Local People, Local Food Solutions (LPLFS) Research Project Findings Report 2015

June 2015

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This project was made possible through funding provided by Gateway Health and Northeast Health Wangaratta through integrated health promotion funding from the State Government of Victoria. It was undertaken as a strategy of the Central Hume Primary Care Partnership (CHPCP) Health Eating Plan 2012-2017.

Acknowledgements

The project team would like to thank all of the participants for the time they took to provide their valuable insight. In particular we would like to acknowledge and thank the Community Research volunteers Jaki Burman, Ann Townsing, Zoe Zwager, Heather Neilsen, Emma McManus, Ben Cane, Annette Monshing and Sakina Babia. We also acknowledge the Wangaratta Food for All Forum Network Members.

We also thank our research supervisors Helen Haines and Lisa Bourke (University of Melbourne) and associate researchers Clare Schultz and Laura Tonkin (Northeast Health Wangaratta), Zoe Black and Coby Brock (Gateway Health), Anna Moran (Charles Sturt University) and Kerry Craig (Rural City of Wangaratta Council) for their input into the project.

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Abbreviations and acronyms

Acronym	Abbreviation
RCoW	Rural City of Wangaratta
CBPAR	Community-based participatory action research
LPLFS	Local People, Local Food Solutions
CRVs	Community research volunteers
AM	Dr Anna Moran
T	Transcript number
VHFB	Victorian Healthy Food Basket
NHMRC	National Health and Medical Research Council
NHW	Northeast Health Wangaratta
OKCHS	Ovens and King Community Health Service

Executive Summary

In Wangaratta over half of the adult population is overweight or obese (57.5%), and 41.9% do not meet the dietary requirements for fruit and vegetable intake (Department of Health, 2013). In the Hume Region the number of children aged 4 -12 years not meeting the dietary requirements for fruit and vegetables is 66.9% (Department of health, 2012).

The risk of obesity is significantly higher for those who have low incomes and who experience food insecurity, than those who do not fall in this category (Burns, 2004) with the most prominent characteristic of food insecurity being a lack of financial resources (Women's Health Victoria, 2010). Single-parent families also face a higher risk of poverty and food insecurity than other groups with day-to-day living expenses consuming half of their income (Women's Health Victoria, 2010). Wangaratta has a high population of low income single parents with 42.3% of individuals earning less than $400 a week compared to 39.9% in Victoria (Department of Health 2013) . In the Rural City of Wangaratta (RCoW), 25.7% of people have reported some foods being too expensive (Department of Health 2014). Furthermore 6.4% of children aged 0 – 12 years in the RCoW come from a household that ran out of food in the last 12 months and were not able to afford to buy more (Department of Health 2013).

In Wangaratta the 18.9% of families with children who fall into a low socioeconomic group would need to spend at least 30% of their total income to buy food items that meet approximately 95% of energy requirements for a typical family (Central Hume Primary Care Partnership 2012). Yet local community consultation reveals that while many people know what should be eaten, it is not often put into practise (NHW and OKCHS, 2014).

Health promotion theory identifies that effective initiatives should involve communities in all aspects of program planning from needs assessments and identifying priorities, through to program implementation and evaluation (Minkler 2010 and Clark et al. 2003).

Research Aims

The purpose of this research was therefore to simultaneously build community capacity for participation in research and change and to investigate the barriers, enablers and potential areas for action around healthy eating for low income families in the Rural City of Wangaratta.

Specifically, we have drawn on multiple data sources to address the following research aims:

1. Identify and explore barriers and enablers around healthy eating for low income families in the Rural City of Wangaratta, using Community Research Volunteers;

2. Identify and prioritise community solutions to improve healthy eating for low income families with children in the Rural City of Wangaratta; and

3. Build capacity within the Rural City of Wangaratta community to work collaboratively with local agencies in identifying and responding to local issues around healthy eating.

Method

We addressed the research aims using a Community Participation Based Action Research (CPBAR) methodology incorporating the following stages:

(i) Identification, recruitment and training of Community Research Volunteers (CRVs)
(ii) Conduct of focus groups, referred to as 'community kitchen table chats', with residents of Wangaratta who had low incomes and families
(iii) Analysis of focus group data
(iv) Conduct of 'Checking back' workshop with CRVs

Results

Summary of key findings

Using this methodology we identified a number of mechanisms that can be used to facilitate healthy eating among low income families of Wangaratta. These include:

- Motivate the community to eat well and address / alter values around healthy eating;
- Address / alter intergenerational eating behaviours;
- Improve knowledge and skills around planning, budgeting, shopping, cooking, sourcing and growing healthy food;
- Encourage social connection within the community;
- Improve skills in efficiency and planning;
- Reduce the cost of healthy produce;
- Improve access to healthy food options;
- Involve schools in action planning and implementing healthy eating strategies; and
- Improve finances and access to income.

These mechanisms may be realised through:

- Including children in family meal planning and cooking; providing easy cookbooks using low cost ingredients; and building connections with others interested in healthy eating.
- Involving children in cooking and gardening activities at home and in the community.
- Attending / providing affordable classes to gain knowledge and skills about planning, shopping, cooking, budgeting, school lunches and gardening.
- Getting together with others to share handy hints, food, seedlings and skills.
- Attend food swaps or other food related activities; volunteer and/or provide access to information about volunteering opportunities and how to get involved; build connections with others interested in healthy eating.
- Building vegetable gardens; forming neighbourhood co-ops or food banks; reduce unhealthy eating options; improve income/finances.

- Reducing waste through donations to a food bank, purchasing food at cost price, bulk buying collectively, and/or consulting with industry.
- Building vegetable gardens in homes and the community as well as planning better locations for healthy food outlets; ensuring better access to transport to buy affordable food; improving promotion of healthy food options in the local community; addressing industry wide issues around marketing of healthy and unhealthy food by the food industry.
- Assisting schools to have a healthy canteen, healthy eating suggestions in the school newsletter, learning skills in the classroom and providing a student lunch making area.
- Provide ways to source extra income (e.g. work opportunities); skills and training in budgeting/prioritising.

Outputs and outcomes resulting from this research

This research has not only identified ways the community of Wangaratta could improve healthy eating options and behaviours for low income families it has started a community conversation about healthy eating and how to improve the current state of affairs.

Key outputs from this research are:

- Training program developed for community research volunteers
- 8 community members trained in facilitating a focus group
- 4 health promotion staff trained in conducting research

Key outcomes from this research include:

A set of local actions to promote healthy eating for low income families, developed from local community input, thus ensuring community ownership. This research also facilitated a relationship between the health promotion team and harder to reach community members in Wangaratta.

Where to from here?

The next phase of the research will be a community event to celebrate the achievements of the project and community researchers and to facilitate community discussion and input into prioritising the findings.

Following this will be the development of a model to enable community members and organisations to participate in creating interventions and initiatives that are based on the research findings.

Conclusion

A community-based participatory action research (CBPAR) approach was used to explore the unique issues and challenges associated with healthy eating for families living on low incomes in the Rural City of Wangaratta. This approach and the use of community research volunteers enabled the collection of local data as well as the building of local community capacity to identify issues and develop local actions to facilitate healthy eating. We have identified that community involvement and community cooperation, encouraging social inclusion and up-skilling and training community members in essential skills like budgeting, prioritising and cooking are key mechanisms that can facilitate healthy eating in this community. These findings will form the basis of interventions to address healthy eating in our local community. The next stage of this research will be to implement the identified solutions.

Introduction

"If you don't know about these sorts of things you can't make changes …"

(T16, line 133)

Worldwide there is mounting concern over the growth in overweight and obesity rates with one in four children in Australia reported as being overweight or obese (Australian Bureau of Statistics, 2012). The World Health Organisation in 2014 stated that 39% of adults were overweight and 13% were obese (World Health Organisation 2015).

Poor diet and eating behaviours are well known contributors to obesity (Jansen, Mensah, Nicholson and Wake 2013). Research suggests there are various factors as to why people do not consume a healthy diet. These include personal and social factors and physical environments with a strong interplay of price, household situation, routine, availability and access being the main drivers of food selection (Ball et al. 2005 and Medibank 2015). The relationship however, between diet and social, economic and cultural factors is complex (Roberts, Cavill, Hancock and Rutter, 2013). To complicate things further, children's eating behaviours are also influenced by parents and caregivers and their decisions in purchasing and preparing food for their children (Crawford et al. 2012 and Hume, Ball, Crawford, McNaughton, and Stephens 2008).

Given people from low socioeconomic status are most at risk of obesity (Burns, 2004), there has been close attention paid to the relationship between diet, eating behaviours and socioeconomic status (Ball et al. 2005 and VicHealth 2005). This research explores the barriers and enablers around healthy eating for low income families with children in a Rural City in Victoria, Australia. It reflects the definition of poverty described by Burns (2004, p.4) 'In Australia and other developed countries, most people are considered poor if their living standards fall below an overall community standard, and they are unable to participate fully in the ordinary activities of society'.

Study Context

This study was undertaken in the Rural City of Wangaratta (RCOW), a local government area in the Hume Region located in the North East of the Victoria, Australia.

In Wangaratta over half of the adult population is overweight or obese (57.5%), and 41.9% do not meet the dietary requirements for fruit and vegetable intake (Department of Health, 2013). In the Hume Region the number of children aged 4 -12 years not meeting the dietary requirements for fruit and vegetables is 66.9% (Department of health, 2012).

