruit consumption (does not include people living on First Nations reserves). However, there was a significantly lower consumption of vegetables and fruit in the lowest income quintile compared to highest income quintile.

Overall, 46% of Canadians reported their eating habits as very good or excellent; a significantly higher proportion of older adults report having very good or excellent eating habits compared to other age groups (see Table 1).6

A high percentage of Canadian households involved the participation of children in shopping for groceries and preparing meals or cooking. In Aboriginal populations living off-reserve there was a significantly higher prevalence of children who prepare meals or help cook food (Table 2).7
### Table 1. Healthy Eating Indicators: Self-Perceived Diet Quality and Fruit & Vegetable Consumption

<table>
<thead>
<tr>
<th></th>
<th>Percentage of population in Canada rating their eating habit as very good or excellent</th>
<th>Percentage of Population in Ontario consuming fruits and vegetables 5 times or more per day</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Estimate (95% Confidence Interval)</td>
<td>Estimate (95% Confidence Interval)</td>
</tr>
<tr>
<td></td>
<td>(CCHS 2013)</td>
<td>(CCHS 2014)</td>
</tr>
<tr>
<td>Total Population</td>
<td>45.9% (44.2%-47.6%)</td>
<td>38.5% (37.2%-39.8%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
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</tr>
<tr>
<td>12-17 years old</td>
<td>45.4% (40.8%- 50.0%)</td>
<td>43.4% (39.3%-47.5%)</td>
</tr>
<tr>
<td>18-65 years old</td>
<td>43.8% (41.82%-45.75%)</td>
<td>36.8% (35.3%-38.4%)</td>
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<tr>
<td>&gt;65 years old</td>
<td>56.9%* (54.4%-59.7%)</td>
<td>44.4% (42.1%-46.8%)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
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<tr>
<td>Males</td>
<td>43.2% (41.1%-45.3%)</td>
<td>31.6% (29.8%-33.4%)</td>
</tr>
<tr>
<td>Females</td>
<td>48.5% (46.3%-50.7%)</td>
<td>45.0%* (43.2%-46.8%)</td>
</tr>
<tr>
<td>Aboriginal Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>37.5% (29.6%-45.3%)</td>
<td>37.0% (30.8%-43.2%)</td>
</tr>
<tr>
<td>Non-Aboriginal</td>
<td>46.2% (44.4%-47.9%)</td>
<td>38.6% (37.3%-40.0%)</td>
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</table>
Table 2. Participation of Children in Household Food Preparation in Canada

<table>
<thead>
<tr>
<th>Population Characteristics</th>
<th>Percentage of households in Canada where children participate in shopping for groceries Estimate (95% Confidence Interval) (CCHS 2012)</th>
<th>Percentage of households in Canada where children help to prepare meals or help to cook food Estimate (95% Confidence Interval) (CCHS 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Population</strong></td>
<td>67.8% (63.1%- 71.5%)</td>
<td>59.6% (55.2%- 63.6%)</td>
</tr>
<tr>
<td><strong>Aboriginal Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>74.0% (61.0%-87.1%)</td>
<td>76.0%* (64.5%-87.6%)</td>
</tr>
<tr>
<td>Non-Aboriginal</td>
<td>67.0% (62.7%-71.4%)</td>
<td>58.7% (54.4%-63.0%)</td>
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</table>
What Works with Food Literacy Programs?

The 2013 report, a collaborative project by Public Health Ontario, *Making Something out of Nothing*, looked at food literacy among youth, young pregnant women and young parents in Ontario who are at risk for poor health. Key learnings were:

- Community cooking programs were considered very helpful, especially for people who were more motivated to learn food skills when they were living independently or entering parenthood.
- Culinary programs leading to job opportunities were welcomed by those who had access to them.
- The internet was not a useful substitute for interpersonal teaching of food preparation skills.
- Recipes were not a helpful learning method for novices in the kitchen.

For Aboriginal people in Canada, Mundel and Chapman reported that their community kitchen program increased participants’ empowerment and capacities. Benefits included sharing of skills, improving cooking and food growing skills, learning cooking skills for healthy meals in a limited budget, building up a social network, and accessing resources.

