



Promising Practice Profiles

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| Project title | Frankston Community Kitchens Pilot Project |
| Project practice | The aim is to build a sense of community and to improve the physical and mental health of participants through promoting healthy eating, learning how to plan, cook and share nutritious low-cost meals and fostering social inclusion. |
| Project undertaken by | Frankston Community Health Service |
| Start date | September 2004 |
| Focal areas | Isolated families Indigenous families/communities Families with a child/children or parent with a disability CALD families |
| Program | Local Answers |
| Issue | <p>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. The issue of poor physical and financial access to quality, affordable fresh produce was identified as a barrier to healthy eating. Local dietitians and health workers observed that a large number of their clients had low motivation to cook and try new foods. Furthermore, clients cited limited cooking skills as a barrier to making lifestyle changes.</p> <p>Community Kitchens enable participants to take control over their own health. The project is based on community development principles and aims to foster personal empowerment through self-help and mutual support strategies. Community Kitchens aim to improve participants' food security through acquiring food knowledge and skills whilst breaking down their social isolation.</p> |
| Program context | <p>Originating in Canada, the Community Kitchens model has been successfully implemented in Victoria by Peninsula Health's Frankston Community Health Service since September 2004.</p> <p>Community Kitchens provide regular opportunities for groups of six to eight people to participate in planning, cooking and sharing nutritious meals together in community-based settings. The project follows the "train-the-trainer" model whereby skill development is largely based on peer education and informal learning. Each group is led by a facilitator who is either a volunteer or a paid worker within the organisation in which the Community Kitchen is based.</p> <p>Community Kitchens can operate in any venue which has a functioning kitchen. Examples include churches, Neighbourhood Houses, health organisations, commercial kitchens, sporting clubs, schools, community halls, housing estates and even private businesses.</p> <p>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 while saving money.</p> |

Community Kitchens are benefiting a broad range of target groups, which include men, single parents, people with disabilities, migrants/indigenous people, those on low incomes as well as the general community. A key ingredient to the success of Community Kitchens is the flexibility and adaptability of the model, which contributes to the project's ability to engage people from "difficult-to-reach" target groups.

The Community Kitchens project 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.

Practice description

The following are the ingredients critical to the effective operation of the Community Kitchens project:

- community ownership;
- the flexibility of the model;
- community partnerships;
- embedding Community Kitchens within organisations; and
- access to skilled facilitators and committed volunteers.

Community ownership

Since its inception, the wider community has been involved in developing and delivering the Community Kitchens project. The first 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.

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 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 fostered this sense of ownership in participants through: building relationships, spending time developing a strong rapport with participants, showing trust and respect, communicating well and involving participants in all aspects of decision-making. Participants are also encouraged to undertake voluntary roles in the project, which further allows them to develop their skills.

Facilitators and participants are involved in decision-making in their own groups (e.g., determining the day, time and frequency of meeting, deciding which recipes are cooked and establishing their own group rules). Feedback from facilitators and participants shapes not only individual Kitchens, but also the project as a whole.

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.

The flexibility of the model

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.

There are three core features of a Community Kitchen: active participation, financial contribution from group members, and no sale of food. While these three characteristics 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 10 weeks in advance. This seems to save time as participants are not always motivated to choose recipes for the following week immediately after cooking.

Experience 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).

Community partnerships

The Community Kitchens model relies heavily on partnerships with community groups and organisations, thereby limiting the need for external funding. For the Frankston Community Kitchens, partners provide:

- a strong client referral base;
- kitchen facilities (and pay overhead costs such as electricity and gas);
- group facilitators;
- subsidised food costs;
- transport of participants; and
- 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, which is a key ingredient towards sustainability of the overall project.

Partnerships can be initiated by extending invitations to attend 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.

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; and
- promoting partners' involvement in media releases and promotional materials.

Embedding Community Kitchens within organisations

Community Kitchens that are supported by, and embedded within, organisations that have generally proved more successful and sustainable. While Community Kitchen project workers provide advice and assistance in the early stages of Kitchen development, Kitchens that are embedded within community organisations tend to require minimal input once established and some operate almost completely independently.

Community Kitchens can involve tasks that require quite a high level of functioning, such as working with participants with complex needs and helping to integrate new members into a group. 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.

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.

Access to skilled facilitators and committed volunteers

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 whose role is to support the running of the group. 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 should be committed to the philosophy, be good communicators, be tolerant of others and not be overpowering or intimidating to other participants. Running training 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 on the information learned in the workshops to participants in their Kitchens informally.

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.

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.

Research base

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” (Strategic Inter-Governmental Nutrition Alliance of the National Public Health Partnership, 2001). At the state level, “promoting accessible and nutritious food” and “promoting mental health and wellbeing” are two of the seven Victorian Public Health Priorities (Department of Human Services, 2007).

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” (Dietitians of Canada, 2007).

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 (VicHealth, 2005a). The Community Kitchens project has demonstrated the ability to attract and retain all of these population groups.

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. These are typically participatory community-based programs such as Community Kitchens or budgeting education programs (Tarasuk, 2001a).

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 (World Health Organization, 2008).

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 (Tarasuk, 2001a). 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 (Tarasuk, 2001a).

In a recent study of Collective Kitchens, (a Community Kitchens model in Canada), 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 (Engler-Stringer & Berenbaum, 2007).

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 (International Union of Health Promotion and Education, 2000) 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 to which they may not have previously been exposed (Pomeroy, 2007). The Pilot Project's nutrition guidelines encourage healthy food choices, especially the inclusion of vegetables and fruit.

Local research undertaken by Doyle and 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). 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%), while lack of transport was cited by 7.2% of respondents as the cause (Doyle & Keleher, 2006).

