food fun friendship

COMMUNITY KITCHENS

Frankston Community Kitchens Pilot Project Report

January 2008

Frankston Community Health Service

PENINSULA HEALTH

Stronger Families and Communities Strategy

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Glossary of Terms

Term	Meaning
Community Kitchen	A group of people that regularly gathers to prepare healthy and affordable meals while socialising.
Co-ordinator	A person who oversees the running of several Community Kitchens in a region, i.e. who has a role similar to the Project Officer in Frankston.
Facilitator	A person who oversees the running of an individual Community Kitchen
Food security	Consistent access to a nutritious, safe, affordable and acceptable food supply. A condition necessary for healthy eating.
kitchen (with a lower case 'k')	Physical kitchen facilities or venue
Kitchen (with a capital 'K')	Shortened version of "Community Kitchen"
Participant	A group member of a Community Kitchen who is not a facilitator
Pilot / Project / Pilot Project	Shortened version of "Frankston Community Kitchens Pilot Project"
Project partner	An organisation or community group that works together with project workers to enable Community Kitchens to operate
Project workers	The Project Manager and Project Officer of the Frankston Community Kitchens Pilot Project

Executive Summary

This is a report of the Frankston Community Kitchens Pilot Project which commenced in late 2004 with funding from the Australian Government Department of Families, Community Services and Indigenous Affairs. While the Community Kitchen concept originated in Canada, the aim of the Pilot Project was to develop a Frankston Community Kitchen model which would empower individuals and their families to improve their physical and mental wellbeing through promoting healthy eating and social inclusion, and which would build community strength.

A Community Kitchen is a group of people that comes together on a regular basis to cook healthy and affordable meals for themselves and their families. The innovative model developed in Frankston is based on partnerships with local organisations, community groups, community projects and fresh food retailers. Community Kitchens can operate anywhere there is an existing kitchen, for example in churches, schools and neighbourhood houses.

Winner of both the Victorian and National 2005 National Heart Foundation Nutrition Awards and highly commended in the 2005 Public Healthcare Awards, this flexible model is now being adopted across Victoria and Australia. The Project Team has supported local organisations to develop 16 Kitchens within the City of Frankston, ten of which continue to operate. A further 40 Kitchens operate around Victoria with another 60 in development at the time of writing.

Community Kitchens established through the Pilot Project received:

- Support and advice from the Project Officer;
- Training for facilitators in group facilitation skills;
- Training for facilitators and participants in kitchen safety, food handling, budgeting and nutrition;
- Resources to set up Community Kitchens including the Australian Community Kitchens website: a central repository for information and resources relating to Community Kitchens.

A key feature of the Pilot Project has been the development of a sustainable model which has been achieved through developing a sense of ownership by group members and the supporting organisation and through strong partnerships. Sustainability has been demonstrated where organisations or community groups have assisted with the provision of kitchen facilities and equipment, coordination and in some cases, facilitation.

Whilst each Community Kitchen has been developed from a common model or framework, each has operated in its own unique and flexible way to suit the range of needs, issues and preferences that have emerged for the different groups of people.

The Pilot Project's success in meeting its objectives was measured at twelve months and after three years. The evaluation findings demonstrate the effectiveness of Community Kitchens in creating opportunities for people to eat healthier, more affordable meals. Improvements were seen in the specific areas of: cooking skills, motivation to cook, number of meals prepared at home, perceptions of healthy eating, frequency of fast-food consumption, consumption of fruit and vegetables and use of a shopping list. It has also been demonstrated that the method of informal practical learning that occurs through participation in Community Kitchens has great potential to foster improved healthy eating behaviours.

Evaluation results also showed that Community Kitchens provide a setting where people can interact socially and expand their friendship networks. This social aspect was shown to be the feature most valued by participants, with some meeting socially outside of the Kitchens.

Community Kitchens were also shown to facilitate greater involvement in community life for many participants, through joining other community groups or activities or volunteering.

Other key learnings from the Pilot Project include the importance of support for project partners. This was highlighted by reactions to the Project Officer's withdrawal from the Kitchens – a planned sustainability measure. Representatives of partnering organisations reported that they had not adequately prepared for the implications of this and felt less supported to operate their Community Kitchens.

The Pilot Project illustrated that the best use of limited resources is to build capacity in the community. In the middle stages of the project, much of the Project Officer's time was spent facilitating Kitchens and assisting participants with personal issues rather than developing more Kitchens. The solution was to direct efforts towards building the capacity of organisations to facilitate their own Kitchens.

The challenges encountered in implementing Community Kitchens are generally those that are common to other community projects, such as the need for transport and childcare, meeting the needs of participants with complex social and mental health issues and recruiting and retaining suitable volunteers.

The Frankston Community Kitchens Pilot Project, together with other Community Kitchens throughout Victoria, has demonstrated that the model is flexible enough to operate in many different settings and to meet the needs of a broad range of population sub-groups, including those who are most at risk of chronic disease and poor mental health, such as new migrants and refugees, people on low incomes, emergency food relief recipients, people with disabilities and socially isolated people.

Successful expansion of the program will depend on the ongoing provision of funding to maintain support for new and existing Kitchens across Australia, through training, maintenance of the website, revision of resources, leadership and central co-ordination.

As a Pilot Project, Community Kitchens has been dynamic, reflective, flexible and responsive to feedback and evaluation results. Over the three years of funding, the model and objectives have changed as the findings have been taken on board and changes implemented. The concept continues to evolve and grow, but requires continued support to realise its full potential as an effective and successful community-based health promotion project of national significance.

Mark's Story

"I have been a part of a Community Kitchen for just over twelve months now. I came to hear about Community Kitchens through an employment support service for people with disabilities – after asking my case manager if there was the possibility of finding a program that would help me to learn to cook.

"I have been a bit frightened about my mum and dad's health problems and my own. My mum has recently been diagnosed with bi-polar disorder and my father is 91. I have mild spina bifida, which encompasses a great deal of physical and intellectual disabilities. It was also the issue of independence for me, when my mother and father are no longer with me, because I am an only child.

"Community Kitchens has taught me many things [such as] basic cooking skills. I now have a new sense of self confidence in going into the Kitchen – that I can help and I can do these things. It has included some new experiences: the experience of cooking something from start to finish and being able to take it home and eat with Mum and Dad. It's wonderful!

"The participation in the program and the sharing of experiences with other members of the Kitchen has led to new friendships. It has also been confidence-building and a great help. Through these friends and through their experiences and their health problems, [this] has reminded me to have another look at the world. Concentrating on others and not just myself as far as my disability goes.

"The sense of community the Community Kitchens has also given me has enhanced that idea that it's not just me with problems. I'm not the only one with spina bifida who has challenges and problems – there are others too. And that is a powerful image and challenges you to strive, even though things may become hard at times. It also gives me (and I think this is probably the most beneficial area) a sense of hope – that I can do things when I put my mind to them, despite my disability and despite many challenges. And that is a very powerful feeling and I hope that I can try to keep improving in the kitchen and with other skills, and hopefully develop my confidence further to be a help to my mother and father and to survive for myself when they are no longer with me.

"Community Kitchens, I feel, is a wonderful program… For me the Kitchen has given a small solution to the challenge that I have with my mother and father's illness as well as my own. And it certainly is an encouragement in developing my independence. I would recommend the Community Kitchens program to any young person who has some sort of disability or a health problem because there are so many benefits, that it really does highlight the Community Kitchens slogan: 'Come for the food, stay for the friendships.'"

– Mark, Community Kitchens participant, Frankston

1 Background

1.1 The Community Kitchens Concept

Community Kitchens are groups of six to eight people that regularly come together to cook and eat nutritious and affordable meals in a friendly and supportive environment. Community Kitchens aim to build a sense of community around food and to improve the physical and mental health of participants through promoting healthy eating and social inclusion. They support participants in making new friends and learning new skills whilst saving money. Community Kitchens can run anywhere there is an existing kitchen facility of sufficient standard, for example at churches, schools, neighbourhood houses, health services, service clubs and even private businesses.

Community Kitchens are based on community development principles and aim to foster personal empowerment through self-help and mutual support strategies. They are designed to enhance participants' food security through acquiring food knowledge and skills and to break down their social isolation. (1)

The Frankston Pilot Project has been recognised at a state and national level through the following awards:

- Winner of the Local Government National Heart Foundation Awards – Victoria for Best Healthy Eating Project
- Winner of the Local Government National Heart Foundation Awards – National Prize for Best Healthy Eating Project
- Highly Commended – Primary Health Institute Awards for Health Promotion Projects
- Highly Commended – Department of Human Services Victorian Public Health Care Awards for Excellence in Community Relations
- Highly Commended – Jenny Trezise (Project Manager), Minister's Award for Outstanding Individual Achievement

The Community Kitchens project has been listed in the VicHealth Health Promotion Priorities Discussion Paper for 2007-2012 as an example of a health promotion intervention that addresses the determinants of key nutrition issues. The paper acknowledges its benefits in nutrition education, food skills and food sharing (2). This acknowledgement demonstrates the increasing community awareness of the project and its outcomes.

1.1.1 Canadian Community Kitchens Models

Community Kitchens were first established in Canada in 1985, where there are more than 1650 Kitchens operating (3). Tarasuk and Reynolds (4) studied the various models in use in Canada and categorised Community Kitchens as:

- Collective Kitchens: Small groups (of up to four) that cook infrequently (usually once a month) and pool their resources and labour to produce large quantities of food (multiple serves of four to five main meals). The goal is to help participants meet their families' food needs through co-operative food preparation and the economy of scale associated with bulk food purchasing and preparation.

- Cooking Classes: Individual participants demonstrate the preparation of one or two dishes while other participants play minor supportive roles, sample the dishes and take home a small amount of food. The goal is to expose members to new foods and different methods of food preparation.
- Communal Meal Programs: Participants prepare and eat a single meal together, perhaps taking turns planning the menu and coordinating the meal preparation, while others assume supportive roles. The goal is primarily to provide social recreation and support.

1.1.2 The Frankston Community Kitchens Model

Peninsula Health is the major health care provider serving the metropolitan and rural areas on Victoria's Mornington Peninsula. In 2003, a dietitian from Peninsula Health's Frankston Community Health Service was awarded a Victorian Travelling Fellowship by the Department of Human Services and the Victorian Quality Council, enabling her to undertake a study tour to Canada which included researching the Community Kitchens concept. Based on advice from Canadian facilitators and discussions with the reference group that was subsequently established in Frankston, elements were selected from each of the above three models to suit the local community. The resulting Frankston model is outlined and compared with each of the Canadian models below.

The three features that differentiate the Frankston Community Kitchen Model from Collective Kitchens, Cooking Classes, Communal Meal Programs, soup kitchens and other such programs are:

1. Active participation of all group members in the planning, cooking and cleaning processes;
2. Financial contribution by all group members wherever possible; and
3. Food prepared is for consumption by participants and their family members only – food is not sold or given away.

As in Canada, the emphasis of individual Kitchens varies widely and is adaptable to participants' needs. For example, a Kitchen may focus on skill development, social aspects, living with a diet-related disease, how to minimise food costs, or independent living skills. Other key features of the Frankston model are:

- Ownership: Group members determine how their Kitchen runs (e.g. the day, time and frequency of meeting; whether a meal is shared together), decide which recipes are used and establish their own group rules. This decision-making capacity helps to facilitate ownership within the group, which usually comprises 6-8 people.
- Partnerships: Community Kitchens are based on partnerships with local organisations and businesses to assist with the provision of kitchen facilities, referrals, transport of participants, equipment or funding, thus enhancing the likelihood of Kitchen sustainability.
- Leadership: Each Community Kitchen has at least one leader (known as a facilitator) who may be a staff member of a community organisation or a volunteer (3), whose role is to support the running of the group. A Community Kitchens Co-ordinator may support and assist individuals, groups and organisations in their community to develop their own Community Kitchens. In the Frankston Pilot Project, this co-ordination role has been assumed by a full-time Project Officer, while a Project Manager has overseen the administrative tasks, dissemination, reporting and financial management.

- Informal learning: Aside from training workshops provided for all facilitators and interested participants on the topics of healthy eating, budgeting for food, kitchen and food safety and group facilitation, there is no formal education component for participants – learning is informal, relying on peer education (knowledge passed from the facilitator to participants and between participants).

1.1.3 Comparison of Canadian and Frankston Community Kitchens Models

Frankston Community Kitchen groups tend to be larger than Collective Kitchens, a factor that tends to inhibit bulk food preparation. However Frankston Kitchens meet and cook more frequently than Collective Kitchens (usually weekly compared to fortnightly or monthly), thus the total quantity of food prepared is comparable.

Although project workers have tried to dissociate the Frankston model from the cooking class concept, some Frankston Kitchens have chosen to emphasise knowledge and skill development based on the needs of the participants. Furthermore, participants of several other Frankston Kitchens have expressed their desire for regular cooking demonstrations. Thus the teaching element of Community Kitchens may be extended in the future.

As with the Communal Meal Program, most Frankston Kitchens eat a meal together, placing emphasis on social engagement. However the differences to the Communal Meal Program model are significant: participants usually prepare more than one meal together and all participants are equally responsible for menu planning, cooking and cleaning up.

1.2 Summative Literature Review

A review of the limited literature available on Collective Kitchens (small groups that prepare large quantities of food) in Canada demonstrates that these Kitchens foster social support and "help socially isolated participants recognise that others have similar hardships" (3). Several authors state that Collective Kitchens impact on multiple social and economic determinants of health (such as social support, education, personal health practices and coping skills and healthy child development) (3). The literature also shows that participation can be empowering for individuals (through skill development and improved food security) and is considered less stigmatising than accessing emergency food relief. Racine and St-Onge (5) observed increases in self-esteem and self-confidence as major outcomes for participants. Furthermore, two studies found that participants became more involved in their communities as a result of their participation in a Collective Kitchen – an indicator of personal empowerment (3). It seems reasonable that the above findings can be extended to other models of Community Kitchens, as the outcomes do not relate directly to the unique features of Collective Kitchens, (i.e. bulk meal preparation).