The Canadian Diabetes Association and the British Columbia Healthy Living Alliance targets low-income, Aboriginal, Punjabi and new immigrant families in British Columbia communities with cooking programs. Participants cook and share meals together and learn about nutrition, safe food handling, meal planning, and healthy snacks. The program also builds social support networks within groups. Evaluation results indicate that participants practice what they have learned, modifying their cooking and eating patterns after completing of the program. The participants also claimed to have greater confidence reading nutrition labels and trying new recipes.
Key Informant Interviews

Purpose

The purpose of this research project was:

• To learn more about food skills programming happening at the community level across Ontario with a focus on Aboriginal populations
• To capture promising practices for food skills delivery, as described by community facilitators, for their communities and target populations
• To inform promising practices and guidelines for implementing community food skills programs

Methods

Aboriginal food skill programming key informants were identified through contacts at the Nutrition Resource Centre (NRC). Between June 13-24, 2016, 25 emails were sent inviting participants to partake in a half hour interview with a Masters Practicum student (see Appendix A for email invitation). Eight interviews (see Appendix B for interview guide) were carried out with key informants in various roles across Ontario including:

• Aboriginal Family Support Worker – Thunder Bay
• Teacher and Life Skill Instructor – Anishinabek – Thunder Bay
• Public Health Dietitian – Thunder Bay
• Canadian Prenatal Nutrition Program Dietitian – Six Nations – Brantford
• Community Nutritionist – Nipissing First Nation – North Bay
• Community Nutritionist - First Nations and Inuit Health Branch – Ottawa
• Project Coordinator, Personal Support Worker & Food Service Worker Training Programs - Anishinabek – Thunder Bay
• Community Action Program for Children (CAPC CPNP) Worker – Madadjwiwin Community Office – Mattawa

Please note that this is not an exhaustive list, but rather examples of some of the food skills programs offered throughout Ontario targeted to Aboriginal people.
Types of Programs

Key informants were asked to describe the type of programming offered in their community to address food skill development and, secondary to Aboriginal populations, which target population they reached. The various program targets were:

• At-risk mothers
• Adults
• Young parents
• Children
• Mature students

The type of food skill programming identified included:

• Cooking classes
• Community kitchens
• Grocery store tours
• Nutrition and healthy eating education
• Food safety
• Gardening and harvesting
• Food service worker training

In addition to traditional food skill programming, two key informants described their programming that included a food skills component but it was not the primary purpose of the program. For example, the Construction Craft Worker Training Apprenticeship included a life skills component with a three day cooking class series and a Food Service Worker Program that incorporated cooking, basic nutrition and food safety.
Program Logistics

The length of the programs range from 3-4 sessions, 6-9 weeks and a few are offered once a month for a full year. The sessions range from 2-4 hours and, in the case of the apprentice training, full day sessions. Programs are offered at friendship centres, band offices, high schools and colleges, wellness centres and regional food distribution associations. Programs are instructed by dietitians, chefs, support workers, life skill instructors, and trained facilitators. When a dietitian was not identified as the primary instructor, several key informants noted dietitians were involved, in part, with training the facilitator and/or with developing the program content.

Program Content

When asked how their programs were developed, the majority of key informants answered “in house.” Other resources that informed the content of their programs included the internet (recipes), resources from public health units, Health Canada and adaptations from other programs including:

- Colour it Up! (Cancer Care Ontario)
- The Healthy Eating Manual (Nutrition Resource Centre)
- Community Food Advisor Program (Ontario Public Health Association)

The topics covered throughout the different programs widely ranged and were dependent on the length of the program and the target audience (children versus adults). The topics included:

- Basic food skills – chopping (knife skills), preparation techniques, when to add ingredients
- Budgeting
- Canning and preserving, food dehydration, smoking
- Chronic disease e.g. cardiovascular disease, overweight, nutritional management of diabetes
- Food security
- Food sovereignty
- Gestational diabetes, diabetes 101
- Health benefits of cooking for oneself
- Healthy selection of foods (label reading and food group recommendations)
- Menu planning
- Portion sizes
- Prenatal nutrition