In 2003, it was identified that 22.6% of women in the most disadvantaged socioeconomic group had nearly double the rate of obesity in relation to those 12.1% in the most advantaged group (O'Brien and Webbie 2003). The risk of obesity is 20% to 40% higher in women who have low incomes and who experience food insecurity, than those who do not fall in this category (Burns, 2004). The most prominent characteristic of food insecurity is a lack of financial resources (Women's Health Victoria, 2010).

Low income combined with high food costs result in households spending a large percentage of their income on food (Women's Health Victoria, 2010). The Victorian Healthy Food Basket (VHFB) food items meet approximately 95% of energy requirements for a typical family (2 adults and 2 children). In Wangaratta the 18.9% of families with children who fall into a low socioeconomic group would need to spend at least 30% of their total income to buy the healthy food basket (Central Hume Primary Care Partnership 2012).

Single-parent families also face a higher risk of poverty and food insecurity than other groups with day-to-day living expenses consuming half of their income (Women's Health Victoria, 2010). Wangaratta has a high population of low income single parents, with the majority being women. Women are more likely to be food insecure than men (Department of Health 2014). In the Rural City of Wangaratta (RCoW), 25.7% of people have reported some foods being too expensive (Department of Health 2014). Furthermore 6.4% of children aged 0 – 12 years in the RCoW come from a household that ran out of food in the last 12 months and were not able to afford to buy more (Department of Health 2013).

Encouragingly, women who experience socioeconomic disadvantage but manage to eat well tend to have good food preparation and cooking skills, support from family members and availability to fruit and vegetables (Hume, et al. 2008). Further, an evaluation report of the Stephanie Alexander Kitchen Garden Scheme in schools found strong evidence for significant improvements in students' food choices and kitchen lifestyle behaviours as a result of participation in the program but did not find a significant increase in fruit and vegetable intake at home. However, it did find that children were more prepared to try new foods and help with cooking and gardening at home through participation in the program (Yeatman et al. 2013).

Local community consultation in Wangaratta however revealed that while many people know what should be eaten, it is not often put into practise (Northeast Health Wangaratta and Ovens and King Community Health Service 2014). Fast food outlets/convenience stores close to home, may also have a negative effect on children's fruit and vegetable intake (Timperio et al. 2008). The ratio of essential to non essential food outlets in the RCoW is approximately 1:4 (NHW and OKCHS 2014).

Health promotion theory identifies that effective initiatives should involve communities in all aspects of program planning from needs assessments and identifying priorities, through to program implementation and evaluation (Minkler 2010 and Clark et al. 2003). By involving communities in the process, there is a greater likelihood of creating ownership, empowerment and sustainability (Baum, MacDougall and Smith 2006, D'Alonzo 2010 and Mantoura and Potvin 2012). Community-based participatory action research (CBPAR) is an approach that aims to build healthy communities by having local people involved in all stages of the research process. CBPAR approaches have been shown to be effective in involving traditionally hard-to-reach groups, such as those from Aboriginal and Torres Strait Islander background and low incomes (Baum, MacDougall, Smith 2006 and Clark et al. 2003). Focus groups, delivered through a CBPAR approach targeting underrepresented "hidden" populations, are effective in gaining broad community input regarding health needs and assets Clark et al. (2003). CBPAR aims to build on the strengths and resources within the community, and promotes co-learning and capacity building amongst all partners (Minkler and Wallerstein 2008).

This report details results from a community-based participatory action research project undertaken in 2014 titled 'Local People, Local Food Solutions' (LPLFS). A localised approach was used to identify the barriers and enablers to eating well for low income families in the Rural City of Wangaratta. It also aimed to identify local, community-driven solutions that could improve food security and eating well. For the purpose of this research 'low income' was defined as either being a holder of a health care card, having a household income of less than $650 per week or the main source of income being from a pension or welfare benefit.

Methods

The aims of the LPLFS research project were to:

1. Explore barriers and enablers around healthy eating for low income families with children in the Rural City of Wangaratta, using Community Research Volunteers

2. Identify and prioritise community solutions to improve healthy eating for low income families with children in the Rural City of Wangaratta

3. Build capacity within the Rural City of Wangaratta community to work collaboratively with local agencies in identifying and responding to local issues around healthy eating.

The research involved a number of components (Figure 1) including identification, recruitment and training of Community Research Volunteers (CRVs); conduct of focus groups, referred to as 'community kitchen table chats', with residents of Wangaratta who had low incomes and families; analysis of focus group data; pre and post structured interviews with the CRVs; self completed evaluation and feedback questionnaires by participants of the kitchen table chats; and a 'checking back' workshop with CRVs.

Community Research Volunteers

Community Research Volunteers (CRVs) (who had experienced providing for a family in Wangaratta on a low income) were recruited to the project (see **selection criteria** below). CRVs worked alongside the principal researchers to both conduct and participate in focus groups with other low income residents of Wangaratta.

In line with the research aims it was hypothesised that the CRVs, with 'street credibility' and similar lived experiences to the target group would tap into the strengths, resources and relationships that exist within the community identity to address communal health concerns (Minkler and Wallerstein 2008). As the researchers had minimal, if any, existing relationships with the target group it was anticipated they would also facilitate capacity building of residents living in the RCoW to identify and respond to local issues around healthy eating. Being both facilitators of and participants in the research it was hoped to enhance the collaborative nature and outcomes of the research as is the case for other social research methods (Miles and Huberman, 1994).

The CRVs were provided with training and support to organise and facilitate focus groups and collect data for the project. The CRVs were also invited to review and comment on the themes that emerged from the data and to present the findings of the study to the community.

The CRVs attended three training workshops before organising and holding focus groups. The workshops introduced them to the project (and each other) and gave them the skills required to facilitate a kitchen table chat (focus group). The workshops were run by the principal researchers and consisted of volunteer induction, modelling a kitchen table chat, and the 'how-to' of facilitation. The modelled kitchen table chats involving the CRVs themselves as participants were recorded and transcribed as part of the data collection.

Sample

The study was undertaken with residents from the Rural City of Wangaratta. We aimed to recruit up to twelve participants as CRVs in line with other public health studies that rely on small sample sizes to enable a detailed study of the data collected (Miles and Huberman 1994). It was anticipated that the CRVs would in turn be able recruit up to 40-60 further research participants. It was felt this number would enable us to achieve enough data to reach data saturation (Miles and Huberman 1994).

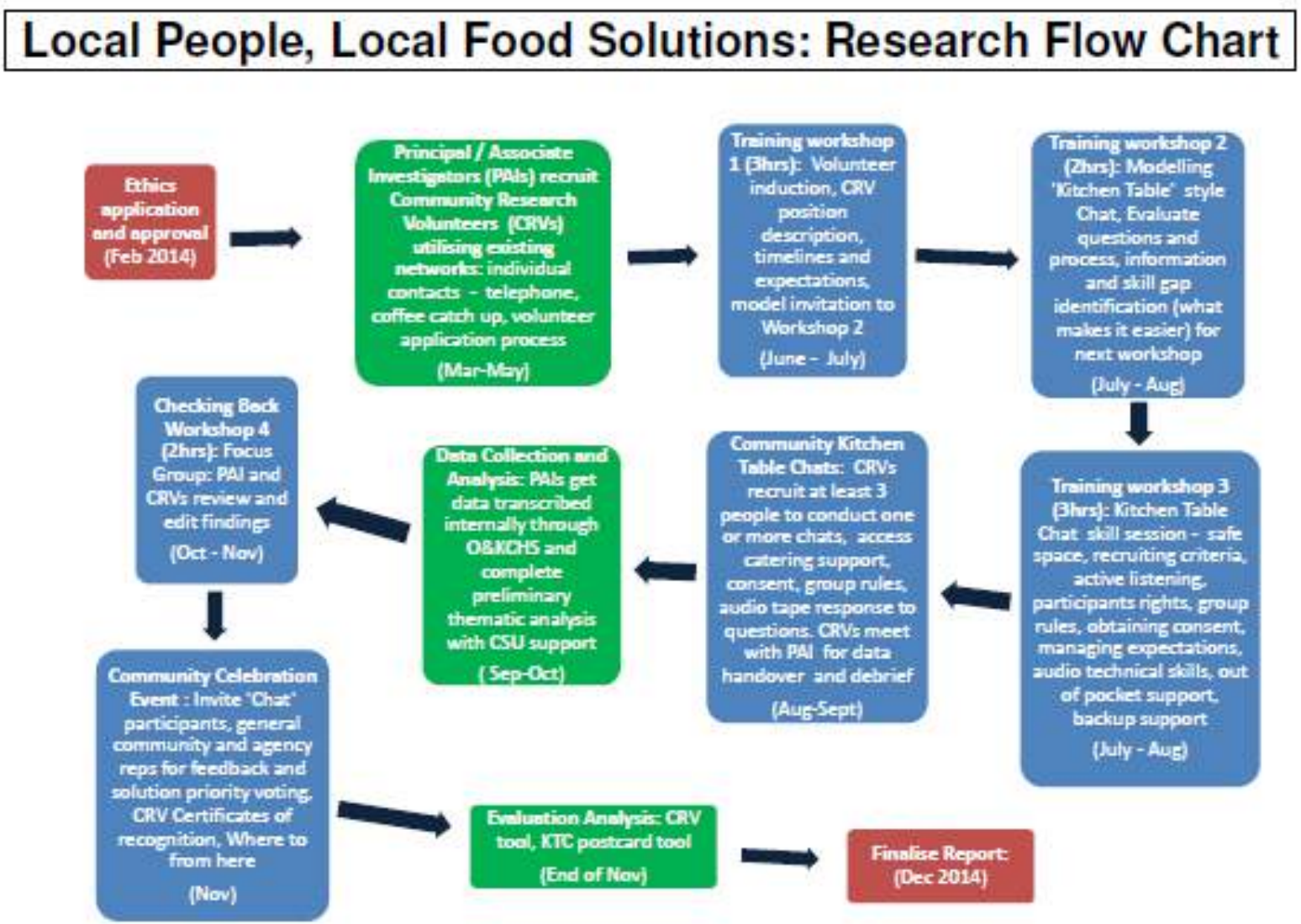
The research wished to explore and better understand issues specifically relating to people living on low incomes. As with the general population, people on low-incomes are interested in programs that are meaningful and relevant to themselves (Minkler 2010, Israel et al. 2008). Thus it was hoped that an invitation to talk about their family food issues, along with a gift voucher incentive, would increase access to participants from the target group. As such purposive and convenience sampling were used (Ritchie and Lewis, 2003) with the following specific selection criteria.