The three-fold goal of the Frankston Community Kitchen Pilot Project relates to promoting healthy eating (including food security), social inclusion and community strength. Food security and social inclusion (as a known determinant of mental health) are recognised as current health promotion priorities at all levels. Two of the six priorities of the National Public Health Nutrition Strategy (Eat Well Australia) are "improving nutrition for vulnerable groups" and "addressing structural barriers to safe and healthy food" (6). At the state level, "promoting accessible and nutritious food" and "promoting mental health and wellbeing" are two of the seven Victorian Public Health Priorities (7). (Local priorities are addressed in section 1.3.6 Health Promotion Priorities.)

1.2.1 Food Security

Food security is said to exist when "all community residents obtain a safe, personally acceptable, nutritious diet through a sustainable food system that maximizes healthy choices, community self-reliance, and equal access for everyone" (8).

Those vulnerable to food insecurity include: low income families, people who are unemployed or have limited formal education, people with a disability, people from non-English speaking backgrounds, frail elderly people, people affected by alcohol and/or substance abuse, homeless people and people from Aboriginal and Torres Strait Islander backgrounds (9).

Concerns regarding the adequacy, appropriateness and sustainability of emergency food relief as a solution to food insecurity have led to community development responses aiming to provide more sustainable solutions to the problems presented by food insecurity. Self-help and mutual support strategies aim to empower individuals to improve their access to food through enhancing their nutrition knowledge and food skills. These are typically participatory community-based programs such as Community Kitchens or budgeting education programs. (1)

The determinants of food security are numerous, but all impact on at least one of the following:

- Food availability/supply: having sufficient quantities of food consistently available;
- Food access: having sufficient resources to obtain appropriate foods for a nutritious diet; and
- Food use: using food appropriately based on knowledge of basic nutrition and care. (10)

Community Kitchens aim to affect change in the domains of food access and food use. Community Kitchens have the potential to enhance a household's self-sufficiency both directly, through augmenting food resources, and indirectly, through helping individuals to enhance their skills in food selection, purchasing and preparation in order to improve the management of limited resources (1). The effectiveness of these strategies depends on the frequency of cooking, the quantity of food prepared, the cost of the food compared with what would have been consumed otherwise and participants' prior level of knowledge and skill (1). Tarasuk and Reynolds (4) found that Collective Kitchens did not have a significant impact on participants' food security due to infrequent cooking, and Crawford and Kalina (11) reported fewer economic benefits than participants had anticipated. However the limited data on diverse groups means that this warrants further investigation (3).

In a recent study of Collective Kitchens, participants reported increases in food security. Participants who cooked more than five meals per month reported increased food resources and increased dignity through not having to access charitable food relief. Some participants reported less psychological distress associated with food insecurity. (12)

Food security can be viewed as a pre-condition for healthy eating. In a review of 20 years of data, the International Union of Health Promotion and Education (13) reported that lower socioeconomic groups have low intakes of vegetables, fruit and wholemeal bread. Therefore any initiative targeted at such groups should aim to increase consumption of these foods. Community Kitchens provide opportunities for participants to try foods and cuisines that they may not have previously been exposed to

(14) and the Pilot Project's nutrition guidelines encourage healthy food choices, especially the inclusion of vegetables and fruit.

1.2.2 Social Inclusion

The VicHealth Mental Health Promotion Framework (15) identifies social inclusion as one of three key determinants of mental health. Social exclusion occurs when people are shut out from the social, economic, political and cultural systems which contribute to the integration of a person into the community (16). The amount of social support available varies by social and economic status and poverty can contribute to social exclusion (17). With depression accounting for the greatest burden of disease in Victoria (18), the importance of addressing the determinants of mental health cannot be understated.

An association has been observed between social exclusion and food insecurity. It has been argued that those affected by food insecurity are forced to consume and acquire food in ways that fall outside social norms, thus contributing to social exclusion (19). An alternative explanation is that socially isolated people endured more severe food insecurity because they lack supportive social networks (19). Wood (20) takes the position that each condition contributes to the other. Regardless of the mechanism of causality, building social support is an essential component of building capacity amongst food insecure individuals.

For participants with limited opportunities to socialise with peers, owing to low incomes or childcare responsibilities, Community Kitchens are highly valued outings (4).

Although Kitchens are often comprised of people from varying socioeconomic circumstances and backgrounds to minimise stigmatisation, some groups benefit from a more homogenous composition. Participants facing particularly difficult and isolating situations benefit from the chance to meet and obtain social support from others with similar struggles (4). Kitchens for these groups have been shown to also attract and retain participants experiencing food insecurity (4).

The relative emphasis that should be placed on socialisation in Community Kitchens is debatable. Tarasuk and Reynolds (4) state that socialisation is inherent in the Community Kitchens model due to the co-operative nature of food preparation, however Fernandez (21) states that "technically focused Collective Kitchens fail to contribute to the development of quality relationships", suggesting that a conscious effort must be made to facilitate strong social connections. Engler-Stringer and Berenbaum (3) advocate for a dual focus on skills and socialisation for optimal impact when they state that, "Collective Kitchens have the potential to influence an individual person, a household, or a community on many levels. In order to do so, [they] must find the proper balance of food skill building and opportunities for participants to explore their social world".

1.3 The Community Context

1.3.1 Frankston City

The City of Frankston is located on the eastern shores of Port Phillip Bay, approximately 40 kilometres south of Melbourne, and has a population of approximately 117,801 (22).

1.3.2 Income

People from low income families or communities experience more health problems and are at greater risk of chronic disease and illness-related disability than people with greater levels of economic and social resources (23). Over 50% of households in the City of Frankston sit in the two lowest quartile income brackets, compared with 44.5% in the whole of Melbourne. The City of Frankston has a higher rate of unemployment for 15-24 year olds than Melbourne (13.9% compared to 12.2%) and a higher unemployment rate for those 15 years and over than Melbourne and Victoria (7.2% compared to 6.6% and 6.8% respectively) (24).

Across all 78 Victorian local government areas, Frankston ranks 22nd on the Socio-Economic Indexes for Areas (SEIFA) index of disadvantage, which reflects economic and social characteristics of families and households and personal characteristics such as qualifications and occupation (25).

1.3.3 Food Security

Local research undertaken by Doyle & Keleher to inform Frankston City Council's Health and Wellbeing Plan 2007-2011 showed food insecurity to be a problem for a significant proportion of the community, attributable to financial inadequacy, transport limitations and distance to fresh produce outlets. Only 12.6% of respondents were able to access fresh fruit and vegetables within 500m of their home (a standard measure of satisfactory access). Although of particular concern in Frankston North and Frankston South, poor access to fresh fruit and vegetables was found to be an issue across the municipality. The proportion of people who reported going without food within the previous six months due to lack of money was 12.3% (compared with the Victorian average of 6.0%), while lack of transport was cited by 7.2% of respondents as the cause. (24)

1.3.4 Social Inclusion

Mental health is a concern in Frankston due to high levels of depression, high levels of family violence, significant socioeconomic disadvantage, a high proportion of lone-person households and single-parent families and poor acceptance and support for people with a disability and people from culturally diverse backgrounds (23). These indicators contribute to, or are worsened by, social isolation.

Social isolation is seen to be an issue across all age groups in Frankston, particularly affecting those in lower socio-economic areas and those with limited opportunities for employment. In their research, Doyle & Keleher (24) cite the main reasons as being lack of local employment opportunities and the subsequent poor access to financial resources, as well as limited public transport options. Reasons cited for the social isolation experienced by the older population were chronic disease, lack of confidence in going outside the house due to frailty and limited transport options.

1.3.5 Community Strength

The Department of Planning and Community Development (formerly the Department for Victorian Communities) developed a set of indicators that examine elements of community strength including community attitudes, participation and the ability to get help when needed. Frankston scored consistently lower than the Victorian average on indicators relating to feeling safe, feeling valued, volunteering, belonging to an organised group, taking community action, being involved in a school, attending community events, having opportunities to have a say on important issues and raising money in an emergency (26). Doyle & Keleher revealed significantly more positive

results in the realms of volunteering and opportunities to have a say, however the authors concurred with the Department for Victorian Communities study that Frankston has lower levels of participation in community structures than in other parts of Victoria (24).

1.3.6 Health Promotion Priorities

Based on available local data, food security has been identified as a health promotion priority in Frankston City Council's current 'Frankston – Healthy City: Health and Wellbeing Plan 2007-2011' (23) and the 'Frankston Community Health Service Integrated Health Promotion Organisational Plan 2007-2010' (27). In addition, Frankston City Council, Frankston Community Health Service and the Frankston-Mornington Peninsula Primary Care Partnership have all identified social inclusion or mental health (of which social inclusion is a determinant) as a health promotion priority. Thus a number of initiatives addressing healthy eating and social inclusion are already underway (e.g. 'Frankston Food for All Project' funded by VicHealth and 'Fruit and Veg for Health' funded by the Victorian Government's 'Go For Your Life' program). Community Kitchens are a key part of the action plan to help address these issues amongst Frankston residents.

1.4 Needs Assessment

The Frankston Community Kitchens Pilot Project arose as a result of national and state-level health evidence in addition to local health workers' perceived gaps in services. At a national level, the last two decades have seen sections of the community experience sharp increases in obesity- and nutrition-related chronic disease, reliance on processed foods and foods consumed outside the home. A search of the literature revealed that 56% of Australian adults and 27% children were overweight or obese, and that Type 2 Diabetes cost the Australian economy $3 million per year. The issue of poor physical and financial access to quality, affordable fresh produce contributes to inadequate fruit and vegetable intakes, which in turn accounts for approximately 11% of the burden of disease from cancer. (18)

At a local level, a Frankston Community Health Service community dietitian observed that her clients experienced low motivation to cook, to try new foods and to look for healthier options in the supermarket. Clients cited limited cooking skills as a barrier to making lifestyle changes. Other health workers at Frankston Community Health Service also expressed their need for support in developing cooking programs and teaching clients about healthy eating.

Following her study tour to Canada, the dietitian held a community information forum in March 2004 to inform and consult the local community. This event was attended by 52 community members and representatives of community organisations and groups. This consultation confirmed the need for a program to support people in making lifestyle changes and in developing social and cooking skills.

1.5 Project Timeline

Following the community forum, a reference group (consisting of the project management team and project partners) and was established to guide the project and separate Working Groups were created to oversee the development of each Kitchen.

In September 2004 the Frankston Community Kitchens Pilot Project received three years of funding through Local Answers – part of the Stronger Families and Communities Strategy delivered by the Commonwealth Department of Families,

Community Services and Indigenous Affairs. This funding has primarily been used to employ a full-time Project Officer since January 2005. The first six Kitchens were established in September 2004, four of which were still operating at the time of writing.

In February 2006 the reference group was dissolved and replaced with a Community Kitchens Network, the membership of which included members of the original reference group, Kitchen facilitators, participants and other interested stakeholders.

In the three years since the funding was obtained, 16 Kitchens have been established in Frankston; resources (including manuals, DVDs and a website) have been developed, produced, updated and disseminated; the concept and model have been disseminated throughout Victoria; community groups and organisations in Frankston and throughout Victoria have been supported in establishing their own Community Kitchens; two rounds of evaluation have been undertaken in Frankston; two rounds of evaluation have been carried out across the state; and a State-wide Community Kitchens Forum has been held to promote networking, share learnings and generate solutions to common challenges.

(See also Appendix 1: Project Timeline.)

1.6 Planning Framework

The planning framework for the project evolved with the project and changed significantly with change of staff (see Figure 1).

The original two goals for the project related to promoting skill development, enjoyment of cooking, community engagement and a sense of community. The objectives related to developing knowledge and skills, expanding friendship networks and reducing time pressures and costs associated with preparing meals. At this stage the target group was undefined, and was to be determined at the community information forum.

The new project manager reviewed and made significant changes to the original planning framework based on the lessons learned in the previous two years of implementation. The revised goal relates to three themes: healthy eating (including the notion of food security), social inclusion and community strength. The revised objectives relate to the corresponding measures and indicators available for each theme. The target group for the project as a whole was identified as ‘socially and economically disadvantaged residents of the City of Frankston’.

(For further detail see Appendix 2: Evolution of the Program Planning Framework.)

Figure 1: Original and current program planning frameworks for the Frankston Community Kitchens Pilot Project

May 2004

Target Group: Community Kitchen participants and their families in the City of Frankston.

Goals

1. To improve motivation and capacity to prepare and cook nutritious and affordable meals.
2. To enhance sense of community in all program members.

Objectives

1. To upskill 80% Community Kitchen participants', knowledge about nutrition and health in twelve months of involvement or at voluntary completion of the program.
2. Create an environment that supports role modelling among participants and / or participants and their families, in all Community Kitchens within 12 months.
3. Reduce perceived barriers to Community Kitchen participants in accessing an affordable, good quality food supply by 30% within 12 months.
4. To reduce the number of participants who report time as a barrier in preparing healthy foods, by 30% after six months in the program or at voluntary conclusion.
5. Increase social networks of participants in Community Kitchens by 10% within 6 months of involvement in Community Kitchens.
6. Create at least 3 multi-organisation partnerships for each Community Kitchen, within 12 months.

July 2007

Target group: Socially and financially disadvantaged residents of the City of Frankston

Vision: To develop and disseminate a sustainable Community Kitchens program that promotes healthy eating, social inclusion and community strength in the City of Frankston.

Goal: To promote healthy eating, social inclusion and community strength in the City of Frankston.

Objectives:

By December 2007…

1. 30% of participants will have increased their economic access to healthy food through participation in Community Kitchens and/or through improved budgeting skills
2. 80% of participants will have improved their knowledge of healthy eating and recipes
3. 80% of participants will have improved their food preparation skills
4. 50% of participants will have increased their confidence and motivation to cook at home
5. 80% of participants will have improved their food safety knowledge and skills
6. 80% of participants will feel valued and respected within their Community Kitchen group
7. 80% of participants will have increased their access to supportive relationships through involvement in Community Kitchens
8. 90% of participants will have built stronger social networks through an increased quality and number of social connections
9. 30% of participants will have increased access to employment and volunteering opportunities
10. 10 collaborative partnerships will have been developed between community organisations within the City of Frankston
11. 60% of organisations and community groups will demonstrate leadership, ownership and control of their Community Kitchen
12. 100% of participants will have increased their involvement in organised community groups and community events.