Key informants were asked to describe the types of resources they developed as well as any external resources required to run their programs. Thunder Bay Cooking out of the Box program has 12 months of seasonal recipes and lesson plans available on their website.
### Internal Resources Developed
- Cooking equipment videos
- Flyer promotions
- Healthy Roots Food List
- Newsletter
- Portion size plates
- Presentation kits (e.g. label reading)
- Recipes to hand out
- Resource book for trainees
- Social media posts (Facebook)
- Training Manuals

### External Resources Required
- Aprons
- Budget to run the programs*
- Cookbook
- Cooking equipment
- Food
- Food containers
- Kitchen facilities

*identified by majority of key informants

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### Evaluation

When asked whether they evaluate their program, the majority (7 out of 8) of key informants answered yes. Most evaluations focus on participant feedback to improve the program versus the impact of the program on food skill development. However, two key informants indicated that they have outsourced full evaluations and one key informant indicated quarterly reporting is part of their funding agreement.

### Barriers and Facilitators

Key informants were asked if they developed any partnerships to develop or run their program. One participant described a partnership with a daycare centre in order to offer a class where participants learned how to make baby food. The daycare centre helped with recruitment as well as child minding while caregivers attended the class. Another described a partnership with the local Kiwanis club who provided funding so that participants of the cooking class could receive a Good Food Box. One participant noted that they did not form any partnerships but were facing financial issues: “if we had partners, we might be able to proceed.”

Examples of other partnerships included:

- Health units
- Friendship centres
- Host agencies e.g. Regional Food Distribution Centre
- Colleges
- Hospitals
- Schools
Barriers and Facilitators (cont’d)

The main barriers cited by key informants to running their programs included budget, in particular, the cost of food, in remote regions especially, transporting food to the site, staff changes that disrupt the planning and coordinating, size of kitchen (not enough stations) and lack of political support especially if there are competing priorities for funding (mental health was cited as a major priority in Ontario). One participant described a time when they tried offering the program virtually through a webinar, however it was not successful as the program was designed to be face-to-face. Another described participation as a barrier: “Our cooking programs are usually full, but other topics like label reading for example are not as popular.”

Key informants were also asked if their target audience expressed any barriers to participating in their programming. The three most common barriers noted were transportation to the site, child minding, and time. However, most programs preempted the first two barriers by offering free transportation (bus vouchers or door-to-door service), on-site child minding or children were intentionally included in the program. Participants’ ability to take food home to their families was noted by one key informant as an important goal of their program. In order to remove the food safety barrier due to long transportation times, participants are given uncooked foods so they can make the meal at home for their families.

The Community Food Educator (CFE) program offered since 2003 through FNIB at Health Canada had funding cut in 2016. The CFE trained front line workers to deliver the following types of programming, which could be accessed by 133 communities: ADI – all ages for diabetes prevention and management; CPNP – providing services to women who could become pregnant, through pregnancy and up till baby is one year of age.
What Works? Recommendations for Aboriginal Food Skill Programming

Key informants were asked to share their recommendations for food skill programming for Aboriginal populations based on their experiences and expertise:

- Involve participants in the recipe selection process so they have a vested interest in what they are making.
- Ensure recipes and ingredients are affordable to replicate at home.
- Incorporate at least one food/ingredient the group has not tried.
- Include Indigenous foods. This is especially important for food skill programming aimed at children. Parents want to use Indigenous foods at home but often do not know how. Children bring these teachings home.
- Make enough food for participants to bring home to their families and provide containers.
- Keep programming as hands on as possible and avoid sessions that are only lecture/education style. If education is important to the program, incorporate it into the meal-time discussion.
- Remove anticipated barriers: provide transportation, child minding, incentives to participate etc.
- Involve Elders in the community to teach part of the program.
- Create space and time for storytelling and sharing.
- Be adaptable, open, and have a calm/mellow demeanor. Strict timed schedules will not work—relax!
- Build trust with the audience. Make sure you know and understand their personal experience to inform the training.
Success Quotes

Key informants were asked to share any success stories:

“I’ve seen individuals take their own health in their hands, for example, lose a significant amount of weight and become a role model in their community.”

“Every kid when they leave asks “when can I come back?””

“Some of our youth workers noticed a need in the community and developed a hot lunch program through the student nutrition program. Every week they serve a meal outside a high school for at-risk teenagers.”