Selection criteria

Participants must:

- Be a resident of the Rural City of Wangaratta
- Care for at least one child aged 0-12 years
- At some stage in the last 5 years;
  - Have had a household income below $650 per week (after tax) or
  - Has held a health care card; or
  - Derived their main source of income from a pension or welfare benefit
- Be able to understand, speak, read and write English
- (For CRVs) know at least 3 people who fit the above criteria for inclusion in the study and who they could invite to a focus group.

Figure 1 Research flow chart



Recruitment

Recruitment of participants occurred in two stages. The first stage was the recruitment and training of community research volunteers (CRVs). The second stage involved the CRVs inviting participants of their choice to attend a focus group.

The CRVs were recruited through a number of different avenues. These included parents of children who attended a local community school (for children who were not currently in a mainstream school), a local health organisation (Gateway Health and Albury Wodonga Health through Wangaratta based workers), members from Rural City of Wangaratta Council Community Action Groups and Neighbourhood Houses.

The principal researchers conducted a number of phone calls and face to face meetings to establish rapport with the potential recruits. The principal researchers supported this relationship by staying as the key contact for the CRV during the duration of the research period (Ritchie and Lewis, 2003).

The second stage of recruitment involved the CRVs (with the support of the principal researchers) inviting participants of their choice to attend a kitchen table chat. While the CRVs could choose who they invited, they were encouraged to invite people who met the above listed **selection criteria**.

While it was encouraged that the CRV recruit participants, some assistance was required to increase numbers. Four of the chats (focus groups) were organised through the principal researchers utilising already established groups or links, three were a mixture of people invited by the CRVs and the principal researchers and the remaining ten were made up entirely of participants recruited by the CRVs (See Table 1 below).

Table 1 Recruitment of kitchen table chat participants

Chats organised by Principle Researchers contacts	Chats organised by mix of principal researchers and CRV contacts	Chats organised by CRV contacts
T1, T2 CRVs T8 Neighbourhood House T13 CRV and MIND worker	T17 CRV and Neighbourhood House T11 CRV and Aboriginal Health Worker T14 CRV and RCOW worker	T4, T7, T5, T9, T12, T6,T10, T15, T16, T3

Data Collection

Data were collected using the following methods:

- Audio recorded kitchen table chats undertaken by CRVs
- Note taking by principal researchers during kitchen table chats
- Pre and post structured interviews with the CRVs by the principal researchers
- Self completed evaluation/feedback questionnaires by participants of the kitchen table chats
- Reflective journals recorded by the principal researchers
- A 'checking back' workshop with CRVs
- Prioritising event for community members to identify and rate solutions identified in kitchen table chats.

Focus groups (kitchen table chats)

For the purpose of this project, and to keep things informal, the focus groups were named "kitchen table chats". The eight CRVs were responsible for facilitating the kitchen table chats. They were given a script to (informally) follow. The script (Appendix 1) was prepared by the principal researchers with input from the CRVs themselves. The script included a statement about the purpose of the discussion, how the data would be used and requested permission to audio-record the discussion. Following this a series of questions were used to address the research aims (Box 1). Each kitchen table chat was audio recorded (with permission) and observational notes were taken by the attending principal researcher. One principal researcher attended each kitchen table chat as observer, note-taker and supporter for the CRV facilitator.

Box 1 Question guide for CRVs

1. What does eating 'well' mean to you?
2. What challenges do you face in getting you or your family to eat well?
3. Thinking about when you buy food for your family, how do you decide what to buy?
4. What helps you and your family to eat well now?
5. What would make it easier for you and your family to eat well in the future?

The combination of these questions was chosen to allow for the desired richness of answers. The first as an icebreaker and to gain an understanding of both how the sample perceived healthy eating and the influence this may have on their food behaviours. The second and fourth questions targeted barriers and enablers to healthy eating with the third to discover themes that both these two may have missed. The final question targeted the identification of possible solutions. Questions two, four and five were based on the National Health and Medical Research Council (2012) community consultations conducted with families at the Victorian consultation forum during the review of the Australian Guide to Healthy Eating Guidelines. Questions one and three were developed by the principal researchers. All questions were reviewed in consultation with the CRVs during the training workshops.

Each CRV conducted at least one kitchen table chat. Some were held with existing groups such as a mother's group at a local neighbourhood house. Others resulted through individual invitations and were held in either private homes or community spaces.

Pre and Post structured interviews of the CRVs by the principal researchers

The principal researchers undertook pre and post evaluation with the CRVs using a one-on-one structured interview (Box 2). These questions aimed to gauge community capacity by enquiring how well they were connected to their community before and after the project, whether the project met their expectations and if they had developed any new skills. The pre evaluation questions were asked during the recruitment phase before their training workshops commenced. The post evaluation questions were asked at the conclusion of the research project.

Box 2 Question schedule used for pre and post evaluation interviews with CRVs

Have you attended a local community event in the last 6 months (like a local fete, school concert, exhibition, festival)?

Do you have involvement with a:-

Sports group			Yes	No
Church group			Yes	No
School/Kinder/Play group			Yes	No
Social/recreation group			Yes	No
Neighbourhood house	Yes	No		
Any other community or action group	Yes	No		
Give details:				

Who do you regularly meet/have contact with?

Friends	Yes	No		
Family			Yes	No
Neighbours			Yes	No
Shop owners			Yes	No
Other parents			Yes	No
Other, give details:				

Have you helped out in your community as a volunteer in the last 5 years (formal and informal)?

No, not at all
Not often/ one off occasion
Sometimes
Yes, definitely
Don't know/ Not sure

What skills, knowledge and experience do you think you bring to the role of a 'Community Research Volunteer'? (Post evaluation) do you feel you now have?

What do you hope to get out of being a 'Community Research Volunteer'? (Post evaluation) what did you get out of it?

How confident do you feel, at the moment, to organise and hold a 'kitchen table chat'?

Not at all
A little bit confident
Fairly confident
Very confident

Added questions for Post- evaluation:

Is the lag of time during the process of recruitment (or any other part of the project) off putting? (lose interest?)

Was too much written material given? How much of it did you take away and was actually read?

Did you feel like you were a valued volunteer? Your time wasn't wasted?

Would you recommend this role to others?

Would you be interested in future volunteer work with us? ie: Food for All forum

Did you find the invitation flyer for the chats useful or did you not really use it?

Was the script useful? What parts of it weren't?

Anything else you would like to comment on about the project?

Self completed evaluation/feedback questionnaires undertaken by participants of the kitchen table chats

Those who participated in the kitchen table chats were asked to complete a one-page voluntary feedback form at the time of participating in the chat (Appendix 2). This form was non-identifiable and included demographic information as well as feedback on the kitchen table chat process.

Reflective journals recorded by the principal researchers

The principal researchers kept reflective journals throughout the duration of the research. This took the form of both individual and group reflections. The reflections were useful for monitoring progress, addressing challenges, passing on learning's and reflecting on community capacity, researcher capacity and any relationships or partnerships that were developed throughout the research process.

'Checking back' feedback workshop

A fourth workshop was held with the CRVs to inform them of the results from the kitchen table chats, to gain their feedback and validate the themes identified. The CRVs were asked if the themes identified reflected what they heard. They were also asked if they heard anything new, not necessarily at the kitchen table chats but spoken about more informally (outside of the chats themselves).

Data Analysis

Focus groups

The audio recordings of the kitchen table chats were transcribed verbatim by the principal researchers, an associate researcher and an administrative worker. The audio recordings were randomly allocated to these workers to transcribe. Each transcript was numbered numerically.

Data were analysed using Framework Analysis (Ritchie and Spencer 1994). Framework analysis was chosen as the method for analysis as it closely reflected the aims and objectives of the research. The framework gave the principal researchers, who were new to qualitative research methods, a clear and succinct structure with which to systematically analyse the data and to answer the research questions associated with the study.

Analysis began with the five researchers (three principal and two associate) familiarising themselves with and individually identifying themes from the same transcript (Transcript 1). This process was the first step for the researchers developing understanding of framework analysis and the guidance of an experienced health services researcher (AM) (Ritchie and Spencer 1994).

The five researchers next attended a workshop facilitated by AM where Transcript 1 was analysed as a group. A framework matrix was identified and established to use for consistent analysis of the remaining transcripts. This matrix based analytic method, as a deductive approach, provided a way of setting themes and subthemes based on the research aims. As the analysis is grounded in the raw data, the framework is inductive allowing for any new emerging themes raised by the participants themselves to be included (Ritchie and Spencer 1994). The analysis template created had themes and subthemes listed under the key headings of; 'what is healthy eating', 'barriers', 'enablers', and 'solutions', and two new themes not previously stated by the researchers 'impacts/outcome' and 'waste' (Appendix 3, Figure 1).