1.7 Evaluation Methodology

For the purposes of evaluation and financial accountability, routine data collection has occurred since the funding period began. Quantitative data collected includes: the frequency of Kitchen sessions; the number of participants of each gender attending a Kitchen session; the number of meals prepared; the cost to participants of meals prepared; the frequency of training sessions, promotional activities and meetings and the attendance at each; enquiries received by project workers from Frankston and Australia; and the number of resources distributed. These statistics were collected by way of facilitator reports and databases kept by project workers. A website hit counter also tracked the number of visitors on the Community Kitchens website.

Preliminary evaluation was carried out twelve months into the project. The data was collected primarily by project workers. The main method for collecting data was written surveys (pre- and post-participation surveys to measure change; participant satisfaction surveys; and Partnership Analysis Tools), however interviews were also conducted with participants who had not completed written surveys or who were willing to give further insights. Other sources of information included: facilitator observation, records kept by project workers and routine data collection from facilitators.

In early 2007, further evaluation was undertaken by an independent consultant. Data collection methods focussed on verbal methods (i.e. focus groups and interviews with participants and key informant interviews with project partners and the project management team), with written surveys playing a minor role.

In mid-2007, two groups of student dietitians undertaking their community nutrition placement carried out an evaluation of Community Kitchens on a state-wide level. The first group of students used written surveys to map the Community Kitchens currently in operation and in development, determine the models in use and target groups catered for and perform a simple cost-benefit analysis. Their surveys received responses from 36 Community Kitchens co-ordinators throughout Victoria (80% response rate). The second pair of students evaluated the impact of Community Kitchens at a state-level through the use of written surveys for participants and focus groups or phone interviews for facilitators and project co-ordinators. Forty-two survey responses were obtained (22% response rate) while focus groups and phone interviews were conducted with 25 facilitators in eight regions of Victoria.

2 Impact of Community Kitchens

2.1 Process Evaluation: Routine Data Collection

2.1.1 Implementation of Activities

Most strategies of the Pilot Project were fully implemented at the time of the Year Three Evaluation (e.g. Kitchens established, resources developed and disseminated, facilitators trained, Network functioning), as documented in databases of activities kept by project workers and as found by the investigator. Thus the effectiveness of the project was ready to be measured. Unless otherwise specified, the findings discussed in sections 2.1-2.5 are taken from the report entitled 'Evaluation of the Frankston Community Kitchens Pilot Project for Frankston Community Health Service' by S. Pomeroy.

Menu Planning and Budgeting

The implementation of the menu planning process was investigated. A series of templates have been designed to guide groups through the planning process:

- A Participant Order Form is used to determine the number of serves each participant wants to purchase. Many groups do not use this template.
- A Recipe Worksheet is used to identify the required ingredients and the estimated cost. 85% of facilitators reported that participants would not or could not complete the worksheet, often leaving the task to the facilitators.
- A Grocery Shopping List is used to classify and compile ingredients for all recipes. Not all Community Kitchens utilise the Grocery Shopping List template.

Participants are also encouraged to bring in current supermarket brochures to estimate the price of ingredients. In practice, these resources were under-utilised, participants preferring to estimate the price based on their own knowledge, or not estimate cost at all. (For more information on the use of these templates, see section 2.1.4 Performance of Materials and Components on page 19.)

Facilitator Training Workshops

Facilitators are expected to attend training workshops and pass on their new knowledge to participants ('train the trainer' model). The training workshops are either run as stand-alone modules or as 'Basic Training Days' where all workshops are covered in one or two longer sessions.

All facilitators reported training in food safety and budgeting principles. The majority (83%) reported workshops covering basic nutrition, group facilitation and reading food labels (the latter topic is covered in the nutrition workshop). Although recipe modification is covered in the nutrition workshop, only one third of facilitators recalled training on this topic. This suggests that insufficient time or emphasis was allocated to this topic.

During evaluation, facilitators requested further training on the following topics:

- Recipe modification
- Medical conditions that their participants experience, e.g. mental illness and diabetes. (In response to participants' requests in 2006, the Project Officer held a workshop for facilitators and participants entitled "Food choices for people

with diabetes", but this second request highlights the need to run such workshops on a more regular basis.)

- Strategies to manage conflict resolution and how to retain participants.

These training requests reflect the issues that these facilitators are trying to manage within their Community Kitchens and the degree of support which they require to sustain their Community Kitchen.

2.1.2 Program Reach

Target Groups

The target group identified in the initial project plan was "individuals and families with time and financial pressures". A range of demographic groups formed around the Community Kitchens: men, women, youth, young mothers, Kooris, newly arrived culturally and linguistically diverse groups, young people with intellectual disabilities, people with autism, people with special dietary needs, the isolated elderly, people accessing emergency food relief, staff at a health service and the general community. The targeting of these groups was the result of input from partnering organisations, including those providing kitchen facilities, those supporting Kitchens and those referring participants.

There is evidence that Community Kitchens have reached groups in the community that are more disadvantaged and socially isolated, including:

- young mums that have accessed emergency food relief;
- homeless youth;
- older people (some with physical impairments and mental illness);
- people with a disability; and
- refugees.

The closure of the Kitchens for young mothers and youth and the relocation of the Kitchen for Koori people reduced the reach into these groups.

Community Kitchens have a presence in the areas where financial disadvantage impacts strongly on food access, such as Frankston North, Frankston South and Seaford. The majority of organisations which support Community Kitchens are represented in these areas.

Attendance

On average, seven participants attended a cooking session. This aligns well with the suggested group size of six to eight. This number of participants seems reasonable, given the equipment and space capacities of the kitchen facilities.

The participant turn-over rate was not well documented, but Community Kitchens were found to have the potential to retain participants for a year or more. When participants discontinue, their position is filled quickly from a waiting list.

The frequency of cooking sessions impacts on the reach of the program into the community and is decided by each group. For example at the beginning of the project, some Kitchens met fortnightly and had separate planning and cooking sessions, thus these groups would only cook once every four weeks. At the end of the project most Kitchens were meeting weekly and cooking at each meeting.

Meals Produced

The total number of meals (or serves) produced over the 39 months of implementation was approximately 8264. On average, three serves are produced per participant each cooking session. Since most groups share a meal together after cooking, this would suggest that each participant takes two serves home to be eaten at another time or to share with family. Little bulk cooking has been done in the Community Kitchens due to time and space limitations, and possibly cost. More bulk cooking would extend the benefits of healthy and affordable meals prepared.

Training

Nineteen workshops have been held in Frankston with 178 attendances by facilitators, other volunteers and interested participants. These workshops included two sessions on nutrition, three sessions on food safety and kitchen safety, one session on budgeting for food, one on group facilitation and seven 'basic training days' covering all topics. Other training sessions provided by project workers for facilitators and participants are: a nutrition session specifically for people with Coeliac Disease, a 'Cooking for One or Two' presentation, a session on healthy eating for people with diabetes and two food skills workshops (one on healthy Asian cooking).

Promotion

The resources developed by project workers to assist others in setting up Community Kitchens have been widely disseminated. Seventy-five manuals, 69 DVDs and videos and 155 budgeting pocketbooks have been distributed throughout Frankston, Victoria and Australia.

The Community Kitchens concept has been promoted to the broader Mornington Peninsula and Victorian community through conferences, local forums and the website. These efforts have resulted in more than 4000 people (including workers and community members) being exposed to the project's activities and outcomes.

The Australian Community Kitchen website was launched in April 2006. In the 20 months since, more than 5100 different people have visited the site. The data collected would suggest that most of these people are workers, since most visits were recorded during business hours on weekdays.

2.1.3 Satisfaction

Participants' Satisfaction

Preliminary evaluation results indicated that participants were very happy with the way their Kitchen was operating. All participants were satisfied with the time, day and duration of their Kitchen and the sharing of tasks. Only two respondents felt there should be more food produced as they have older children who require larger serving sizes. Nearly all (98%) of participants surveyed enjoy participating in the Kitchen greatly or moderately and felt respected by other participants (93%) and by their facilitator(s) (86%). Seventy-one percent reported that the Kitchen meets their individual or family needs "greatly", and 29% "somewhat" or "a little". (28)

The Year Three Evaluation demonstrated that 95% of participants were satisfied with the friendliness of people in their Kitchen, the approachability of the Project Management Team, the day which the Community Kitchen meets and the affordability of the food. Eighty percent were satisfied with the location of the Community Kitchen and kitchen equipment. This finding is similar to the satisfaction level reported by participants in the Twelve Month Report.

Only 42% of participants were satisfied with the length of time devoted to cooking in each session and the taste of the meals prepared. This was attributed to more time than necessary used in the planning of recipes which reduced the time for cooking and eating the meal; the choice of recipe; and the omission of recipe ingredients to the point where the cooked food lacked flavour.

Participants offered a range of suggestions to improve Community Kitchens, which are listed below.

- Plan several cooking sessions at the same time and in advance of the cooking session
- Allocate a few minutes at the beginning of each cooking session to explain modifications to the recipe and demonstrate any new cooking techniques.
- All food prepared in all the Kitchens should be healthy, allowing all the participants to enjoy all the meals.
- Careful attention to the allocation of participants to the different Community Kitchens. For example, where the majority of participants have complex mental problems, a specially trained facilitator may be required.
- Induction should include the use and cleaning of kitchen equipment. A roster system could be implemented to ensure a fair allocation of cleaning duties amongst participants.
- Training for Project Officer, facilitators and participants in the skills of conflict resolution. The expectation that all participants will follow kitchen rules was considered unrealistic.
- More training for participants and facilitators in the skills of planning, budgeting and ingredient substitution (especially the impact of omitting major ingredients).

Project Partners' Satisfaction

The Year Three Evaluation included key informant interviews with 12 representatives from partnering organisations. Ninety-five percent of these representatives supported the philosophy of the Community Kitchens. In their view, the philosophy included five components – a safe environment; improving skills in cooking healthy, low cost meals; creating friendship opportunities; improving budgeting skills; and improving food purchasing skills.

Eighty-five percent reported that the Community Kitchens model has the potential to extend beyond these five components into a broad range of areas which would benefit their clients. Examples provided by these representatives are listed below.

- A place to learn food and kitchen skills that are transferable to work opportunities and/or further education and training.
- An environment with an established social network where people can take part in regular physical activity. This was considered important in the management of health risks and in the prevention of chronic diseases in new arrivals.
- An opportunity where people can come together and organise travel to low cost food outlets such as markets and community gardens. The view was that this opportunity would help clients socially interact and overcome lack of transport which can be a food access barrier.
- A setting where people can go to socialise around food. For example, participation in food festivals and the enjoyment of utilising local eating places

and restaurants. This suggestion was highlighted as being important for people living alone, living in isolated situations and new arrivals to Australia.

- A place to learn and practice independent living food skills. For example, storing food safely, cooking a meal in one pot and purchasing food in supermarkets and local fresh food shops.
- A place to learn and practice literacy skills. This suggestion was highlighted as important for people learning English and for people who have difficulty reading instructions.

These suggestions emphasise the importance of education and training, independent living skills, food security and social inclusion. Healthy eating (including food security), social inclusion and community strength play a central role in the new objectives for Community Kitchens (2007) (see Appendix 2: Evolution of Program Planning Framework).

2.1.4 Performance of Materials and Components

Menu Planning and Budgeting

A series of templates were designed to guide groups through the planning process. They are listed below with the findings about the use of each.

- A Participant Order Form is used to determine the number of serves each participant wants to purchase. Facilitators and participants reported little need for this template, however it was viewed as an important tool for Kitchens that cook food in bulk.
- A Recipe Worksheet is used to identify the required ingredients and the estimated cost. Both facilitators and organisations endorsed the value of this template as important in the management of food insecurity. In their view, this tool adds "a skill and a routine to the daily lives of people living in an insecure food environment." Twenty-one percent of participants reported using a version of the recipe worksheet at home. However 85% of facilitators reported that participants would not or could not complete the worksheet, often leaving the task to the facilitators. Column descriptions were considered difficult to understand and numerical calculations difficult to compute.
- A Grocery Shopping List is used to classify and compile ingredients for all recipes. Completing a grocery shopping list, taking it to the food store and buying the food was reported by 23% of participants as an "enjoyable experience", although not all Community Kitchens utilise the Grocery Shopping List template.

Participants are encouraged to bring in current supermarket brochures to estimate the price of ingredients. In practice, these resources were under-utilised, with participants' preferring to estimate the price based on their own knowledge, or not estimate cost at all.

Summary

Completing a grocery shopping list, taking it to the food store and buying the food gave some participants new confidence which they carried over into their home life. There is limited evidence for the use of the cost estimation tools within the Kitchens. Many participants seem to have difficulty understanding and following the directions listed on the templates. Facilitators widely advocated for a budgeting framework aimed at different target groups, for example older people. It would be reasonable that the

Project Management Team develop a policy whereby the development of planning tools should involve target groups in the design, implementation and testing phases.

2.2 Impact Evaluation: Healthy Eating and Food Security

The results below are taken from the "Frankston Community Kitchens Project Twelve Month Evaluation Report" by J. Trezise (28) and "Evaluation of the Frankston Community Kitchens Pilot Project for Frankston Community Health Service" by S. Pomeroy (14).

Cooking Skills and Behaviours

More than half (54%) of participants surveyed or interviewed during the Preliminary Evaluation felt that their cooking skills had improved greatly since joining Community Kitchens. Fifty-eight percent of participants reported using recipes from the Community Kitchen at home occasionally. Fourteen percent reported preparing more meals from scratch. Over 40% reported feeling more motivated to cook at home and 50% reported cooking more meals at home since joining a Kitchen.

Nutrition Knowledge

Year Three Evaluation showed that while 42-48% reported discussing nutrition within their Kitchens, 60-70% of participants were able to identify healthier food choices from a list. This rate could be improved and demonstrates the need to identify learning needs and tailor education strategies to further develop the skills of the broad range of participants.

Eating Behaviours

Participants interviewed reported healthier eating since joining Community Kitchens in both rounds of evaluation. Preliminary Evaluation showed that this could partly be attributed to feeling more motivated to cook at home (43%). Increased motivation and using Community Kitchens recipes at home resulted in 64% of participants reporting a reduction in fast food consumption in Preliminary Evaluation, compared with 47% in Year Three Evaluation. Forty-three percent reported that they have increased their consumption of fruit and vegetables, which is very similar to the 45% found in the Preliminary Evaluation. Some participants stated that they now used less salt in cooking and consumed fewer high fat meals.