Social inclusion

The VicHealth Mental Health Promotion Framework (VicHealth, 2005b) 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 (Cappo, 2002). The amount of social support available varies by social and economic status and poverty can contribute to social exclusion (VicHealth, 2005c). With depression accounting for the greatest burden of disease in Victoria (Mathers et al., 2000), 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 who are affected by food insecurity

are forced to consume and acquire food in ways that fall outside social norms, thus contributing to social exclusion (Tarasuk, 2001b). An alternative explanation is that socially isolated people endured more severe food insecurity because they lack supportive social networks (Tarasuk, 2001b). In contrast, Wood (2004) argued that each condition contributes to the other. Regardless of the mechanism of causality, building social support is an essential component of building capacity among 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 (Tarasuk & Reynolds, 1999). Participants facing particularly difficult and isolating situations benefit from the chance to meet and obtain social support from others with similar struggles (Tarasuk & Reynolds, 1999). Kitchens for these groups have been shown to also attract and retain participants experiencing food insecurity (Tarasuk & Reynolds, 1999).

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 (Frankston City Council, 2007). 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 (2006) 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.

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 (Department for Victorian Communities, 2007). Doyle & Keleher (2004) 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.

Outcomes

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).

Despite this, evaluation results have demonstrated that Community Kitchens have had a significant impact on participants regarding many aspects of healthy eating. These include: improvements in cooking skills, meal planning, budgeting and shopping habits, fruit and vegetable consumption and food safety and hygiene practices.

Evaluation results show 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. The project also has the ability to make significant impacts on participants' mental health and wellbeing.

The Community Kitchens project has contributed towards community strength by providing opportunities for participants to become involved with the wider community, for example organised groups, community events and volunteering

opportunities. Involvement in Community Kitchens has also been a catalyst for connecting partners with each other and, in some cases, reorientation of work practices.

In summary, there is evidence to show outcomes in the following areas:

- healthy eating
 - cooking skills and behaviours nutrition knowledge
 - eating behaviours
 - food spending habits
 - menu planning
- social inclusion
- community strength.

Evidence of outcomes

Preliminary evaluation was carried out twelve months into the project. At this time the data was collected primarily by project workers. The main data collection methods were 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. While every effort was made to collect information from a representative sample, participant responses were predominantly from two Kitchens, which is likely to have skewed results.

Nonetheless, both rounds of evaluation demonstrated the project's success in meeting its objectives around healthy eating, social inclusion and community strength.

The results below are taken from the *Frankston Community Kitchens Project Twelve Month Evaluation Report* by Trezise (2006) and *Evaluation of the Frankston Community Kitchens Pilot Project for Frankston Community Health Service* by Pomeroy (2007).

Healthy eating

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 (58%) of participants reported using recipes from the Community Kitchen at home occasionally. Fourteen percent (14%) 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. Regarding food hygiene practices, 66% reported improved hand-washing practices during Year Three Evaluation.

Nutrition knowledge

Year three evaluation showed that while 42–48% of participants 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 (43%) 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.

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 the Preliminary Evaluation, 28% of participants reported an increased use of a shopping list and 7% in meal planning. In the 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.

Social inclusion

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. 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.

Fifty-eight percent (58%) of participants interviewed in the 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.

Community strength

One indicator of community strength is membership of an organised group. Forty-three percent (43%) of participants interviewed in the Year Three Evaluation 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. Community Kitchens have the potential to facilitate participation in community life beyond the Kitchens themselves, and therefore create stronger communities.

Sixty-nine percent (69%) of participants interviewed in the 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.

In addition, the Year Three Evaluation showed that all partnering organisations could identify with some aspect of the Community Kitchens model and 95% supported the philosophy of the project. In their view, Community Kitchens provide:

- a place to learn food skills that are transferable to work opportunities/further education—especially for young mothers, youth and the unemployed;
- a safe place with an established social network where people can take part in additional activities—especially for people living alone, the socially isolated and new arrivals; and
- a place to learn and practice independent living skills.

Two partnering 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.

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| Policy analysis | <p>The Frankston Community Kitchens Pilot Project is a positive example of a Stronger Families and Communities Strategy's Local Answers funded project.</p> <p>It provides evidence regarding the practice of Community Kitchens in achieving increased health eating, social inclusion and community strength.</p> |
| Evaluation | <p>The Frankston Community Kitchens Pilot project has been evaluated at two time points: after 12 months operation in 2004, and after a further three years of operation in 2007. The twelve month evaluation was conducted internally while the following evaluation was undertaken by an external independent evaluator.</p> |
| Project related publications | <p>Trezise J. (2006). <i>Frankston Community Kitchens Project twelve month evaluation report</i>. Frankston Community Health Service, Frankston.</p> <p>Pomeroy S. (2007). <i>Evaluation of the Community Kitchens pilot project for Frankston Community Health Service</i>. [Unpublished].</p> |
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Contact

Julia McCartan
 Community Kitchens Project Manager
 PO Box 52
 Frankston 3199
 Phone: (03) 9784 8582
 Fax: (03) 9784 8149
jmccartan@phcn.vic.gov.au

Website

<http://www.communitykitchens.org.au>

More information

More information on the Frankston Community Kitchens Pilot and Promising Practice Profiles can be found on the Communities and Families Clearinghouse of Australia website.

**Communities and Families Clearinghouse Australia**

Australian Institute of Family Studies
Level 20, 485 La Trobe Street, Melbourne Vic 3000
Tel: (03) 9214 7888 Fax: (03) 9214 7839
Email: cafca@aifs.gov.au

www.aifs.gov.au/cafca