The five researchers analysing the data were then allocated a varied amount of transcripts each to analyse by one of the principal researchers. These were allocated

according to who was the note taker at the kitchen table chat and/or who transcribed the audio recording to maintain consistency and familiarity with the data. A second researcher cross referenced the transcript with them. Each researcher added 'sticky notes' to a wall chart listing supportive quotes against existing and/or new themes identified in each transcript to organise the data (Appendix 3, Figure 2).

The five researchers progressed through the framework analysis past familiarisation to organisation of the transcript data utilising the steps adapted from those of Ritchie and Spencer (1994) (Table 2).

Table 2 Stages of Framework Analysis, taken from Ritchie and Spencer (1994)

Stage	Definition	Example
Indexing/ coding	Raw data examined and assigned a numerical code Subthemes within each were identified, assigned numerical codes 1.0 what healthy eating means 2.0 barriers to healthy eating 3.0 enablers to healthy eating 4.0 impacts/outcome 5.0 solutions 6.0 waste	1.0 What is healthy eating Theme: 1.3 Time to plan and prepare Subtheme: 1.3.1 Structured eating 1.3.2 Making things from scratch
Charting	Sticky notes on wall charts were used to organise themes involving principal and associate researchers. Themes and associated quotes were combined in to the one excel spreadsheet. Quotes were labelled with the transcript number and line number. Individuals were not identified.	Appendix 3, Figure 2 Appendix 3, Figure 1
Mapping	Themes identified in the excel spreadsheet were summarised and listed on large wall charts. This allowed for information to be shared with the CRVs for checking. At this point the theme 'waste' was included as a sub theme within 'solutions'. Data were analysed under the headings *barriers* and *enablers* to healthy eating, which were subsequently reframed to form *mechanisms* for promoting healthy eating among a community of low income families. These mechanisms were then linked to solutions identified by community members.	Appendix 3, Figure 3 Appendix 3, Figure 4

The analysis process showed evidence of data saturation. New themes arose less frequently as analysis continued and repeated themes were evident even from the beginning of analysis (Appendix 3). This was validated by the CRVs in the 'checking back' feedback workshop.

Reflective Journals

Reflective journals served a number of purposes. They guided discussion that allowed the principal researchers to reflect on participant recruitment issues and work out strategies to maximise numbers. The journals were also about ensuring data was as accurate as possible and to analyse any biases that may have been brought in. The journals helped the researchers to clarify the themes identified in the data analysis.

Pre and Post structured interviews of the CRVs by the principal researchers

An independent evaluator (a volunteer public health graduate looking to gain further work experience) was invited to collate and analyse the data collected using the pre and post evaluation interviews question schedule with CRVs (Box 2). This was chosen as a way to reduce researcher bias as strong relationships had formed between the principal researchers and the CRV's. Regular meetings were held between the evaluator and two researchers to review and comment on the themes that emerged from the data. The information from the report was used to gauge the efficacy of the training and involvement of the CRV's.

Self completed evaluation/feedback questionnaires undertaken by participants of the kitchen table chats

The feedback forms gave the researchers demographic information which was analysed using descriptive data analysis utilising the Survey Monkey web based tool. The results were displayed in a table format and were used to check that the participants met the target group criteria.

The consolidated criteria for reporting qualitative research (COREQ) guided the reporting approach used for this study (Tong et al., 2007). LPLFS received ethics approval in February 2014 from Northeast Health Ethics Committee, project number 130, and Charles Sturt University Ethics Committee, project number 2014/071.

Results

Participants

Community Research Volunteers

Eleven participants were registered as volunteers with Gateway Health to be the project CRVs. Of these, eight CRVs continued for the entire duration of the project. The other three had changed personal circumstances and chose not to continue beyond the initial sign up stage.

Kitchen Table Chats

In total the CRVs held, and participated in, 17 kitchen table chats that involved 48 participants (Table 3).

The kitchen table chats took the form of:

- One-on-one discussions (2 chats)
- Two participants (6 chats)
- Three participants (4 chats)
- Four participants (1 chat)
- Five participants (2 chats).

Table 3: Kitchen table chats

Chat	Date	No of participants	Facilitator	Venue	Length
1	5/08/14	4	Principal Researcher (PR)	Uniting Church Meeting Room Wangaratta	57.08
2	8/8/14	4	PR	Villa Maria Wangaratta	48.32
3	29/8/14	2	CRV	Wangaratta	4.32
4	11/9/14	2	CRV	Wangaratta	7.30
5	12/9/14	2	CRV	Masonic Centre Appin St, Wangaratta	16.02
6	12/9/14	3	CRV	Moyhu, local hotel	-
7	14/9	5	CRV	Wangaratta	20.05
8	15/9	5	CRV	Open Door Neighbourhood House, Wangaratta	36.29
9	25/9	1	CRV	Wangaratta	4.03
10	26/9	2	CRV	Glenrowan Primary School	15.15
11	29/9	3	CRV	Wangaratta	17.00
12	10/10	1	CRV	Wangaratta	9.12
13	14/10	3	CRV	MIND – Wangaratta	21.01
14	17/10	3	CRV	Wangaratta	-
15	23/10	2	CRV	Glenrowan	19.14
16	27/10	2	CRV	Sydney Hotel – Wangaratta	-
17	29/10	4	CRV	Pangerang Neighbourhood House – Wangaratta	-

Kitchen table chat participants

Table 4: Kitchen table chat participants (n=46) taken from feedback forms

Demographic	Category	N	%
Gender	Female	41	91.1
	Male	4	8.9
	Skipped Question	1	
Age (years)	18-25	8	17.4
	26-35	10	21.7
	36-50	20	43.5
	50+	8	17.4
Residency	Rural City of Wangaratta	29	63
	Outside of RCoW *	3	6.5
	Skipped Question	14	30.4
Background	Australian	33	71.7
	Aboriginal/Torres Strait Islander	7	15.2
	Born overseas	4	8.7
	Skipped Question	2	4.3
Income source *(may be more than one source)*	Salary/ wages	24	46.2
	Centrelink	20	38.5
	Other**	8	15.4
Health Care Card	Yes	30	65
	No	12	26
	Chose not to provide	1	2.2
	Skipped Question	3	6.5
Children in your care	0-12 years (27 people cared for 52 children in this age bracket)		
	12-18 years (3 people cared for 3 children in this age bracket)		

* Three of the participants resided outside of the RCOW, despite this being a prerequisite for participation in the KTCs. The reasons for this were mixed, one participant was from Western Australia and staying at the researcher's residence – therefore she participated. The principle researchers also did not clarify this point at the start of the KTC therefore the community research volunteers may have forgotten this point.

** These participants ticked other yet did not clarify what this was.

Focus Groups

The results described below are structured around headings reflecting the interview schedule (Box 1) and coding framework (Appendix 3). They include: what is healthy eating; barriers to healthy eating; enablers to healthy eating; impacts; solutions.

Theme 1: What is Healthy Eating?

In order to examine the issues associated with healthy eating, it was important to understand what healthy eating meant to participants. A number of sub themes were identified as part of what healthy eating means to the participants. They are summarised in Table 5 and then expanded further below.

Table 5: 'What is Healthy Eating?'

Theme	Example
Well Balanced	*"combination of your meats, your fruit/veg, your breads and cereals, and your dairy…the triangle with the 5 groups…I always thought that was important"* (T12 line 2-4)
Healthy	*"It means you get better health if you eat good fresh food and fruit"* (T5 line 2)
Time to Plan & Prepare	*"regular meals at meal times"* (T12 line 2); "*Making the time to ensure that you do have that well balanced diet. Good preparation for food so that you can have that healthy diet/ good well rounded diet"* (T1 lines 9-10)
Actually Eating	*"eating the right food possibly or just eating in general, some people might not eat at all"* (T11 line 3-4)
Diet & Dietary Restrictions	*"I definitely know the health benefit of being a vegan is very important"* (T8 line 4)

T= transcript number

Well Balanced

Participants perceived that healthy eating involved consuming all food groups and avoiding or minimising 'bad food'. Many spoke about balancing the diet with plenty of fruits and vegetables and as such, many thought of fruits and vegetables when thinking about healthy eating.

Healthy

A number of themes arose around 'what is healthy' or 'what is health' that enabled clarification of participants' perceptions of healthy eating. Participants discussed a number of concepts including health of the mind, the body, general health and living

longer. Often people spoke about having energy for their children as an important element of good health.

Time to Plan and Prepare

Many spoke of the importance of making the time to eat well and prepare meals. This included having structured eating, such as "*…3 meals a day"* (T7, line 18) and making things from scratch *"at least I know what's going in there" (T13, line 6).*

Actually Eating

Some participants commented on their ability to acquire food and feed themselves and their families as a bare minimum. Healthy eating may therefore be defined by this sample as the basic human need to eat rather than exactly what is eaten.

> *"…eating the right food possibly or just eating in general, some people might not eat at all"* (T11, line3-4).

Many comments in relation to actually eating reflect a deeper understanding about what healthy eating means to those from low socioeconomic backgrounds. That is, the ability to acquire food and therefore having something to eat constitutes healthy eating because eating is a basic requirement for living.

Diet and Dietary Restrictions

The primary reason for noting this theme was the associated health benefits being the driver for a particular diet. For example one participant expressed *"…I definitely know the health benefit of being a vegan is very important"* (T 8, line 4). The comments around a vegan diet were somewhat related to consuming fruits and vegetables and therefore this meaning of healthy eating may be closely linked to the theme of a well balanced diet, whereby the incorporation of fruits and vegetables is important.

Most comments relating to 'diet' were around dietary restrictions, resulting from allergies or health issues. It may be inferred then that healthy eating means adhering to a particular diet or regime in order to improve health.