Some participants reported using the extra meals from the Kitchen for lunch the next day. Furthermore, participants were sometimes seen as role models and supports by fellow group members who needed help in following a healthier diet.

Food Spending Habits

Many participants discussed changes to their food budgeting habits. They were looking for cheaper options, "shopping around", writing shopping lists and reading food labels. They also discussed buying fresher ingredients and buying in bulk when possible.

On the other hand, half of the participants surveyed in Preliminary Evaluation perceived that they were spending less on non-nutritious food, yet perceived overall spending had increased slightly. Participant interviews provided some insights for the reasons for this, suggesting a combination of: fresh food costs increasing considerably over this time; and eating at home more frequently. Heightened enthusiasm about going shopping (50%) and increased confidence to try new foods may also lead to spending more on groceries.

Menu Planning

In Preliminary Evaluation, 28% of participants reported an increased use of a shopping list and 7% in meal planning. In Year Three Evaluation, participants reported discussions within their Kitchens on the modification of recipes to save money (95%), the estimation of food costs (100%), writing a shopping list (74%) and reading food labels (42%). Limited literacy and numeracy skills are likely barriers to adopting these behaviours for many respondents.

Conclusion

Despite no formal education within Kitchens about budgeting, shopping, cooking skills and nutrition, there have been significant changes in participants' lifestyles as a direct result of their participation.

Overall these findings demonstrate the effectiveness of Community Kitchens in creating opportunities for people to eat healthier, more affordable meals. The findings also suggest a positive association between facilitator training, Kitchen discussion and participant behaviour. This demonstrates that informal practical learning through participation in Community Kitchens has great potential to foster improved healthy eating behaviours.

2.3 Impact Evaluation: Social Inclusion

Many of the Frankston participants are socially isolated to varying degrees, so social inclusion is one of the three themes identified in the revised program goal. A major outcome of the project is a perceived increase in social connectedness.

Participants surveyed for the Preliminary Evaluation stated that their favourite part of being involved in Community Kitchens was the social aspect: the friendships developed and social interaction. This was also highlighted in the participant interviews where 91% commented that their favourite aspects were "the companionship" and "making new friends".

One of the main findings of the Preliminary Evaluation was that participants join Community Kitchens for a range of different reasons (e.g. for the social aspects, to learn to cook or to save money on food) and they benefit in different ways. But the reason that participants continue in the Kitchens is the friendships that they develop.

Participants and facilitators reported friendships developing as a result of participating in Community Kitchens, reporting that they regularly get together to engage in common interests outside of the Kitchens. For example, a facilitator and a participant who began their relationship with an argument subsequently developed a friendship based on their common interest in computers. They now see each other outside of the Kitchen as well as maintaining regular contact via email. The same participant gained employment through his relationship with another member of the Kitchen.

The original Community Kitchens Implementation Plan (29) included the following objective: that 75% of members will have expanded their friendship network. In Year Three Evaluation, one quarter (26%) of participants surveyed reported that they had increased their friendship network since joining the Community Kitchens. This is somewhat less than the reported 90% improvement in the Twelve Month Report. This finding is most likely the result of a strong representation from one Kitchen where conflict had been an issue.

Conclusion

Taken together, these findings demonstrate that Community Kitchens provide a setting where people can interact socially and expand their friendship networks.

2.4 Impact Evaluation: Community Strength

One indicator of community strength is membership of an organised group. Forty-three percent of participants reported joining other community groups in the Frankston area since joining Community Kitchens, including other activities offered by the organisation hosting their Kitchen such as the Men's Shed.

Other indicators of community strength include volunteering and participation in community life. Participants of the Women's Kitchen have begun volunteering at a shop that is owned and operated by the organisation hosting their Kitchen. A participant from the Peninsula Access Support and Training (P.A.S.T.) Kitchen (for young people with disabilities) began volunteering as a waitress at a nursing home. These findings show that Community Kitchens have the potential to facilitate participation in community life beyond the Kitchens themselves, and therefore create stronger communities.

2.5 Other Impacts

2.5.1 Education and Employment Pathways

Kitchens that place a greater emphasis on training and skill development have demonstrated positive outcomes regarding the creation of employment opportunities for participants. For example, all participants in the P.A.S.T. Kitchen for young people with disabilities have completed commercial kitchen cleaning and Occupational Health and Safety training provided through Brotherhood of St Laurence, who provides the kitchen facility. Outcomes include:

- Two current participants completing Food Handlers certificates at Skills Plus, a partnering Employment Training Organisation.
- One participant now being employed at a restaurant five days a week. "While participating in the P.A.S.T. Kitchen, this participant learnt that he enjoys preparing meals and kitchen cleaning. These skills have earned him employment." – P.A.S.T. facilitator
- Two participants transferring to hospitality courses.

Similarly, the Peninsula Care House have reported Community Kitchen participants returning to education opportunities and moving back into the workforce through volunteering in shops operated by this organisation.

2.5.2 Self-Confidence

Sixty-nine percent of participants interviewed in Year Three Evaluation reported improved confidence in taking on new tasks, which is similar to the Preliminary Evaluation findings (60%). There are many opportunities within Community Kitchens for participants to develop their self-confidence, such as: taking on responsibilities, participating in a group setting, experiencing the satisfaction of having prepared a new meal, developing friendships and gaining skills which can lead to volunteering or employment opportunities.

2.5.3 Mental Health

Fifty-eight percent of participants interviewed in Year Three Evaluation reported an improved sense of confidence, happiness and health since joining Community Kitchens. Over half of the participants reported improvement in their sense of personal happiness (53%) and health (52%). One third (30%) of interviewed participants reported participating in discussions about health problems such as relapses in existing illnesses, accessing the medical system and changes to pharmaceuticals which demonstrate that Community Kitchens create a setting where people feel confident discussing and sharing health experiences.

2.5.4 Partnerships Built with Other Organisations

The successful operation of Community Kitchens depends on the building and maintenance of partnerships. For the Frankston Community Kitchens, partners provide: a strong client referral base, kitchen facilities, a variety of foods and the finances to cover costs such as public liability insurance. With this support from partners, the Community Kitchens are able to maintain a low cost funding base.

Between 2004 and 2007, the total number of partnerships remained almost the same (n=25), however the balance of partnerships changed. The number of organisations which refer clients has doubled (from three to seven) while the total number of food business partners has reduced from nine to three. This result suggests increased access to participants but less access to a range of foods at a reduced cost. This finding shows the importance of maintaining a balance in the diversity of partnerships.

At the time of the Year Three Evaluation there were seven operating Community Kitchens and five closed Kitchens. With the exception of the Koori group, the representatives of the four organisations with closed Kitchens had maintained their involvement in the Community Kitchens Network and have expressed their intention to re-open their Community Kitchens. These relationships require regular review and attention in order to be maintained. The building of new partnerships continued throughout 2007 with three new Kitchens commencing in the Frankston region.

Year Three Evaluation included a partnership analysis. Twelve interviewees representing key organisations were asked to identify their relationship with the Project Management Team from a diagrammatic continuum. Eighty percent reported a "networking" relationship. In their view, they had a "cooperating" relationship during the implementation phase – when there was the common purpose of implementing Community Kitchens, the Reference Group was operating and the Project Officer was highly visible in the Kitchens.

It is not expected that all organisations need to maintain a "collaborative" partnership with the Project Management Team throughout the project. However strong links are crucial to the sustainability of the project. This change in relationship from "cooperating" to "networking" appears to be an outcome of the change in direction of the Community Kitchens. That is, the decline of the Project Officer's visibility in each of the Kitchens and the change in committee structure (from the Reference Group to the Community Kitchens Network).

Despite the Project Officer's withdrawal from the Kitchens being planned and discussed with partners, representatives of partnering organisations reported that they had not adequately prepared for the implications. The Project Officer had played a major role in teaching participants how to work in teams, resolve conflict and prepare food in line with guidelines of the Community Kitchens. Partners perceived the link with

Community Kitchens had been reduced and felt less supported to operate their Community Kitchens.

The purpose of the Community Kitchens Network was initially to provide a forum for facilitators to discuss issues related to the Community Kitchens. Partnering organisations involved with Community Kitchens were then invited to attend the Network to join in the discussions and problem-solving (performing a similar function to the previous Reference Group). This transition seems to have had an impact on the longstanding relationships – these partners felt less connected to the Community Kitchens project.

According to the community development model, organisations should have ownership of their project from the beginning, rather than ownership being later transferred. The importance of this point is recognised, and this is the way that the Frankston Kitchens have been established from the middle of 2006 onwards.

2.5.5 Partnerships Built Between Organisations

Many of the partners reported pre-existing and active relationships with other organisations involved in Community Kitchens. For other organisations, rewards for being involved were specifically in the areas of developing professional and personal networks and resources.

2.6 State-Wide Evaluation Results

This section covers the evaluation of Community Kitchens at a state level. Although not strictly part of the Frankston Pilot Project, dissemination of findings throughout Victoria was a condition of the Travelling Fellowship. The Project Manager was consulted frequently by people from other regions wishing to start their own Community Kitchens. The written and visual resources developed as part of the Pilot Project have proved useful not only for Frankston Kitchens, but also for Community Kitchens co-ordinators and facilitators throughout Australia.

The success of, and enthusiasm for, Community Kitchens across Victoria is evidenced by the popularity of a State-wide Community Kitchens Forum held in late 2007, which attracted 70 project coordinators, facilitators and project partners.

2.6.1 Process Evaluation of Dissemination

Reach

The Community Kitchens concept has been widely disseminated across Victoria and readily embraced by a variety of organisations and groups. At the time of mapping (September 2007) there were 50 known Community Kitchens operating in Victoria, with another 60 intended to be established by the end of 2007. Approximately 320 people are being reached by these Community Kitchens across Victoria. (30)

This extensive adoption is thought to stem from: the concept's wide appeal due to the broad range of potential outcomes for participants; the low cost funding base required; and the resources developed and provided by the Project Team that enable people to develop their own Kitchens independently.

Implementation

The majority of respondents from around Victoria reported implementing their Community Kitchen(s) based upon the Frankston model. There was consistency demonstrated between the Frankston model and other Community Kitchens regarding planning framework, structure, etc., with many organisations consulting the Frankston

Community Kitchens manual and/or the Australian Community Kitchens website developed through the Frankston Pilot Project. (30)

Most organisations reported consulting external organisations and their community when determining the need for and feasibility of establishing a Community Kitchen, although anecdotal evidence was also commonly referred to as a basis for introducing Community Kitchens.

The majority of Victorian Community Kitchen projects have not yet been evaluated, suggesting the need to promote the importance of evaluation in the implementation of the project. Most respondents reported that they needed further support in the form of stronger partnerships to ensure that their Community Kitchens could be considered sustainable. (30)

Quality and Satisfaction

Few Kitchens have conducted evaluation with respect to participant satisfaction, making it difficult to generalise the results obtained across all Kitchens. Overall the Community Kitchens website and manual have been positively received by those who have utilised them, with suggestions to enhance their ease of use and application to all Community Kitchens. The majority of respondents were not satisfied with the current level of networking between the different Kitchens, suggesting the need to establish an email registry, a newsletter, regular network meetings and promote more wide-spread use of the website and online forum. (30)

Cost-Effect Analysis

Based on a simple cost-effect analysis of inputs and outputs, Community Kitchens were shown to have a better cost-efficiency regarding both the number of people-meetings affected and number of meals prepared per facilitator hour than two other cooking programs (Nutrition Australia's "Cooking for One or Two" program and West Gippsland Healthcare Group's "Light on the Waist, Light on the Pocket" budget cooking program). The Community Kitchens were shown to be a relatively cost-effective program to address both social isolation and food security. (30)

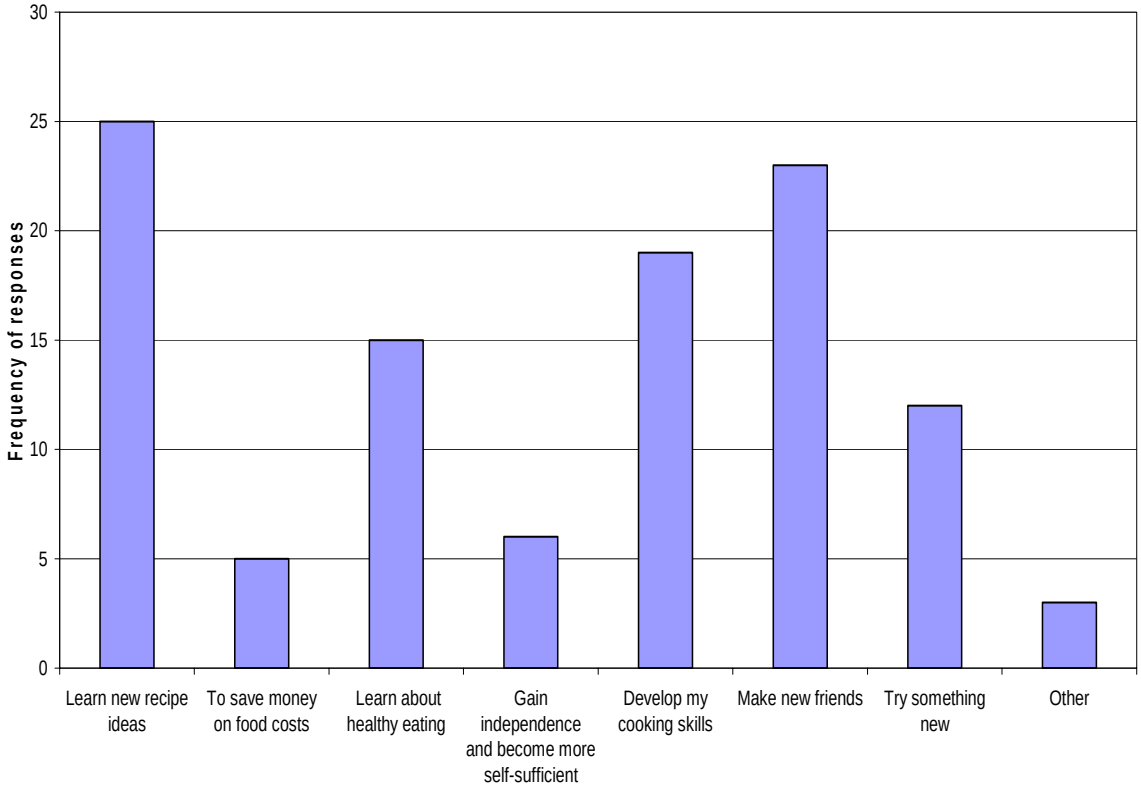
2.6.2 Impact Evaluation of Community Kitchens Across Victoria

Questionnaires were sent to 185 Community Kitchens participants in four regions of Victoria, gaining a response rate of 22% (n=42). The four regions were Frankston, Mornington Peninsula, West Gippsland and Hume. The results below are taken from Granados and Murphy's "Community Kitchens Project Report" for Frankston Community Health Service (31).