“There was a family in the community whose daughter was struggling with Leukemia, one of the participants decided to take her lasagna over to this family. It’s amazing to see how these families develop bonds together. You can see it unfolding in the program but also spilling over into their lives outside of the program.”

“One participant fell in love with nutrition and went on to become a Registered Dietitian.”

“[The participants] tell me they make things at home. They loved the cauliflower steaks and made them at home!”
Acknowledgements

Camille Borysewicz, Thunder Bay Indian Friendship Centre

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Julie Harmer, Anishinabek Employment and Training Services

Hailey Watson, Anishinabek Employment and Training Services

Kim, McGibbon, Thunder Bay District Health Unit

Lisa Dietrich, Six Nations – Brantford

Sarah Miller, First Nations and Inuit Health Branch

Erika Weidl, Lawrence Commanda Health Centre

Wendy Trylinski, Nishnawbe Aski Nation
References


Appendix A: Invitation to participate in key informant interviews

Hi________________

My name is Natalie Laframboise and I am a master’s student from Western University completing a placement at the Nutrition Resource Centre at the Ontario Public Health Association. During my time here I am working on a Community Food Skills toolkit to include guidelines and promising practices for communities to implement food skills programming.

The intent of the toolkit is to address promising practices in different priority populations. But during my placement I will focus on Aboriginal food skill programming.

Would you be willing to speak to me for about ½ hour at your convenience?

Thank you in advance,
Appendix B: Food Skills Programming Interview Guide

Purpose
To learn more about food skills programming happening at the community level across Ontario. To capture promising practices for food skills delivery, described by community facilitators, for their communities and target populations.
To submit a copy via email: __________________

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<tr>
<th>CONTACT DETAILS</th>
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<tbody>
<tr>
<td>Contact Name</td>
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<tr>
<td>Position</td>
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<tr>
<td>Email &amp; Phone</td>
<td>E:</td>
<td>T:</td>
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<tr>
<td>Health Unit/Community</td>
<td></td>
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<tr>
<td>Program Name</td>
<td></td>
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<tr>
<td>Main Target Population</td>
<td>Choose an item.</td>
<td>Notes:</td>
</tr>
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<tr>
<th>SECTION 1: PROGRAM LOGISTICS</th>
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<tbody>
<tr>
<td>1. What type of program is your food skills program? (e.g. cooking class, cooking demonstration, presentation, shopping tour, community garden, community kitchen)</td>
<td>Also gather how long it’s offered, age group</td>
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<tr>
<td>2. Who instructs the program? (e.g. dietitian, volunteer, trained facilitator)</td>
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<tr>
<td>3. How do you train your program instructors? (e.g. train the trainer, professional, how long and often is the training?)</td>
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<td>4. Where is the program delivered? (e.g. community kitchen, school, church)</td>
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## SECTION 2: PROGRAM CONTENT

1. How was your program content developed?  
   (e.g. by staff, adapted from other programming, references to support the content?)

2. What is the main focus/topic of your program?  
   (e.g. teach shopping skills, menu planning, cooking skills, food prep, nutrition labelling, gardening)

3. What resources did you develop to run your program?  
   (e.g. teacher guides, recipe books, factsheets)

4. What other resources do you need to run your program?  
   (food, equipment, budget for instructors, promotions)

5. Do you evaluate your program?  
   If yes, what are you measuring?  
   Do you have an evaluation tool and can you share it?
## Appendix B: Food Skills Programming Interview Guide (cont’d)

### SECTION 3: BARRIERS & FACILITATORS

| 1. Have you developed any partnerships in your community to deliver your food skills program? (e.g. NGO, grocery store, health unit, food council) |
| 2. Have you experienced any barriers to delivering your food skills program? (e.g. funding, political support, space, kitchens) If yes, were you able to overcome the barrier(s)? |
| 3. Have your participants expressed any barriers to participating in your food skills program? (e.g. time, transportation, child minding) If yes, were you able to find solutions to remove the barrier(s)? |
| 4. Have you discovered aspects of food skill programming that work better for your target audience? (e.g. hands on, simple recipes) |
| 4. Do you have any success stories you would like to share? Do you have any champions in your community? |
| 5. Do you have any resources that you can share for a best practices toolkit on food skills programs? Do you have any pictures that you can share? |