Theme 2: Barriers to Healthy Eating

There were a number of complex and not so complex barriers to healthy eating for this sample. One issue which arose time and time again was cost and income, particularly the cost of healthy produce and meat. Many commented on the need to accommodate for a range of fussy eaters while avoiding waste. These barriers along with others are summarised in Table 6 and then expanded further below.

Table 6: 'Barriers to Healthy Eating'

Theme	Example
Cost and Income/Finances	*"It tends to be food goes last on your list when you've got financial difficulties"* (T2 line 239)
Food Preferences	*"They have very different tastes and that becomes hard to incorporate them in to one family meal"* (T12 line 12-13)
Time	*"It's pretty sad finding the time to do it all"* (T10 line 166)
Access	*"Cooking facilities can be an issue for those living in tents"* (T1 line 29)
Knowledge/Skills	*"A lot of people might not know how to eat healthily"* (T8 line 231)
Addiction/Vices	*"I could give up tobacco, spend another $20 on food there, but you've got to have some kind of vices otherwise you'll go mad [chuckle]"* (T1 line 66-67)
Motivation	*"My number one thing is I hate cooking"* T3 line 8

T= transcript number

Cost and Income/ Finances

Many people commented on the price of produce inhibiting one's ability to buy healthy food and therefore to eat well. One stand alone sub theme in relation to produce was 'meat'. This was often raised as an item outside of what their budget could manage. Some participants spoke about the price of a car and petrol which meant that access to facilities to purchase food was poor and that they were unable to access what was perceived as 'cheap produce' .

> *"…the only issue I have with doing that though is where it runs into the petrol budget cause you're running around after everything"* (T14, line 178).

Many people recognised the cost-effectiveness of bulk buying however, some argued that to buy in bulk can be hard if you have a tight budget.

"Sometimes I think the specials are more appealing to people that have more money [emotional tone here] so they can buy bulk" (T1, line 54-55).

The cost of utilities and general living was also an issue. The impact of this often meant a ripple effect on what people were eating as illustrated by the following quote.

"When you talk about freezer space you also have to talk about the cost of power in that element when you look at freezing a big portion of meals and so forth" (T16, line 216).

Competing demands on finances also meant that healthy food isn't always a priority.

"It tends to be food goes last on your list when you've got financial difficulties…you've got to pay rent, you've got to pay the bills, you've got to get petrol so you can take the kids to school or…food's just not quite there, it's sort of lingering on the bottom of your list of things to do…by the time you think of it, you need something quick and easy, I've had enough stressors for the day...." (T2, line 239-242).

In regards to the cost of acquiring additional resources at home to eat healthily, mention of the benefit of vegetable gardens was raised. However, the cost of supplies for establishing a garden was perceived as often out of people's budget.

"When I lived on a farm I had massive vegetable gardens but the water was free so I'm coming to Wang [referring to now living in a town where you have to pay for water], I don't do that anymore" (T14, line 259-260).

Food Preferences

'Fussy eating family members' was regularly brought up in a number of the chats. It often related to the need to accommodate certain dietary requirements. The issue of waste was often discussed in relation to this theme in that if the food is not going to be

eaten it is going to be a waste money. Therefore, there was an identified need to buy what the family would eat as opposed to what they 'should' eat.

> *"They have very different tastes and that becomes hard to incorporate them in to one family meal"* (T12, line 12-13*)*

The influences of not only family, but of marketing and temptations were also recognised as impacting on food preferences.

> *"I've got into that mode that if the specials, but I have to stop myself and go ok, no you don't need that"* (T15, line 49-50);

> *"How they market it to children as well. If I take him shopping it's like Mum we'll have this 'cause he's seen it on TV"* (T6, line 307);

> *"Temptations of takeaways makes it hard"* (T1, line 17).

Convenience was also mentioned as a food preference influence .

> *"The drive- through is convenient for a start because you don't have to get two little children out of the car and back in. And then, also because it's so cheap....So it's a real trap"* (T6, line 157).

Time

Many spoke about their time-poor lifestyles and a perceived inability to make time to plan, prepare and even think about eating well.

> *"It's pretty sad finding the time to do it all"* (T10, line 166).

Convenience was also recognised as having an impact on time-efficiency.

> *"Because it's quick and easy, run down to Maccas or something, oh yeah, 10 minutes and it's done"* (T9, line 37-38).

Access

Geographical access to facilities to purchase healthy food for some was a major issue. Living out of town and/or not having access to transport often limited a person's ability to access fresh produce. Conversely, some mentioned the benefit of living out of town limits access to temptations such as takeaway as a choice, therefore acting as an enabler to eating well (see 'Theme 3 – Enablers').

In addition, access to facilities, appliances and storage space and food safety restrictions was raised a barrier to accessing healthy food options as illustrated by these quotes.

> *"…if you don't have a bloody computer or you can't afford to get the internet connected that doesn't help you does it. Not everybody has a friend with a computer that they can get online and order either. So people can't take advantage of home delivery* (T17, line 419);

> *"…cooking facilities can be an issue for those living in tents"* (T1, line 29).

> *"…having enough freezer space is the challenge"* (T16, line 73); *"…legally they aren't allowed to sell past its use by date [referring to supermarkets selling food cheap that is old]"* (T14, line 238).

Knowledge/ Skills

Many said (often in third person) that people may not know where to go for help and resources, may not have the skills to cook and prepare nutritious meals, may not know how to eat healthily in general or may not have the shopping skills required to be resourceful.

> *"I don't know around here where to get it [help and resources]"* (T11, line 113);

> *"People don't know how to cook them"* (T8, line 90);

> *"A lot of people might not know how to eat healthily….They're not very knowledgeable"* (T 8, line 231-232);

"…whether you have….the knowledge…to maybe grow something at home or maybe have a look around to see well where can I buy things that are locally grown instead of going to the supermarket and getting things that have been in the cold store" (T8, line 249-251);

"If you don't know about these sorts of things you can't make changes unless you know" (T16, line 133).

Addiction/ Vices

Addiction was identified as a barrier to healthy eating in that it takes priority over purchasing healthy food. This included the issue of gambling where one participant reported they *"…would actually go to the pokies to try to make money for food"* (T1, line 75).

This theme is closely related to competing demands and the ability to prioritise. For example food was reported to be continuously placed at the 'bottom of the list' because of competing priorities. Vices such as smoking being one -

"I could give up tobacco, spend another $20 on food there, but you've got to have some kind of vices otherwise you'll go mad [chuckle]" (T1, line 66-67).

Food cravings were also recognised as a form of addiction impacting on eating behaviours.

"Some people live on coke and they've got to have their coke [referring to the soft drink] (T16, line 129);

"I like to cut them out on sweets, I just got to stop myself….I still sit down every night and have chocolate with my cup of tea" (T11, line 85 and 90).

Motivation

Many reported they lacked the motivation to be resourceful and prepare healthy meals.

"I'm not a cook…I don't like cooking actually" (T12, line 44-45);

"My number one thing is I hate cooking" (T3, line 8);

"Whether you have…the motivation to maybe grow something at home or maybe have a look around to see ...where can I buy things that are locally grown…" (T8, line 249-251).

Sole living was also raised as impacting on one's motivation to cook and eat well. Participants reported they lacked the motivation to prepare meals for just themselves.

"…often people that live on their own don't eat well do they" (T8 line 300).

This theme was strengthened during review of the results with the CRVs. It was stated that if one does not have the motivation to eat well, no other influence on healthy eating has a big enough impact. In other words, motivation to eat well needs to be established before one can pursue healthy eating any further.

Theme 3 Enablers for Healthy Eating

Participants identified a number of enablers to healthy eating. Having the knowledge and resourcefulness to eat well were identified as important elements to healthy eating. Further detail of the enablers of healthy eating are summarised in Table 7 and then expanded further below.

Table 7: 'Enablers for Healthy Eating'

Theme	Example
Enjoyment/Motivation and Values/What's important	*"I found sitting all together and it makes a big difference for a bigger family. Because they see everyone else eating it and then they tend to try"* (T13, line 51-53)
Resourcefulness	*"hiding food [to get kids to eat their vegetables*]" T2 line 323
Knowledge	*"The specials are always on the other levels, not eye level"; "Go around the outside, all your aisles around the out, because 90% of your stuff that you usually buy"* (T1, line 204-205 and 222-223)
Income/Finances	*"Now that I have a job it makes it so much easier because there's that bit of extra income"* (T1, line 311-312)

Social Support/Connections	*"…I had a friend who used to do that and he used to always bring me a lot of silver beet, tomatoes, all this stuff…"* (T14, line 262-264)
Access	*"when I lived in town I would tend to get takeaway more….Living out of town and we don't tend to do it"* (T15, line 177 and 187) "*Out of sight out of mind*" (T15, line 184).

T= transcript number

Enjoyment, Motivation and Values (What's Important)

Enjoyment, motivation, values and what's important to you were universally identified by participants as important underlying enablers to eating well. Having the motivation to eat well and to cook healthy meals was expressed. For others, their motivation was the importance of eating well for their health and as such prioritised healthy eating. Others mentioned the value they placed on family or cultural rules which enabled them to eat healthily, these 'rules' ranged from eating together at the dinner table, to having 'junk' food only as a special treat.