The most common source of income for respondents was a pension or Centrelink benefit (64%). Only 12% had full time employment, the majority of who were from the staff Community Kitchen at Frankston Community Health Service. While reasons for joining Community Kitchens varied widely (see Figure 2), the three most common reasons identified related to both healthy eating and social inclusion:

- to learn new recipe ideas;
- to make new friends; and
- to develop cooking skills.

Figure 2: Participants' reasons for joining Community Kitchens



Healthy Eating

When asked about perceived changes in meal planning skills since joining Community Kitchens, 64% indicated their skills had improved "a little" or "a lot". Twenty-five respondents (60%) were able to identify at least one way in which they plan for meals, such as: writing a menu/shopping list; stocking the pantry with more basic items and then plan the week's menu; and shopping for discounted foods and freezing more.

When asked about the perceived change in their weekly food spending since joining Community Kitchens, 33% of respondents thought their spending had decreased "a little" or "a lot" and 10% thought it had increased "a little", but the majority (55%) reported no change. Reasons given for spending more on food were:

- Using more ingredients;
- Purchasing better products; and
- Spending more to stock pantry with basics initially, but expecting to decrease.

Reasons identified for spending less on food were:

- Knowing what foods are cheaper;
- Less impulse buying "especially at lunch as I bring leftovers"; and
- Buying healthy foods and "cutting out the junk".

Sixty-four percent of respondents perceived that their knowledge of healthy eating had improved "a little" or "a lot" since joining Community Kitchens. When asked to list three ways to identify a healthy meal, 71% of respondents were able to identify at least one method. Some examples were: to consider fruit and vegetables, fat and sugar levels and nutrition guidelines.

When asked about perceived change in food preparation skills since joining Community Kitchens, 74% thought their food preparation skills had improved either "a little" or "a lot".

Sixty-seven percent of respondents felt their confidence in preparing healthy meals had increased since joining Community Kitchens.

Seventy-four percent of respondents reported increased motivation to prepare healthy meals since joining Community Kitchens.

When asked about perceived change in the number of meals cooked at home since joining Community Kitchens, 38% of respondents indicated that it had increased while 60% indicated no change.

Seventy-one percent of respondents thought that their food safety knowledge had improved since joining Community Kitchens, 45% indicating that it was "a lot better". When asked to identify three things they do to ensure their food is safe, 83% of respondents were able to identify at least 3 ways, such as: making sure the fridge is at the correct temperature, checking the use by date and cleaning hands and area to prepare food.

Social Inclusion

In response to the statement "I feel valued and respected by group members of Community Kitchens", 79% indicated that this was "always" true for them.

Nearly all (98%) of respondents thought that they had increased the number of friendships since joining Community Kitchens. (Only one person did not respond to this question.)

In response to the statement "I enjoy meeting with Community Kitchens members during the session", 81% indicated that this was "always" true for them.

Community Strength

The majority (69%) of respondents indicated they had not participated in other community groups and/or events referred through their Community Kitchens.

2.6.3 Comparative Analysis

Throughout the Pilot Project, project workers observed some differences between Kitchens in rural and metropolitan settings, and between Kitchens with paid facilitators and volunteer facilitators. In order to investigate these speculations, focus groups and phone interviews were conducted with twenty-five facilitators in eight regions of Victoria (three metropolitan and five rural regions[1]), representing half of the Kitchens then operating in Victoria. Ten facilitators were paid and 15 were volunteers. Facilitators were asked about perceived barriers and enablers to operating and sustaining Community Kitchens. The qualitative data collected was analysed and categorised into themes for the purpose of comparison. The results below are also taken from Granados and Murphy's "Community Kitchens Project Report" for Frankston Community Health Service (31).

[1] Metropolitan settings were classified as regions accessible by metropolitan train and tram services: Frankston, Sunshine and Inner Melbourne. Rural settings were: Geelong, Gippsland, Mornington Peninsula, Yarra Valley and Hume.

Metropolitan and Rural Settings: Barriers

The top five perceived barriers for running Community Kitchens were assessed for metropolitan and their rural counterparts (see Table 1). Two barriers were common to both settings: "Kitchen – Facilities" and "Participants – Attendance". These themes reflect challenges in the adequacy of kitchen facilities and equipment as well as levels and consistency of participant attendance.

Table 1: Comparison of top five barriers for Community Kitchens for metropolitan and rural settings

Barriers			
Metropolitan		**Rural**	
Theme	**Frequency**	**Theme**	**Frequency**
Food – Quantity	4	Community opportunities	8
Participants	4	Participants – Attendance	8
Kitchen – Facilities	3	Kitchen – Facilities	7
Support – Dietitian	3	Transport – Public	7
Participants – Attendance	3	Food – Cost	6

"Participants" was the most frequently identified barrier in the metropolitan setting, reflecting general challenges relating to participants (including demographics and composition of the group). Comments related to:

- Limitations of having a defined target group (some miss out);
- Participants lack motivation and are not as eager to participate in other community groups;
- Individual circumstances and struggles faced by participants, i.e. mental illness and social issues.

"Food – Quantity" was the other most frequently identified barrier in the metropolitan setting, indicating the preparation of insufficient meals/serves and not being able to buy in bulk, which may partly be a consequence of inadequate kitchen facilities and possibly due to the problems with participant attendance. Another possible explanation is the number of people in the group, as a larger group hinders bulk food preparation.

"Participants – Attendance" and "Community opportunities" were the most commonly identified barriers in the rural setting, the latter referring to difficulties in providing other opportunities for participants to be involved in the community due to: a small population, insufficient volunteering opportunities, insufficient community connections and Kitchens being seen as an 'endpoint' for participants referred from other groups. Public transport was also identified as a barrier in the rural but not the metropolitan setting, reflecting more limited services. The cost of food was also seen as a barrier in rural settings, which could be explained by higher food costs in rural areas due to food transport issues and less competition.

The other barrier for metropolitan Kitchens was "Support – Dietitian" relating to the level of support required or supplied by dietitians. It was felt that input from a dietitian was vital in conveying healthy eating messages, and that this task requires a lot of a dietitian's time.

Metropolitan and Rural Settings: Enablers

The top five perceived enablers for running Community Kitchens were assessed for metropolitan and rural settings (see Table 2). The responses from each setting were very similar. "Food – Choices" was clearly the most commonly identified enabler for both settings, referring to positive decisions made around food, especially towards healthy choices. Comments related to:

- Using simple recipes that are quick to prepare;
- Selecting healthy recipes, sometimes influenced by people with diet-related chronic disease;
- Using fresh vegetables and fruit;
- Vegetable gardens encouraging the use of fresh ingredients;
- Modifying recipes to make them healthier;
- Learning and using healthy cooking methods;
- Trying a variety of different foods and cuisines; and
- Choosing meals together.

Table 2: Comparison of top five enablers for Community Kitchens for metro and rural settings

Enablers			
Metropolitan		**Rural**	
Theme	**Frequency**	**Theme**	**Frequency**
Food – Choices	10	Food – Choices	14
Participants – Ownership	7	Social – Environment	11
Training – Participants	5	Social – Participant interaction	9
Community opportunities	5	Training – Participants	7
Social – Environment	5	Communication	6

Other enablers common to both settings were "Training – Participants" and "Social – Environment", the former referring to the knowledge and skills acquired by participants, and the latter referring to an atmosphere that encourages and facilitates social interaction, such as:

- Allowing people to step out of their comfort zone
- An open, inclusive and safe environment that allows participants to be themselves
- A comfortable, friendly environment
- Unstructured environment works well, with no pressure to be involved in meetings
- Participants enjoy the company and want to be there
- Allows participants to feel competent and successful
- Food is great common ground for single mums
- Informal teaching works well

Interestingly, "Participants – Ownership" was a frequently identified enabler for the metropolitan setting, indicating that participants are willing to take control of the Kitchen tasks including budgeting, shopping, cooking and cleaning. "Social – Participant interaction" was identified quite strongly as an enabler by rural facilitators, with comments such as:

- Social aspect is the most important aspect of Community Kitchens;
- Participants mingle and care for each other; and
- Participants see each other outside of Community Kitchens (e.g. go back to someone's house to have a social afternoon, do weekend activities together).

These comments show that supportive relationships are being built and this is seen by facilitators in the rural setting as being of great importance.

While "Community opportunities" was identified as the top barrier for the rural setting, it was one of the top enablers for the metropolitan setting, reflecting the greater availability of services and volunteering opportunities.

"Communication" was a frequent response from rural facilitators, referring to communication between participants and between participants and facilitators.

Summary of comparison of Community Kitchens in metropolitan and rural settings

Many similarities were evident in perceived enablers between both metropolitan and rural settings. However there were significant differences between the settings in perceived barriers. Overall, there was a trend for enablers to be related to the three themes comprising the Frankston Pilot Project's goal: healthy eating, social inclusion and community strength. Conversely, the barriers were more likely to focus on the practical and logistical aspects of running a Kitchen, such as transport and food quantity. This suggests that while Kitchens may share a similar philosophy, the setting may dictate the practical obstacles encountered. The opportunities for participants to be involved in their communities make a significant difference to the success of Kitchens. (31)

Paid and Volunteer Facilitated Kitchens: Barriers

Table 3 shows the top five barriers to running a Community Kitchen as identified by paid and volunteer facilitators. Interestingly there were no common barriers identified by both groups.

Table 3: Comparison of top five barriers for Community Kitchens between paid and volunteer facilitators

Barriers			
Paid		**Volunteer**	
Theme	**Frequency**	**Theme**	**Frequency**
Food – Cost	5	Kitchen – Venue	9
Transport – Public	4	Participants – Attendance	8
Food – Quantity	3	Food – Choices	6
Kitchen – Facilities	3	Social – Participant interaction	6
Funding adequacy	3	Training – Facilitators	5

"Food – Cost" and "Transport – Public" were the most frequently identified barriers for paid facilitators. These refer to difficulties experienced relating to the cost of healthy food and budgeting issues, and the poor accessibility of public transport to kitchen facilities.

"Kitchen – Venue" and "Participants – Attendance" were the most commonly identified barriers for volunteer facilitators. The former shows the challenges in securing appropriate venues in which kitchens are located, including their adequacy, availability and level of sharing. This may be due to these Kitchens being less likely to be linked with organisations that provide adequate kitchen venues or facilities. The latter refers to the level and consistency of attendance by participants. Kitchens with volunteer facilitators often rely solely on participant contributions towards the cost of ingredients, therefore consistent attendance is of high importance to ensure adequate cash flow. (31)

Interestingly, "Funding adequacy" was identified as a barrier only by paid facilitators. Presumably this is due to the increased funding requirements of having a paid facilitator.

"Social – Participant interaction" was identified as a barrier only by volunteer facilitators. This may be due to volunteers having less experience or training in supporting participants with special social, mental or learning needs than paid facilitators who may already be working with the target group. This notion is supported by volunteer facilitators also identifying "Training – Facilitators" as a barrier, indicating that they are aware they could benefit from further training to more effectively interact with the diverse participants. (31)

Paid and Volunteer Facilitated Kitchens: Enablers

There was great consistency in the most commonly identified enablers to running a Community Kitchen according to paid and unpaid facilitators (Table 4 shows the top five enablers for each group). Both groups share the same top four enablers, albeit in a different order.

Table 4: Comparison of top five enablers for Community Kitchens between paid and volunteer facilitators

Enablers			
Paid		**Volunteer**	
Theme	**Frequency**	**Theme**	**Frequency**
Food – Choices	9	Community opportunities	14
Social – Participant interaction	7	Social – Environment	14
Social – Environment	6	Food – Choices	12
Community opportunities	4	Social – Participant interaction	12
Participants – Ownership	3	Food – Ownership	9

While all four themes were identified almost equally by volunteer facilitators, paid facilitators most frequently recognised "Food – Choices" (explained above under 'Metropolitan and Rural Settings: Enablers').

The other top enablers were "Social – Participant interaction", "Social – Environment" (both of which are explained above in 'Metropolitan and Rural Settings: Enablers') and "Community Opportunities" (explained above in 'Metropolitan and Rural Settings: Barriers').

"Food – Ownership" represents comments on participants' attitudes towards the food they are preparing, including recipe choices as well as the role they take in shopping and cooking.

Summary of comparison of paid- and volunteer-facilitated Community Kitchens

This analysis suggests that volunteer and paid facilitators share the same enablers, but face very different challenges. The challenges faced by volunteer facilitators tend to be related to participants (their attendance, interaction and food choices) while paid facilitators tend to face challenges that are more structural in nature (e.g. food cost, public transport, kitchen facilities and funding).

The enablers identified by paid and volunteer facilitators again focused on how the Kitchens were meeting the objectives of healthy eating ("Food – Choices"), community strength ("Community opportunities") and social inclusion ("Social – Participant interaction" and "Social – Environment"). This indicates that facilitators address these three themes regardless of their salary status. (31)

3 Enablers for Sustainability

3.1 Community Ownership

Since its inception, the wider community has been involved in developing and delivering the Community Kitchens project. The community information forum held in early 2004 brought together community members and representatives from organisations and community groups to discuss the merits of Community Kitchens, possible target groups and the direction the Project should take. Consistent community involvement has helped to develop a sense of ownership of the project within the community.

Facilitators and participants are involved in decision-making in their own groups. Over time many groups have changed the structure of their Community Kitchen sessions to better suit the group, demonstrating not only their sense of ownership and creativity, but also the flexibility of the model. Feedback from facilitators and participants shapes not only individual Kitchens, but also the project as a whole. The good rapport built between project workers and facilitators/participants enables this vital feedback to occur, ensuring that the needs of the community are being met.

Local organisations and community groups have readily adopted the Community Kitchens model. The process often begins with an enthusiastic 'project champion' within the organisation. Although project workers generally assist workers in gaining management approval and providing advice in the early stages of Kitchen development, these Kitchens tend to require minimal input once established. Some operate almost completely independently of Frankston Community Health Service. Such ownership by project partners greatly enhances the sustainability of these Kitchens.

3.2 Community Partnerships

Community Kitchens has sparked the interest of, and commitment from, a broad range of groups and organisations both within and outside of the traditional health sector. It is thought that the high level and breadth of interest may be attributable to the community development principles on which it is based, the holistic approach with wide-ranging benefits and the current emphasis on preventative approaches to healthcare.

The model is based on partnerships with organisations and community groups that may: provide kitchen facilities (and pay overhead costs such as electricity and gas and cover public liability insurance); provide facilitators; promote Community Kitchens to clients; refer participants; donate produce or offer discounted food; subsidise the cost of ingredients; provide transport for participants; offer student placements; and be involved in committees (e.g. reference group, working groups).

Partners of the Frankston Community Kitchens Pilot Project have included: state government departments, local government, non-government and not-for-profit service organisations and programs from a range of sectors including health, welfare, community, disability, employment and education. Partnering organisations include the Brotherhood of St Laurence, Anglicare, Peninsula Youth and Family Services (Salvation Army), Menzies Inc., Mornington Peninsula Youth Enterprises, local churches, neighbourhood houses, senior citizens groups and private businesses. Local programs that have partnered with Frankston Community Kitchens have included a community breakfast program, Connecting the Pines Project, the Frankston Men's Shed and the Food for All project. The large number of partners has assisted in the promotion of the project through "word-of-mouth".

The Peninsula Care House is one example of a partnering organisation that has readily adopted Community Kitchens. The Care House is affiliated with a church and has operated three different Kitchens. Community Kitchens have thrived in this organisation due to its commitment to the concept, the pre-existing systems for other programs, the contact and rapport between the organisation and the participants and word-of-mouth promotion between participants.

Two local churches have been providing emergency food relief to individuals and families in their locality. They saw the Community Kitchens model as an opportunity to reorient their practice from the traditional welfare model towards a more empowering approach. Similarly, several disability services who were conducting cooking classes for their clients have turned to Community Kitchens for a more holistic approach.

Involvement in Community Kitchens has also been a catalyst for connecting partners with each other. For example, the disability services are now linked in directly with the local community gardens project.

Project workers were contacted by the owner of a restaurant on the Mornington Peninsula who offered her facility for use by Community Kitchens and her help with food safety training. Project workers supported the establishment of the first Kitchen in this facility, however it is now co-ordinated by Peninsula Community Health Service. This is the first local example of private enterprise becoming an integral project partner.

The Frankston Men's Shed has become a valuable project partner. The Men's Kitchen was relocated from Frankston Community Health Service to the Men's Shed facility which offers a more welcoming and casual environment for this group. The co-ordinator of the Men's Shed plans to incorporate other health-related programs including healthy supermarket tours and plans to construct a vegetable garden onsite, which will be a valuable addition to the Community Kitchen.

3.3 Community Kitchens Network

The Frankston-Mornington Peninsula Community Kitchens Network evolved out of the Reference Group and Facilitators' Network to provide an opportunity for facilitators and workers to network, share ideas and assist one another. It was renamed to better reflect the membership which included not only facilitators, but members of the original Reference Group (including managers and staff of partnering organisations). Since many of the project partners are also involved in Community Kitchens on the Mornington Peninsula, and since the project workers had supported the establishment of Kitchens on the Peninsula, it seemed logical to collaborate with this region through the Network.

The Network has facilitated: better connections between project partners; discussion around evaluation and sustainability measures; ownership of the project by partners; support for Kitchens; a review of materials and resources; and the generation of innovative solutions to common challenges.

Members of the Network expressed a need for more social opportunities between Kitchens and more experiential learning opportunities for participants. The result was a basic skills workshop run by a project partner with culinary training, and included cooking demonstrations by several Kitchen groups (such as 'how to microwave vegetables' by a group of young people with disabilities), which was attended by participants from six Kitchens. Feedback was very positive and attendees identified future training needs.

3.4 Promotion

While the Community Kitchens concept was heavily promoted initially, ongoing promotion has not been necessary. Thus the exponential growth that occurred towards the end of the funding period is not a result of heavy promotion by project workers. The partnerships created in Frankston have helped to spread the concept, as many of these organisations are state- or nation-wide and have used their own communication channels to promote Community Kitchens.

In May 2005 the Project Manager conducted a workshop entitled 'How to Set Up Community Kitchens' at the National Dietetics Conference held in Perth. This proved to be an effective promotional tool, raising the profile of the Community Kitchens model with nutrition professionals around Australia and resulting in new Kitchens commencing in several communities. Notably there were key 'champions' in each of these areas, advocating for Community Kitchens and forming partnerships.

The Project Manager also provided an opportunity for people to participate in a typical Community Kitchen session to develop their understanding of how a Kitchen operates and to experience cooking with strangers. This workshop was quickly oversubscribed and seven more were scheduled, both in Frankston and around Victoria.

Community Kitchens were promoted through the print media and radio. An article in 'The Age' newspaper in October 2004 generated a great deal of interest. Other publicity channels included: local newspapers in Frankston and the Mornington Peninsula; Peninsula Health publications; local radio on the Mornington Peninsula; Dietitians Association of Australia publications; Department of Human Services publications; local church newsletters; local health expos for seniors; and a desktop calendar for seniors in the local area.

The Australian Community Kitchens website developed as part of this project constitutes a central repository of information on Community Kitchens. It has attracted much interest from the broader community, despite being underutilised by participants of Frankston Kitchens. A tracking system shows that the website is viewed largely during business hours.

Project partners have championed Community Kitchens in creative ways. The Peninsula Care House held a barbecue for the affiliated church and the wider community. The sole purpose was to raise awareness and advocate for the Community Kitchens being run through the organisation.

Many self-referrals were received, demonstrating that local publicity attracted the attention and interest of community members. Referrals also came from more than 30 different organisations in Frankston and the Mornington Peninsula, and more than 200 enquiries were received from organisations based outside of the Mornington Peninsula, demonstrating that the project is widely known across the state.

3.5 Volunteers

The Frankston Community Kitchens Pilot Project would not be as successful without committed volunteers. Their willingness to take on tasks and assist in any way they can is invaluable. Many work beyond their specific roles and provide practical assistance at all Community Kitchens functions. Their contribution to the project promotes community strength and has allowed the Project Officer to focus on other tasks.

Using volunteers in the promotion of the concept has proven effective in gaining the support and trust of potential partners. Several participants have voluntarily spoken at Community Kitchens functions with first-hand experience and passion for the project,

grabbing the attention of the audience in a way that paid workers cannot. Passionate participants share their personal stories and come from a different viewpoint. The enthusiasm of volunteers has often been the "clincher" that sold the concept to the audience.

Several facilitators, volunteers and kitchen hosts spoke of their involvement in the project at the first anniversary celebration. As well as giving them a sense of pride and achievement, it served as a reminder of how important it is to have community members as enthusiastic about the concept as the project workers.

3.6 Resource Development

Several resources have been developed for parties wishing to know more about Community Kitchens or set up their own Kitchens. These resources include: a comprehensive manual detailing how to set up and run Community Kitchens; a promotional and explanatory video and DVD; a budgeting pocketbook; a facilitators' manual; and a participants' folder. All of these resources and many more documents are available to download from the Community Kitchens website.

Together with workshops and introductory forums held throughout Victoria, these comprehensive resources have enabled project workers to build the capacity of workers in other regions to develop new Kitchens. This has facilitated the spread of Community Kitchens across the state without reducing the capacity of the project workers to attend to the Frankston Pilot Project.

These resources are not static. The manual has been revised several times to reflect new findings and changes in practice and most resources have been developed or revised based on feedback from participants and facilitators. A manual specifically for facilitators was developed in response to a discussion at a Community Kitchens Network meeting about how to address the difficulty in obtaining regular data from facilitators.

3.7 Skilled Facilitators

Good facilitation is a key enabler for successful Kitchens. Facilitators play an important role which requires a diverse skill base, thus it can be useful to have more than one facilitator for each group. Co-facilitation not only increases the likelihood of all skills being covered, but it also lightens the load for both facilitators.

Facilitators require good communication, interpersonal, organisational and group facilitation skills. Cooking skills are not a prerequisite. Facilitators may require a calm temperament and patience to encourage participants to engage in the Kitchen processes and to get along with each other.

3.8 Flexibility of the Model

While the three distinguishing features of a Community Kitchen (active participation, financial contribution and no sale of food) are fixed, decisions regarding the details of format and structure are left to the groups. The structure of individual Kitchens has evolved over time, with some common patterns emerging. Most of the early Kitchens held separate planning and cooking sessions. As time went by the groups became more comfortable with the processes and more confident in their cooking, so combined planning and cooking into the one session (cooking followed by planning for the following session). All groups that were meeting fortnightly have changed to meeting weekly so they can take home food more often. Many groups are now having a recipe selection day, where recipes are chosen for up to ten weeks in advance. This seems to

save time as participants are not always motivated to choose recipes for the following week immediately after cooking.

The Staff Kitchen was initially run after work, however the participants found this made their day too long, and this also prevented more people from attending. After a break of some months, this Kitchen re-opened at lunchtime. An allocated time period of one hour forced the group to 'keep it simple' by cooking one quick and easy recipe each session and limiting the number of serves ordered to avoid lengthening the cooking time and to allow time to share the meal together.

The Koori Kitchen in Frankston had inconsistent and poor attendance. The facilitator and participants suggested that it be relocated to combine with weekly art classes in Hastings. Hastings has a larger Koori population and existing community groups, including the art classes that were well attended. It was also felt that transport and recruitment of new participants would be easier in this location. This transfer occurred and resulted in better attendance, and the Kitchen is now overseen by the Mornington Peninsula Community Kitchens co-ordinator.

4 Challenges for Sustainability

4.1 Working with Participants with Complex Needs

While Community Kitchens in Frankston target a range of population sub-groups, many participants have complex needs. Most are on low incomes and a high proportion of participants receive government benefits due to physical and/or psychiatric disabilities. Many participants also live alone. Some Kitchens have required more intensive support from project workers or other organisations due to the mental illness and/or difficult social or economic circumstances experienced by their participants. Where possible, links were established with relevant organisations to help support the development of these Kitchens. Below are some examples of Community Kitchen target groups with special needs and the challenges faced.

4.1.1 Youth

The Youth Kitchen was one of the first started up in Frankston. Partnerships had been established with the youth organisations in the community, all of which contributed funds to subsidise food costs. A variety of young people attended for several months, including homeless youth. However attendance was inconsistent and often low as it was difficult to get the young people to the Kitchen on the right day and at the right time. Since it was close to Christmas, the decision was made to suspend the Kitchen until the following year. A plan was developed which included talking to social workers in the local schools, following up more closely with referrers and reviewing the strategy with partners. However, shortly thereafter, both facilitators could no longer continue and replacements were not found, so this Kitchen never re-opened.

4.1.2 The Koori Community

A Koori Kitchen was another of the first Community Kitchens in Frankston. This group also experienced challenges with attendance. As most of the participants did not have their own transport, the Peninsula Health Koori Access Worker was driving long distances to collect people and was therefore often late. The Koori Access Worker later left the organisation, leaving project workers to contact others in the community who may have links with the Indigenous community to continue the Kitchen.

Inconsistent attendance made it extremely difficult to be accurate with planning sessions, which presented problems for shopping and recouping costs. The format was therefore changed to allow planning and cooking on the same day, with recipes adapted according to numbers attending on the day.

4.1.3 CALD Groups

Several organisations in the municipality that work with culturally and linguistically diverse (CALD) groups felt that a Multicultural Community Kitchen could greatly benefit their clients. Project workers subsequently partnered with local government and a local employment training organisation to form a working group. Initially it was difficult to explain the Community Kitchens concept to non-English speakers, so they were invited to attend a cooking session. This was very well received.

Although this Kitchen did not get off the ground immediately due to staff turnover, project workers later established a working group with Skills Plus (an employment training organisation), New Hope Migrant and Refugee Centre, Brotherhood of St Laurence and Centrelink to start a Multicultural Kitchen for newly arrived migrants and

refugees. Since the facilitation of this Kitchen required more work and specialised skills (such as cultural sensitivity), a paid facilitator was employed for a fixed term. The facilitator frequently visited the English classes held at the employment training organisation, building a rapport with the students. This proved to be an effective way of recruiting participants and soon there were two full groups of people from a range of cultural backgrounds. Participants were from Sudan, Sierra Leone, India, Korea, China, Turkey, Germany, South East Asia and the Middle East.

Due to the language barrier, all parts of the planning and cooking sessions took longer than in other Kitchens. A visual flip-chart was created to familiarise the participants with foods commonly consumed and their origins, and lots of gestures and actions helped with communication.

A local women's health organisation became involved in the working group. After the facilitator's fixed term came to an end, Frankston Community Health Service successfully handed over both Multicultural Kitchens to this organisation which now auspices the Kitchens and has continued the employment of the facilitator.

4.2 The Application of Community Development Principles

The community development principles upon which the Community Kitchens model is based are often unfamiliar to community members and can be difficult for them to grasp. A misconception amongst some participants is that a Community Kitchen is an organised cooking class, rather than a group that is owned and run by its members. The out-workings of such a view is that participants do not fully understand their responsibilities, i.e. commitment shown through consistent attendance and participation in all planning, cooking and cleaning processes. Without consistent attendance, accurate menu planning, budgeting, payment and shopping are impracticable and the participation of every group member to the best of their ability is important for smooth functioning of the group.

Two Kitchens were particularly troubled by inconsistent attendance due to these misunderstandings. Attendance fluctuated between two and 11 participants in one Kitchen. The large membership prevented the Project Officer referring new participants into the group, despite the actual attendance often being low.