> *"I found sitting all together and it makes a big difference for a bigger family. Because they see everyone else eating it and then they tend to try.*" (T13, line 51-53)

> *"We have no choice because of my son...he's just a little tacker so we have to eat well."* (T8, line 355-357)

> *"That's why I like the Italian values, because they're really family, hands on, they like to get the family involved and that's where they're learning, the whole family and to appreciate cooking and what goes in to it and all that sort of stuff." (T2, line 447-449)*

Resourcefulness

Resourcefulness includes having the skills and abilities that enable people to eat well. These included good planning and embedded routines, bargain hunting (buying what's on special) and finding creative ways to cook to accommodate different tastes such as *"…hiding food [to get kids to eat their vegetables]"* (T2, line 323).

Cooking in bulk was also discussed, allowing meals to be frozen and then eaten as leftovers. As one participant states, this means "less cooking required" (T8, line 386-

390). Being creative in how you buy food such as substituting products was also discussed.

> *"I think a week ahead of time; what has to be provided. Often lunch, school lunches are very prominent in my mind, and dinners"* (T12, line 17-18).

Knowledge

Knowledge was identified by participants as a major influence on what people decide to eat. While it was addressed as a barrier for many, there was evidence of how much knowledge participants actually did have when it came to shopping and food in general. Many relied on word of mouth and media to enhance this knowledge. Others gained it by simply observing their surroundings –

> *"We've got plenty of good shops here, plenty of fresh produce in them always"* (T5, line 69-70).

Some were also very knowledgeable about how to navigate their way around supermarkets to optimise their shopping experience as expressed by these participants:

> *"The specials are always on the other levels, not eye level"; "Go around the outside, all your aisles around the out, because 90% of your stuff that you usually buy [is here]"* (T1, line 204-205 and 222-223).

It was evident throughout the discussions that some were more knowledgeable than others about what was healthy and how to cook healthy alternatives.

Income/ Finances

Having adequate income/finances was also identified as an enabler to healthy eating.

> *"Now that I have a job it makes it so much easier because there's that bit of extra income"* (T1, line 311-312).

Having the ability to budget, prioritise and follow a budget was also seen as an enabler.

> *"…anything extra, any treats, that comes afterwards" (T8, line 297).*

Social Support/Connections

Many spoke about the transfer of knowledge, skills and ideas as a result of sharing and doing things with others. Social support and the connections people have with others were often discussed, sometimes directly, other times indirectly in relation to enabling healthy eating.

> *"There is also that community garden too. I had a friend who used to do that and he used to always bring me a lot of silver beet, tomatoes, all this stuff and he said all you have to do is go down and volunteer a bit and you can get this yourself"* (T14, line 262-264).

This links with how well connected you are within your own community. Participants expressed that these factors can impact on their ability to lead a healthy lifestyle. Not only did this subtheme identify sharing of knowledge with others, but also the sharing of resources, support and encouragement family members receive from each other, from schools and other community groups (such as religious organisations).

> *"…in Glenrowan…with the kitchen garden program with the kids cooking and all the different types of food that they cook and try"* (T10, line 140)

> *"Because I'm a Christian, I sometimes have a little extra in there just in case someone I know says you got any meat"* (T17, line 396).

Access

Many people commented on the benefit of growing their own vegetables and therefore having readily available access to healthy produce.

> *"…you save so much money growing it yourself and it's a lot fresher as well"* (T8, line 348).

Access to adequate transport can enable people to access affordable food.

> *"…eating well means for me I have to travel, I go to Kennedy's and Arnolds every fortnight to get my fruit and veg and my meat. It's actually cheaper for me to*

drive over there and get that [as it is located in Wodonga and she is travelling from Wangaratta] "(T17, line 2).

Theme 4 Impact

This theme identified behaviours and issues that had an impact on healthy or unhealthy eating behaviours and also how the ability or inability to eat healthily impacted on them and the community. The elements of 'Impact' are summarised in Table 8 and expanded further below.

Table 8: 'Impact'

Theme	Example
Social Inclusion/Exclusion/ Connections and Values	"*My kids won't go there, they think it's for povos"* (T17, line 353-354)
Antisocial Behaviour	*"I've actually resorted to stealing things like that"* (T1, line 273)
Intergenerational Behaviours	*"not every child that grows up has this fantastic home life where their mother teaches them to cook"* (T17, line 70)
Health and Wellbeing	*"I want to eat healthier because I'm tired of feeling tired…I want to eat better so that I can feel better"* (T1, line 380-382)
Where Food is Coming from	*"We try to get food made in Australia"* (T5, line 34)
Schools	*"Schools are a big influence… well that's where they spend 90 percent of their time…"* (T13, line 172 and 194)

T= transcript number

Social Inclusion/ Exclusion/ Connections and Values

There was evidence of the power of social connectedness and how this can impact on the ability to enjoy eating, eating healthy meals, seeking assistance and general health. Eating out was perceived as an enjoyable social activity but affording it was not often possible and perceived to increase the chance of social isolation and a lack of connectedness with the community.

"Eating out…can't even think about it" (T 1, line 47).

Some spoke about the feeling of shame associated with seeking emergency relief. These feelings of shame could lead to feelings of exclusion within their community.

"My kids won't go there, they think it's for povos" (T17, line 353-354);

"…they won't walk in to these facilities because they're embarrassed…A lot of people wouldn't go to the food van because they knew the police were going to come" (T1, line 347-348).

Conversely some people recognised the benefit of emergency food relief as an opportunity to connect and feel included.

"I think Carevan is also a very social thing" (T17, line 332).

Some expressed that their eating behaviours were influenced by social pressures, which in turn could in some instances result in eating healthier as expressed here;

"I think there's a lot of social pressure, well not pressure. It's fashionable to be healthy at the moment." (T4, line 42-43)

Or social pressures could be a barrier to healthy eating;

"…you don't want them missing out on it because other kids get it so you feel kind of obligated to give it to your kid [referring to junk food] " (T13, line 152-153).

There was also discussion about the support or lack of support by schools and there was evidence of miscommunications between parents and schools.

"…they don't contact the parent until it's too late [referring to a lack of communication around food policies and what their child is doing at school] " (T13, line 217-218).

Feeling connected in your community and having various support networks was identified as an important element of not just healthy eating but health overall.

"…often people that live on their own don't eat well do they" (T8, line 300).

Antisocial Behaviour

Linked with social exclusion, the issue of antisocial behaviour arose. There was discussion about actions and behaviours undertaken in order to survive and/or to get the opportunity to eat well. For example, stealing

> *"…you heard of fregans? They jump in to the bins and pull out all the good stuff, it's not allowed, it's illegal"* (T8, line 221-225);

> *"I see myself as an honest person, I don't like to steal but I've done it one or two times, and your worm tablets, your pets need things like that. It's just so outrageously dear, that occasionally, and I say it's only been a couple of times, but I've actually resorted to stealing things like that….not good…and I think there would probably be a few other people out in the community that do that too"* (T1, line 269-273).

Drug taking was also seen to be associated with being socially excluded;

> *"I was smoking once upon a time and once you do it, you're always classed as it, regardless of whether you give it up or whatever; you're always classed as that type of person"* (T13, line256-257).

Intergenerational Behaviours

There were a number of comments made which indicated the influences that occur throughout generations. This was examined through the lens of societal change, familial intergenerational or the culture in which people are exposed to. There was evidence of access to affordable, fresh food becoming harder in the modern world;

> *"…in the other days, you'd pick them off the apple tree"* (T12, line 84);

> *"…you used to get everything half price…towards the end they used to clear it all out…but that doesn't happen anymore"* (T8, line 212-217).

Others spoke about modelling healthy behaviours for their children and how the family operate in to the future;

> *"…to be able to teach them the right foods that they should be eating so they can instil it in to their children"* (T8, line 33-34);

> *"…not every child that grows up has this fantastic home life where their mother teaches them to cook"* (T17, line 70).

Culture was brought up a few times in the discussions and how this impacts on eating behaviours;

> *"…growing up with a French mother, onion and garlic's a staple", "Yes as are spuds with me"* (T15, line 107-108);

> *"I think I started eating vegetables, fresh vegies, when I got married to my ex husband. I was 18, and because he was Indian and they all had salads with their…" (T2, line 299-301).*

Of the many comments made in context of generational behaviours and influences, it was evident that it had a large impact on the decisions people make about eating especially once they reached adulthood.

Health and Wellbeing

As previously discussed, there were a number of impacts mentioned not only on healthy eating but on overall health. This theme however, also recognises the impact of eating behaviours on health including physical and emotional/mental health;

> *"I want to eat healthier because I'm tired of feeling tired…I don't want to have this lack of energy and this tiredness so I want to eat better so that I can feel better"* (T1, line 380-382).

In addition, the health and wellbeing of someone can impact on their ability to eat well;

"The more anxious he gets, the more he eats" (T13, line 61).

"I sometimes go days without eating food, umm, it's just the depression that I have and I don't feel like eating, when I do eat, I feel a replenishment, and the energy that it gives you" (T17, line 34).

Certain dietary requirements were frequently brought up, not only in relation to the impact on health, but how this health issue impacts on convenience and cost;

"We don't have much processed food at home, but that's because of allergies I have so that means we are all healthier" (T7, line 8);

"My daughter with all her allergies, I've got to be really careful with what I cook. And my husband, he can't have onion or garlic and he's lactose intolerant so that also constrains me in what I can cook" (T15, line 104-107);

"People who have health issues, who have allergies, gluten free things like that, its very, very expensive anywhere you go to buy it" (T17, line 629).

There were a number of complex elements incorporated in this theme. Overall, it was evident of the correlation between eating behaviours and a person's health and wellbeing.