To address this problem, the facilitator and Project Officer contacted every member to determine their willingness and ability to commit to the group. Guidelines for participation were drawn up and given to all new and existing members to ensure that all participants understood their responsibilities from the outset, primarily focusing on consistent attendance and participation. An induction package was also developed for participants, outlining the Community Kitchens philosophy, general information and what is required of participants.

4.3 Recruiting and Retaining Facilitators

Due to the needs of the participants involved in the Frankston Kitchens (e.g. limited literacy, mental illness, lack of transport, reliance on pension), most Kitchens require substantial leadership by facilitators, including taking responsibility for all documentation, shopping, financial management and reminder calls and providing heavy support during the cooking process. This is a lot to expect from a volunteer and requires a diverse skill set.

The original sustainability plan involved succession planning – i.e. facilitators training up at least one other group member in facilitation – however participants have generally

been unwilling to step into this role or take on more responsibility. Below are some examples of Community Kitchens that have suffered through poor access to facilitators and which highlight the importance of the role.

- The Men's Kitchen was run at Frankston Community Health Service for almost three years by the same volunteer facilitator, and no other potential facilitators were found in the group. It was hypothesised that the participants viewed their Kitchen as a program run by the project workers for them, rather than truly owning their group. One strategy employed to encourage ownership and responsibility was to get each participant to take on a different task. This had some success, however the group still required the Project Officer to deal with some of the more difficult tasks such as conflict resolution. The Project Officer continues to co-facilitate this group.
- The Young Mums' Kitchen was suspended when the two peer facilitators (also sisters) moved out of the area and could no longer attend. A number of the participants who were friends with them decided not to continue the Kitchen without them, thus the Kitchen closed.
- A minimum of two facilitators were required for the Youth Kitchen to supervise the participants. The Youth Kitchen had been operating for several months before one volunteer was unable to continue and a second volunteer was forced to quit due to ill health. As replacement facilitators could not be found, this group folded and never re-opened.
- The Mahogany Kitchen has operated for more than three years with the same committed volunteer facilitator. This facilitator has experienced some ill health during this period, occasionally causing the sessions to be cancelled if the Project Officer could not attend in his place. On several occasions dates were changed without all group members being notified. This inconvenience and the subsequent long wait before the next session (as this Kitchen was meeting fortnightly) led several of the participants to leave the group. The project workers have been unsuccessful to date in seeking a co-facilitator to lighten the load and participants have not been willing to assume this role.

The Community Kitchens Network provides opportunities for facilitators to share successes and challenges with fellow facilitators in a supportive environment. This ongoing support for facilitators is vital as they undertake what is sometimes a very difficult task.

4.4 Reliance on Volunteer Facilitators

For the first two years the Pilot Project relied heavily on volunteers for the success of individual Kitchens, and some were threatened by volunteer fatigue. This appeared to be an issue particularly for Kitchens with only one facilitator. The results were poor record-keeping, mismanagement of funds, issues with group dynamics and poor recipe choices leading to sub-optimal meals. One solution employed was to emphasise the sharing of responsibilities amongst the group by allocating tasks to all members.

Reliance on volunteers can create some issues with their capacity to undertake the required tasks. For example, facilitators without training in health or welfare may struggle to understand the issues faced by some of their participants and how these influence the way they behave in the Kitchens; some volunteers are not interested in participating in Network meetings or training; and some do not have the organisational or financial management skills required to run the Kitchen smoothly. These deficits lead to an increased reliance on project workers for support and raises issues with

sustainability. In light of this, the facilitator training methods were reviewed and more regular and comprehensive training is conducted to equip new facilitators before their Kitchen commences and to refresh existing facilitators.

To overcome the issue of over-reliance on volunteers, a strategic change was required. About two years into the project it was decided that all new Kitchens would require a worker and support from an auspicing organisation. When the role of supporting a Community Kitchen (through facilitation or simply being available if needed) is embedded within a worker's job description, the Kitchen can operate more independently from project workers. Such support from an organisation has been identified as an essential element for sustainability of Community Kitchens.

4.5 Securing Appropriate Kitchen Facilities

While most of the Frankston Kitchens have secured kitchen facilities free-of-charge relatively easily through the community organisations hosting them, this task can sometimes be a challenge. The Multicultural Kitchen was established for newly arrived migrants and refugees. The only organisation on the working group that was able to offer kitchen facilities was the Brotherhood of St Laurence, which owned a brand new commercial kitchen near the centre of Frankston.

Just prior to the launch of the Multicultural Kitchen it was discovered that participants would be required to complete specific cleaning and occupational health and safety training in order to use this facility. The working group members agreed that this would be too difficult for new arrivals with limited English. For over a month the Project Officer sought alternative venues but obstacles were encountered such as public liability issues, bonds and high venue hire fees. Some time later the partnership with Brotherhood of St Laurence was revisited and negotiations resulted in only the facilitator and volunteers being required to complete the training, thus the Multicultural Kitchen operated from this facility.

Some project partners believed that a commercial kitchen facility may not be an appropriate environment for new arrivals, thinking that a kitchen that more closely mirrored their home environment would be more suitable in developing transferable skills. Conversely, other partners believed that a commercial kitchen is an ideal environment, offering pathways to further training and employment opportunities. This argument is especially relevant given the significant unemployment issue for this target group.

The high level of interest and good attendance at the Multicultural Kitchen led to the group splitting into two groups that met on alternate weeks. Despite this successful engagement of the target group, the lack of childcare facilities at the Brotherhood of St Laurence kitchen site was a barrier to some parents attending. When Women's Health in the South East joined the working group and became the auspicing agency, they decided to relocate the Kitchens to a local church that could provide childcare.

4.6 Data Collection

Collecting qualitative data in a method appropriate to the target group was a challenge. Groups that had a high turnover of participants or low literacy levels proved the most challenging. In these cases, facilitators were asked to complete a survey on behalf of the group. While this method has its limitations (i.e. relying on facilitators' observations and opinions rather than the participants' perceptions, and obtaining one overall response rather than many individual responses), it enabled the collection of some valuable data.

Approximately two years into the project, the Project Officer took a more remote role in individual Kitchens to support community ownership and sustainability, and referrals began to be made directly to some Kitchen facilitators. Thus she no longer knew all the participants and had fewer opportunities for informal observational insights into the workings of each group.

Collecting information regarding attendance, meals cooked and meal cost often required repeated reminders to facilitators. The Network felt that being able to enter this data online would remedy this situation. However the launch of the website enabling online data entry did not see a great improvement and some facilitators experienced network security-related problems that prevented its use. Further consultation with the Network resulted in a return to hand-written reports through the development of a new Facilitators' Manual which included a basic reporting template to be completed on-the-spot at each Kitchen session. This method resulted in greater compliance.

The online discussion forum, to which facilitators are encouraged to share ideas, stories and advice, was intended to assist in gathering qualitative information about the successes and challenges for each Kitchen. However this website feature has not been well utilised by facilitators.

4.7 Time and Capacity Limitations

Throughout the Pilot period many enquiries (235) were received from throughout Frankston, metropolitan Melbourne, regional Victoria and, more recently, Australia. Responding to enquiries was very resource- and time-intensive in the early stages of the project and was limiting the resources available to support the Frankston Pilot Kitchens. The decision was made for the Project Officer to prioritise support for the existing pilot Kitchens (and delay starting up new Kitchens), while the Project Manager worked on resources to assist others in setting up Kitchens. As a result the project workers were better resourced and experienced with the pilot Kitchens to assist others to set up Kitchens.

Later the Project Officer was again stretched with the volume of work, as much of her time was spent facilitating Kitchens and dealing with some of the participants' personal issues that were impacting on their involvement in the Kitchens. The solution to this was to direct efforts towards building the capacity of organisations to facilitate their own Kitchens rather than facilitating them herself.

4.8 Conflict

The Frankston Community Kitchens have attracted people with a wide variety of personalities from quite disadvantaged backgrounds, many of whom have a mental illness, so undertaking a co-operative process such as menu planning, cooking and cleaning sometimes leads to disagreements. One Kitchen in particular has been plagued with interpersonal issues between participants, and measures were needed to prevent these disagreements escalating to open conflict.

The project workers' response to this challenge was twofold. Firstly, basic behavioural standards agreed upon by the group were incorporated into the group guidelines for each Kitchen. These standards are made clear to all newcomers and signed by all participants. Secondly, group facilitation training for facilitators (and interested participants) was developed and included conflict resolution strategies.

Participants' social skills are sometimes lacking, requiring an ongoing and concerted effort on behalf of all participants and facilitators to understand and accept participants and their idiosyncrasies. One facilitator who comes from a corporate background is

very task-focused and time-pressured. This approach does not work well for people who need to undertake tasks in a time and fashion appropriate to their condition. Some participants of this group have displayed little tolerance of others' difficulties. As such, there has been ongoing tension in this group. Group facilitation training (incorporating working with people with mental illness and disabilities) for the facilitator resulted in little change. The next step was to work with individual participants who were particularly dissatisfied with the group to identify specific issues that could be addressed. The counselling team at Frankston Community Health Service was engaged and participants were encouraged to adopt strategies to deal with their anxiety and frustration in the Kitchen with the hope that outward tension may be diffused. A co-facilitator was found for the short-term with a background in health and welfare. Her strengths in group facilitation, interpersonal communication and community development complemented the original facilitator's strengths in organisation. This Kitchen is now co-facilitated by the Project Officer.

4.9 Childcare

Several aspects of the Community Kitchens model are subject to legislative regulations. While most of these have been relatively easily settled and are covered by Community Kitchen guidelines (e.g. food handling, public liability, first aid, occupational health and safety and working with volunteers), the issue of childcare has not been fully resolved. While some guidelines do exist (e.g. qualified child carers not required for less than five children under six years of age in the absence of parents or guardians), other boundaries are not so well defined. As such it has been difficult to develop guidelines and policies concerning childcare and to advise others of the implications of the law as it relates to Community Kitchens. This aspect of Kitchen functioning necessitates further investigation and expert legal advice.

4.10 Divergence from the Philosophy

Two of the Kitchens have moved away from the core philosophy of "participation by all group members in all processes". The first is the Koori Kitchen. The relocation of this Kitchen and its link with the Koori Art Class did not improve participation rates as much as hoped. Most attendees are Koori workers and one participant tends to be the key decision-maker. The meal is then distributed to all attending the art class, making it more similar to a catering service. The workers have a good understanding of the Community Kitchens philosophy, however the group does not wish to operate in this way. This mismatch of purposes may reflect insufficient community consultation at the beginning. In cases such as this the group members' wishes are respected and the Community Kitchens model is never forced on a group.

Another Kitchen has also sometimes struggled with full participation, with some participants preferring to sit back rather than get involved in the meal preparation and cleaning. The Project Manager reviewed the group guidelines with the group and emphasised the importance of participation. Together the group members discussed and reworked the guidelines, with all individuals signing off on them. This process led the project workers to recognise the importance of introducing group guidelines to new participants.

5 Lessons Learned

5.1 Fostering Community Ownership

Building a sense of community ownership is vital not only to the short-term effectiveness of the project, but also to its sustainability. Community members and partnering organisations alike must feel that Community Kitchens meet their needs, that their role is important and that they have control over the direction of their Kitchen(s). Project workers have tried to foster this sense of ownership in participants and organisations alike through: building relationships, showing trust and respect, communicating well and involving participants in decision-making.

For project workers, establishing a sense of ownership in community members has entailed:

- Spending time developing a strong rapport with participants – remaining non-judgemental and always being respectful.
- Inviting community members' involvement on all committees, giving them responsibilities and inviting their input to decisions.
- Ensuring that the decisions made in each Kitchen (e.g. in relation to format, group rules, recipe selection, problem solving and task delegation) are made by the participants themselves.
- Encouraging participants to undertake voluntary roles in the project, allowing them to develop their skills.
- Having regular social activities and celebrations to bring all Kitchen groups together.

For project workers, fostering a sense of ownership in partnering organisations has involved:

- Spending time developing relationships with workers that extend beyond Community Kitchens.
- Understanding partnering organisations' motivation for involvement.
- Being open to partners' suggestions and ideas – the flexibility of the Community Kitchens model enables this.
- Being reliable and communicating openly and regularly.
- Promoting partners' involvement in media releases and promotional materials.

5.2 Embedding Community Kitchens within Organisations

Experience has shown that many disadvantaged groups are not able to be completely autonomous. There are tasks that require quite a high level of functioning, such as helping to integrate new members into the group and completing documentation. One solution to this challenge is to have people of varying levels of cognitive competence in each group so that these more challenging tasks can be undertaken. It appears that there will always be a need for a co-ordinator for Kitchens that are peer facilitated and not supported by an organisation. Several of the Frankston Kitchens are in this category and when a facilitator leaves or is ill, the Project Officer is required to step in.

Alternatively Kitchens can be supported by, and embedded within, community organisations. Kitchens supported by organisations have generally proved more successful and sustainable. If a non-peer facilitator is required, a worker may take on this role and have it included in their job description. Workers know their target group, which assists in building relationships and coordinating groups. Organisations may also be able to assist with transport or food costs. Ideally, Community Kitchens will be able to use kitchen facilities located within an organisation, as these are usually accredited and insured.

Organisations taking ownership of their Kitchens has enabled project workers to spend more time on administrative, promotional and capacity building tasks, such as developing resources and supporting the development of new Kitchens.

5.3 Sustaining Individual Community Kitchens

It was originally thought that each Community Kitchen would be permanent or long-term, however the Frankston Pilot Project has demonstrated that this notion may be unrealistic as circumstances can, and do, change (e.g. volunteers, staff, funding). While ten of the Frankston Pilot Project Kitchens continue at the time of writing (including four of the original six), four have closed, one has relocated to a neighbouring municipality and one has merged with a continuing Kitchen.

Individual Community Kitchens are now considered to have a lifespan. A lifespan of 2-3 years for a Kitchen supported by an organisation seems reasonable. The overall number of Community Kitchens in a region may be a better measure of sustainability than longevity of individual Kitchens.

The reasons for Kitchen closure vary. Kitchens embedded within organisations have proven more sustainable, however even some of these Kitchens have closed. The Special Dietary Needs Kitchen closed as group members felt that their needs had been met. One Kitchen merged with another (that was meeting on alternate weeks and had some of the same participants) to allow more frequent cooking and more consistency for participants. Others have closed for reasons such as: illness in workers' family members, participants leaving due to illness, or lack of initial community consultation.

5.4 Participant Pathways

Along with long-term Kitchens, the initial Community Kitchens concept included long-term involvement by participants. Although the average length of participation is not known, some participants have continued their involvement for more than two years. While this demonstrates enjoyment and satisfaction, such long-term involvement reduces the places available for new participants and therefore limits the potential reach into the community. Project workers now think of Community Kitchens as being one step along a 'pathway' rather than the destination.

The P.A.S.T. Kitchen, which has a primary focus on skill development, finds it useful to register participants on a term-by-term basis. This enables the facilitator and participants to identify learning goals at the beginning of each term and assess whether they have been achieved at the end. The Frankston Men's Shed has a similar practice of reviewing the progress of each participant towards their goal and referring participants to other programs when it has delivered all desired benefits. Since its relocation to the Men's Shed, the Men's Kitchen will implement a similar strategy.

Participants are now encouraged to set short-term goals for themselves. These goals may relate to cooking skills, nutrition knowledge, social skills, confidence, budgeting skills, or any other outcome sought. These goals can be seen as steps along a particular

pathway, for example a skill development, healthy eating, food security or social inclusion pathway. Once Community Kitchens can no longer assist participants to progress any further, participants will be referred to other programs or opportunities in their community that can assist with this.

Evaluation results showed that participants join Community Kitchens for a variety of reasons but in some instances, they feel that the group is not addressing their needs. This finding spurred the project workers to hold discussions with each Community Kitchen, asking participants and facilitators to identify the main purpose of their group, e.g. socialisation, skill development or healthy eating. The participant registration form now asks for the reason for joining. This information can be used to match the participant with a Community Kitchen appropriate to their needs.

5.5 Developing Partnerships

The Community Kitchens model relies heavily on partnerships with community groups and organisations, thereby limiting the need for external funding. Partnerships can be initiated by extending invitations to introductory forums to a range of organisations and groups (e.g. public and private sectors; health and non-health sectors; community groups concerned with food security, social inclusion or community strength). Attendance by people with varying fields of expertise and resources helps to facilitate timely partnership development. The success of the Frankston Pilot Project is partly due to involving many people and organisations in the developmental phase.

5.6 Promoting the Concept

Promotion by word-of-mouth has been very successful in Frankston. The Project Manager began by promoting the concept through her existing networks and contacts. The idea tends to "sell itself", so others become advocates too.

When promoting Community Kitchens, it should be emphasised that they are for all people and not just for disadvantaged groups. This view reduces stigmatisation and recognises that all people can benefit from participation. Catchy names for Kitchens, such as "Slice'n'Dice", "Strong & Spicy" or "Chop & Chat", also help to attract potential participants and reduce the possibility of stigma.

It is important that Community Kitchens are not promoted primarily as cooking classes, as this may be a deterrent for many. Evaluation results show that lifestyle changes can and do occur without a formal education component for participants.

5.7 Recruiting Facilitators

Facilitators do not require any qualifications or experience, but they should be committed to the philosophy, be good communicators, be tolerant of others and not be overpowering or intimidating to other participants. Although it can be difficult to get community members to take on the role of facilitator, it is important not to push them before they are ready. Instead, develop their skills and confidence until they are ready.

Running workshops for facilitators around food and kitchen safety, nutrition, budgeting and group facilitation is important to ensure safety and to maximise the health outcomes for participants. Facilitators should be encouraged to pass the information learned in the workshops on to participants in their Kitchens informally.

6 Conclusions and Recommendations

Since late 2004, a flexible and innovative Community Kitchens model has been devised based on intersectoral community partnerships. Piloted in Frankston, the project has successfully engaged a wide variety of target groups in addition to organisations and community groups. The Pilot Project has met its objectives around the themes of promoting healthy eating (including improved food security), social inclusion and community strength in the Frankston community. Other outcomes for participants include improvements in self-confidence, mental health and opportunities for education and employment.

The model has been developed and refined to support sustainability, achieving this goal through community ownership and strong partnerships, but requires ongoing support, capacity building, resource development and co-ordination.

Not only has the model been successfully and effectively implemented in Frankston, but it has been readily adopted throughout Victoria, with the number of Community Kitchens growing exponentially in 2007. The Frankston Community Kitchens Pilot Project team has thus far supported the state-wide roll-out through consultancy and resourcing.

Community Kitchens has the potential to be an effective and successful national health promotion program. The maintenance and continued expansion of Community Kitchens in Australia will require ongoing funding for training, revision of current resources such as the website and manual, strong leadership and co-ordination.

It is recommended that:

- Ongoing funding be provided to continue training of co-ordinators and facilitators, maintain the Australian Community Kitchens website and revise current resources.
- Community Kitchens throughout Australia be centrally co-ordinated to lead, consult and support the project's maintenance and expansion.

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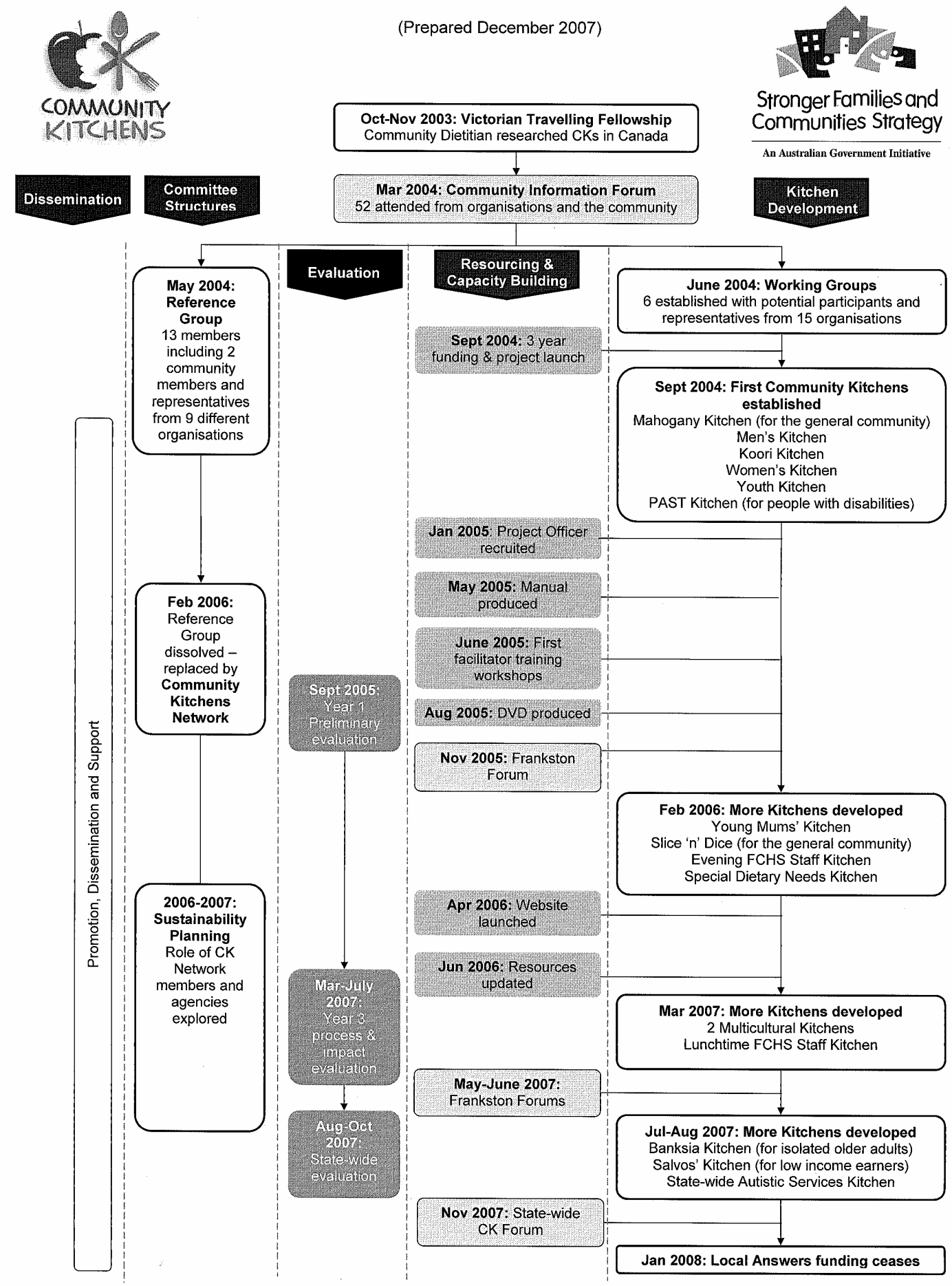
Appendices

Appendix 1: Project Timeline

Appendix 2: Evolution of Program Planning Framework

Appendix 1: Project Timeline



Appendix 2: Evolution of Program Planning Framework

The following pages show the development of the goals and objectives for the Frankston Community Kitchens Pilot Project. The modifications reflect learnings, changeover of project staff and the decision to make the project goal broader.

May 2004

Target Group: Community Kitchen participants and their families in the City of Frankston.

Goals

1. To improve motivation and capacity to prepare and cook nutritious and affordable meals.
2. To enhance sense of community in all program members.

Objectives

1. To upskill 80% Community Kitchen participants', knowledge about nutrition and health in twelve months of involvement or at voluntary completion of the program
2. Create an environment that supports role modelling among participants and / or participants and their families, in all Community Kitchens within 12 months.
3. Reduce perceived barriers to Community Kitchen participants in accessing an affordable, good quality food supply by 30% within 12 months
4. To reduce the number of participants who report time as a barrier in preparing healthy foods, by 30% after six months in the program or at voluntary conclusion.
5. Increase social networks of participants in Community Kitchens by 10% within 6 months of involvement in Community Kitchens
6. Create at least 3 multi-organisation partnerships for each Community Kitchen, within 12 months.

June 2004

Goals

1. Promote enjoyment and develop capacity in participants to prepare and cook nutritious and affordable meals.
2. Enhance the sense of community in all program members.

Objectives

1. Create a supportive environment for participants to learn new recipes, share cooking skills & nutrition information.
2. Create a fun environment for people to cook and make new friends.
3. Reduce the time pressures on individuals and families to prepare meals at home.
4. Reduce costs associated with preparing fresh, healthy meals for individuals and families.

June 2004

Goals

1. To further develop the enjoyment of cooking as well as the skills and ability of participants to prepare and cook nutritious and affordable meals.
2. To optimise community engagement within the program and enhance the sense of community in all program members.

Objectives

1. To create supportive environments where participants can learn and share new recipes, cooking skills & nutritional information.
2. To create an enjoyable environment that encourages people to cook and develop new friendships.
3. To reduce the time pressures on individuals and families to prepare and cook meals.
4. To reduce the costs associated with preparing and cooking fresh, healthy meals.

July 2006

Primary Aims

1. To further build opportunities and skills of individual participants and their families to prepare and cook nutritious and affordable meals.
2. Build partnerships between local services strengthening support to families and communities, so they deliver better services and meet unmet needs

Secondary Aims

3. Assist members of the community to get involved in community life through local volunteering.
4. Enhance the sense of social connectedness within Community Kitchen Participants.
5. Build opportunities and skills for economic self-reliance in families and communities.

Objectives

1. To create supportive environments where participants can learn and share new recipes, cooking skills and nutritional information.
2. To create an enjoyable environment that encourages individuals to develop new friendship networks.
3. To reduce the time pressures on individuals and families to prepare and cook meals.
4. To reduce the costs associated with preparing and cooking fresh, nutritious meals.

August 2006

Goal: To improve access to nutritious & affordable meals for Frankston residents

Objectives

1. To improve cooking skills

- Create supportive environments where participants can learn and share recipes and cooking skills.
- Build more opportunities to prepare nutritious and affordable meals.

2. To improve knowledge of basic nutrition

- Create supportive environments where participants can learn and share nutritional information.

3. To reduce the costs associated with preparing nutritious meals

- Build partnerships between local services so they deliver better services that meet the community's needs.
- Build opportunities and skills for economic self-reliance.

4. To reduce the perception of time as a barrier to preparing nutritious meals
5. To increase motivation to prepare nutritious meals

- Increase enjoyment of preparing nutritious meals
- Increase the value/perceived importance placed on preparing nutritious meals

6. To improve physical access to healthy food

- Build partnerships between local services so they deliver better services that meet the community's needs.

November 2006

Goal: To promote healthy food access, social cohesion and community strength in the City of Frankston through a Community Kitchens program.

Objectives

1. To provide a supportive and sustainable environment in which the project can develop and expand.
2. To build partnerships with local organisations to promote community-wide support of the project and to improve links between community services.
3. To increase awareness of, and participation in, Community Kitchens.
4. To improve knowledge, skills and motivation in the areas of cooking, nutrition, budgeting, food safety and group facilitation for community members.
5. To promote community strength and social cohesion in the City of Frankston.

July 2007

Vision: To develop and disseminate a sustainable Community Kitchens program that promotes healthy eating, social inclusion and community strength in the City of Frankston.

Target group: Socially and financially disadvantaged residents of the City of Frankston

Goal: To promote healthy eating, social inclusion and community strength in the City of Frankston.

Healthy Eating Objectives:

By December 2007…

1. 30% of participants will have increased their economic access to healthy food through participation in Community Kitchens and/or through improved budgeting skills
2. 80% of participants will have improved their knowledge of healthy eating and recipes
3. 80% of participants will have improved their food preparation skills
4. 50% of participants will have increased their confidence and motivation to cook at home
5. 80% of participants will have improved their food safety knowledge and skills

Social Inclusion Objectives:

By December 2007…

6. 80% of participants will feel valued and respected within their Community Kitchen group
7. 80% of participants will have increased their access to supportive relationships through involvement in Community Kitchens
8. 90% of participants will have built stronger social networks through an increased quality and number of social connections
9. 30% of participants will have increased access to employment and volunteering opportunities

Community Strength Objectives:

By December 2007…

10. 10 collaborative partnerships will have been developed between community organisations within the City of Frankston
11. 60% of organisations and community groups will demonstrate leadership, ownership and control of their Community Kitchen
12. 100% of participants will have increased their involvement in organised community groups and community events