Where the food is coming from

There was a considerable amount of discussion about Australian made as well as imported and exported products. The values associated with this were recognised as influencing what people decided to purchase. Some said they preferred to buy local products and there was negativity towards imported products;

"We take very good care looking at what country they come from because we don't want any Halal or Chinese food. We try to get food made in Australia" (T5, line 33-34);

"It's only because their standards aren't like Australia's standards that's why I don't like eating their shit...and it literally is" (T 8, line 133-134).

Schools

While schools have been addressed in various themes, it was decided that it also needed to be a stand alone theme under 'Impact' given its heavy discussion from both a positive and negative angle. There was much discussion about the great things some schools are doing to encourage healthy eating. However, communication barriers were shown to influence the perception of schools' contribution to healthy eating. Nonetheless, what was very evident is that parents perceive that schools have a large impact on how children's behaviours can be shaped when it comes to healthy eating and health in general;

"Schools are a big influence… well that's where they spend 90 percent of their time if you think about it, you know, it's 5 days a week" (T13, line 172 and 194-195).

Theme 5: Solutions

The final question asked of participants was one based on possible solutions they could think of which would help them and their family to eat well in the future. This was a crucial element of the research in that the intention is for these results to guide future interventions and actions. Themes are summarised in Table 9.

Table 9: 'Solutions'

Theme	Example
Vegetable Gardens	"maybe if you told people more about vegetable gardens and things like that they can do their own vegies" (T9, line 41-42)
Affordable Classes	"if I could do a little…course that didn't cost the earth, to teach me to have the confidence in the kitchen where I could just cook quickly and simply" (T12, line 59-60)
Schools	"They can sell healthy food in that canteen; there would be no reason why they can't do that" (T13, line 187)
Cooperating with Others And Building Connections	"So what we've done in the past is shared and with plants, you know you get three in a punnet. I might get one and a friend takes one and give one to dad. You still get them for the cheaper price but you share the buy" (T16, line 81)

Children Involvement	“Get them to help peel things and get things going so that it's a family thing and you'll find that when you do that kids will eat it because they've helped cook it" (T8, line 373-375)
Access	"Less takeaway shops too I reckon" "more health food" (T9, line 35-37)
Volunteering	"I wouldn't mind doing that, going to help and it’s all free. Most of it you can donate to charities and that anyway if need be" (T13, line 240-241)
Avoiding Waste	"What's the chance of you looking at throwing away these items? …what's the chances of either having them donated to a food bank…or can we maybe purchase it on cost price?" (T1, line 470-472)

T= transcript number

Vegetable Gardens

Vegetable gardens were often at the forefront of people’s minds when the question around solutions arose. The benefit of a vegetable garden in their own homes was highlighted, but also that of community gardens so long as they were set up approrpiately and were easily accessible and affordable;

> *"maybe if you told people more about vegetable gardens and things like that they can do their own vegies" (T9, line 41-42); "…even a community vegie patch around the corner...that would be terrific. And the kids could get involved and then they could eat the food they grow would be lovely, and I think they would appreciate it more too"* (T12, line 90-94).

Many also went into detail of how these vegetable gardens could actually work and what you could do in order to set them up;

> *"…sometimes it's good to know are you planning to plant pumpkin or zucchini so you know what not to plant [referring to swap with a neighbour who would then plant something else]"* (T6, line 423); and

> *"…we could approach Bunnings to donate things…. I would tend to be steering away from them [Bunnings], go to a local business, put the money back in the community"* (T17, line 194 and 204); and

"…some people may not be physically fit to put a garden in but with a helper they may be able to maintain it" (T17, line 186-187);

Affordable Classes

'Affordable classes' was a prominent theme. This included learning basic cooking skills for not only cooking nutritious meals for themselves, but to accommodate for the family. This included discussion around how to pack children's school lunches. When cooking classes were discussed the need to keep them affordable was consistently raised, an example is expressed here by one participant *"Teaching parents how to pack school lunches"* (T8, line 46).

Budgeting was also an important skill that participants identified as an enabler to eating that also required training and education in shopping and cooking skills.

"It's good that people need to learn how to cook healthy, but also shop, so those two actually need to be married together" (T8, line 399-400).

As part of this skill development, planning was also a skill that participants recognised as essential.

"That's something we learnt in our course…menu planning" (T8, line 313).

Schools

Schools were recognised as playing an important role in any solution associated with healthy eating within the community interviewed. The identified solutions for schools were having better facilities for children's lunch preparation, including canteen policies and teaching children life skills.

"Wouldn't it be great if they could just go and make their own toasted sandwiches or heat their own pie up…they could have a loaf of bread there and they could make their own sandwiches...your kids would be eating more healthy and then they would also be able to be learning skills at the same time" (T1, lines 118-122);

"They can sell healthy food in that canteen; there would be no reason why they can't do that" (T13, line 187);

"…things like that starting at even primary schools is a good idea. Teaching them gardening, teaching them how to cook, that's what you're going to use when you get out" (T2, line 500-501).

Tapping in to school newsletters and programs was also identified as a means to involve parents in healthy eating solutions.

"Education maybe sometimes is like a tick for like in the newsletters at school… good websites for suggestions or the weekly thing in the newsletter, the healthy meal for the week…something simple, quick and easy, tasty and different in the newsletters" (T16, line 366-369]

Cooperating with Others and Building Connections

As previously discussed, social connectedness was recognised by participants as having a major influence on eating behaviours. There were a number of solutions discussed which are about working with others and bringing people together to combat food insecurity. These ideas included having some kind of co-op or food bank, getting together with others to bulk buy, swapping produce, sharing ideas and sharing transport.

"So what we've done in the past is shared and with plants, you know you get three in a punnet. I might get one and a friend takes one and give one to dad; You still get them for the cheaper price, but you share the buy" (T16, line 81).

Participants also suggested cooperating with the food industry to discuss things like cost, marketing and working with local producers.

"Cheaper food at least on vegies and fruit and stuff…whereas junk food should be dearer so you can't afford it" (T 9, line 29- 30);

"We should be supporting our farmers, not our supermarkets" (T8, line 207).

There was also discussion of expanding services to further enhance food security such as having a better bus route to certain produce stores (T17) and increasing access through better opening times of services (T14).

> *"…and I explained to them look it would be nice if there was a day over at the West End and within 2-3 weeks there was one right behind my house. So I'm pretty rapt you know, that people out there listen"* (T17, line 159-161)

Children Involvement

Involving children was often spoken about throughout the chats. Many commented on involving children in preparing food as well as sitting as a family during meals.

> *"Get them to help peel things and get things going so that it's a family thing and you'll find that when you do that kids will eat it because they've helped cook it"* (T8, line 373-375);

> *"Eating up at the table more often"* (T6, line 246).

Some also spoke about involving the kids in community activities as expressed here by one participant *"…you can get the kids to go to a community garden and take them down on the weekend"* (T13, line 263).

Access

Access to the 'right' produce and access to money were identified as solutions by the sample. Participants expressed that access to healthy food, as a solution, should also include less access to unhealthy food both in the community and inside supermarkets.

> *"Marketing is very powerful. And you have a look at every register you go to, is full of junk food, do they have fruit and veg there for a treat for the kids, no." (T17, line 558-589);*

> *"Less takeaway shops too I reckon….more health food" (T9, line 35-37).*

Knowing about actual affordable food and transport options was also recognised an important component to accessing healthy food;

"That's another idea; if you want to promote things, like you did get a bus service running to Kennedy [in Wodonga] and that, put those pamphlets at shopping registers. You have to get it out there. If someone like me doesn't know about the fruit and veg here [referring to Pangerang Neighbourhood House], I did know the boxes were coming but I didn't know they were here. I didn't know they were active and up and running." (T17, line 600-603).

While a lack of access to finances was a barrier to healthy eating, having finances was an enabler and therefore access to finance was also identified as something which would help them to eat better. Finance was mostly referred to as Centrelink payments, discounts and employment.

"…it isn't going to happen but the Government should of really reinstated the pensions until the kids turn 18 instead of what they have done" (T17, line 659-660);

"I think the best point today so far has been, um has been pension discount for meat" (T17, line 656);

"Now that I have a job, it makes it so much easier … It's not a lot, but that little bit makes a big difference" (T1, line 311-312).

Volunteering and mentoring

Volunteering in community activities to promote healthy eating was discussed by participants as another potential solution. Participants recognised the benefit that volunteering provide. Receiving mentorship and providing mentorship in healthy eating was also suggested as a solution.

"I wouldn't mind doing that, going to help and it's all free. Most of it you can donate to charities and that anyway if need be" (T13, line 240-241);

"All you have to do is go down and volunteer a bit and you can get this yourself" (T14, line 262-264).

Participants were also open to being involved in community food projects *"Give pamphlets to people like us, [to] letter box drop"* (T17. Line 309)

Avoiding Waste

The issue of food wastage, and the need to avoid it, was considered important to participants. The participants defined waste in a number of ways and came up with numerous solutions to negate waste. The sub theme areas of avoiding waste were:

- Business/supermarket waste e.g. food products destined to be thrown away by retailers
- Household waste e.g. leftover food not used or consumed or family dislike of frozen leftover food

These sub themes were not only seen as wasting food, but also as a waste of money, impacting on limited budgets.

A number of strategies were identified to help reduce or avoid waste. These were in both the supermarket and the home environments.
They identified that better ways of reducing waste could be providing access to this food before it spoiled. The concept of freezing as a way to reduce waste was frequently raised but often discussed as difficult due to the cost of running or buying a freezer and some families' dislike of frozen food. The ability to utilise ingredients in numerous ways was also discussed as a solution to wastage.

> *"Like the bakeries…what's the chance of you looking at throwing away these items? What are the chances of either having them donated to a food bank we're looking at doing or can we maybe purchase it on cost price?"* (T1, line 470-472)

> *"I try and buy something I can use a few times…."* (T3, line 16)

Pre and Post structured interviews with CRVs by the principal researchers

The results from the survey tool administered (Porter 2015) showed that:

CRVs regular contact with people (friends, family, neighbours, shop owners, other parents) either increased from the pre survey or stayed the same. Four CRVs had contact with neighbours in the pre survey compared to 7 in the post survey. Two CRVs involvement in social groups (sport, school, kinder, play groups, church groups or neighbourhood house) increased while six CRVs involvement stayed the same. All CRVs answered 'yes, definitely' to helping in the community post the event. Before only three had said yes definitely, three only sometimes, one had once before and one had never helped out.

CRVs stated at the post survey that they now have more confidence talking to a group and had gained great ideas, initiative and the ability to conduct a group chat. Further comments related to the impact of being a Community Research Volunteer included:

> *"Got to meet new people"," made new friends, got to meet lovely local people"," being able to help people and to share ideas".*

More than half of the respondents reported in the post survey that they were very confident in the ability to hold a kitchen table chat and only 2 said they were fairly confident. The pre survey showed none of the CRVs reported being very confident in organising and holding a kitchen table chat.

With regards to the process of recruitment and was it off putting; only one CRV stated:

> *"It was long, was wondering when it was going to get going".*

When asked if there was there too much written material, participants had a range of comments, e.g.

> *"No, it was just the right amount", "I took it away and looked at it", "No, I read it all" and "information overload"*

All participants felt they were a valued volunteer and would recommend this role to others.

In regard to the invitation flyer for the chats CRVs commented:

"Used it by posting the invitation on social media", "very useful", "I gave it to people; it's good to verbally tell them but also give it to them to put on their fridge"

All respondents commented that the script was useful. However, they also noted to shorten the script and to simplify it.

Final comments from the CRVs included:

"Brilliant idea", "done excellent"

In summary, results from the pre survey to post survey showed there was a change in three main areas by the eight CRVs:

- Increased confidence
- Increased networking within social groups
- Increased knowledge of healthy habits

Discussion

Through community-led kitchen table chats (focus group discussions), we have identified a number of mechanisms (see table 10) that can be used to facilitate healthy eating among low income families of a rural city in Victoria, Australia. 'Mechanisms' is used here to describe both the 'barriers' and 'enablers' as identified in the research. The presence or absence of these mechanisms was viewed as an enabler or barrier as evidenced in the results section.

These include:

- Motivate the community to eat well and address / alter values around healthy eating;
- Address / alter intergenerational eating behaviours;
- Improve knowledge and skills around planning, budgeting, shopping, cooking, sourcing and growing healthy food;
- Encourage social connection within the community;
- Improve skills in efficiency and planning;
- Reduce the cost of healthy produce;
- Improve access to healthy food options;
- Involve schools in action planning and implementing healthy eating strategies; and
- Improve finances and access to income.

Through a mapping exercise, these mechanisms were then linked to solutions to promote healthy eating, identified by community members, and what impact such solutions and mechanisms could have on promoting healthy eating (Table 8). For example suggested ways to 'encourage social connection within the community' included: getting together with others to share handy hints, food, seedlings and skills; attend food swaps or other food related activities; volunteer and/or provide access to information about volunteering opportunities and how to get involved; and build connections with others interested in healthy eating. As identified by participants, the impact of improved social connection, through these suggested actions, could potentially be less antisocial behaviour, improved social inclusion and improved

intergenerational behaviours. Combined, these outcomes should assist with promoting healthy eating among low income families.

This study has revealed the importance of a community response to facilitating healthy eating among less fortunate community members. Being connected with and supported by others was perceived by participants as key to promoting, enabling and sustaining healthy eating. A community-wide coordinated approach to sourcing, purchasing and growing food was one of the most commonly suggested actions by participants to ease access to healthy food options and overcome some of the financial barriers to purchasing healthy food. The importance of including children in food preparation and activities in schools, in the home and in the community, was also recognised as an important way to develop and sustain healthy eating values. Others studies support these findings. Social connectedness (feeling able to participate in community life) and improved access to healthy food options have been linked, in other studies, to improved health and wellbeing (Burns 2004, Volunteering Victoria 2015, Hume et al 2008, NHW and OKCHS 2014).

Community led 'up-skilling' in shopping, planning, cooking and budgeting, beyond just telling them what to eat, was identified as a means to give people the opportunity to learn how to eat well so that it's simple and sustainable for the individual. Having the knowledge and skills to provide healthy family meals has been reported elsewhere as key to improving family values around healthy eating (Hume et al 2008 and Women's Health Victoria 2010). Similarly skills in prioritising healthy food with competing demands of other household bills are considered important to minimising food insecurity (Robert et al. 2013 and NHW and OKCHS 2014).

This research highlighted the importance of involving schools to provide supportive environments that allow students to prepare or purchase healthy lunches; using the school newsletters to educate and inform parents; and having a curriculum which supports life skill development for students was also perceived as key to promoting healthy eating. These strategies have been shown to be effective elsewhere (Yeatman et al 2013).

Table 10: Mechanisms for promoting healthy eating

Theme	Mechanisms to promote healthy eating		Community Identified Solutions (how to realise mechanisms)	Potential outcome/impact
	Barrier to healthy eating	Enabler to healthy eating		
Motivation/ Values	Fussy eaters and lack of motivation to cook healthy meals.	Motivation to cook and eat well. Knowing about handy hints.	Include children in family meal planning and cooking. Provide easy cookbooks using low cost ingredients. Build connections with others interested in healthy eating.	Social inclusion; value changes; improved health and wellbeing.
	Mechanism: Motivate the community to eat well; address / alter values around healthy eating.			
Intergenerational Trends	Unhealthy behaviours passed down through family culture and/or society.	Healthy behaviours being passed down through family culture.	Involve children in cooking and gardening activities at home and in the community.	Improved intergenerational behaviour and values towards food/healthy eating; improved health and wellbeing.
	Mechanism: Address / alter intergenerational eating behaviours.			
Knowledge and Skills	Not knowing how to plan, shop, cook, budget or grow food.	Being resourceful with shopping and cooking.	Attend / provide affordable classes to gain knowledge and skills about planning, shopping, cooking, budgeting, school lunches and gardening.	Improved health and well being (through skills and knowledge)
	Mechanism: Improve knowledge and skills around planning, budgeting, shopping, cooking, sourcing and growing healthy food.			
Social	Being isolated,	Having people to talk to and the	Getting together with to share	Less antisocial behaviour;

Connectedness	being judged on where you live. Limits to what you can afford (i.e. eating out).	confidence to connect by attending community events.	handy hints, food, seedlings and skills. Attend food swaps or other food related activities. Volunteer and/or provide access to information about volunteering opportunities and how to get involved. Build connections with others interested in healthy eating.	improved social inclusion and intergenerational behaviours.
	Mechanism: Encourage social connection within the community.			
Time	Busy lifestyle.	Better planning skills.	Provide training in how to plan.	Improved health and well being (through skills and knowledge)
	Mechanism: Improve skills in efficiency and planning.			
Cost	High cost of healthy food; low income; high level of waste.	Higher cost to buy unhealthy food. Sourcing healthy food and reducing waste.	Build vegetable gardens; form neighbourhood co-ops or food banks; reduce unhealthy eating options; improve income/finances. Ways to reduce or avoid waste could include donations to a food bank, purchasing food at cost price, bulk buying collectively, and/or consulting with industry.	Less antisocial behaviour; social inclusion; improved health and wellbeing.
	Mechanism: Reduce the cost of purchasing, accessing and storing healthy produce.			
Access	Lack of access to healthy produce.	Living further away from takeaway outlets. Better access to healthy food options.	Vegetable gardens in homes and the community as well as better location of healthy food outlets. Better access to transport to buy affordable food. Improve promotion of healthy food options in the local community. Healthy food rather than junk food	Improved social inclusion; improved health and wellbeing.
	Mechanism: Improve access to healthy food options.			

			marketed towards children by the food industry.	
Schools	Lack of communication between parents and teachers	Support from schools.	Healthy canteen, healthy eating in the school newsletter, learning in the classroom and providing a student lunch making area.	Improved intergenerational behaviour and values towards food/healthy eating; improved health and wellbeing.
	Mechanism: Involve schools in action planning and implementing healthy eating strategies.			
Income and finances	Low income.	Financial relief and employment.	Extra income (work); skills and training in budgeting/prioritising.	Less antisocial behaviour; improved health and wellbeing (through better access to healthy food)
	Mechanism: Improve finances and access to income.			

Limitations

With the exception of associate researcher AM, we were novices to conducting research. To increase our research skills we participated in University of Melbourne, Department of Rural Health series of workshops in 2013 and 2014. Topics included:

- So you want to do a research project
- Taking the mystery out of statistics
- Qualitative research project design
- Questionnaire and survey design
- Getting published
- How to write a good journal article
- Conference presentations and posters

The methodological approach (CBPAR) allowed us to develop our skills alongside the community research volunteers coupled with help, guidance and mentoring from a number of experienced researchers. Framework analysis also provided a clear and structured platform to analyse the data.

Despite training provided to the CRVs and the benefits the CRVs brought to the study, they too were novice at facilitating a focus group and collecting data. Further, while reflexivity was encouraged as much as possible, there is a possibility that researcher bias may have been introduced by the community research volunteers who did not necessarily reflect on their own influence on the data. This was, in part, overcome through the presence of a researcher who also took notes at each kitchen table chat, through researcher triangulation (a total of 12 persons collected the data and 5 analysed the data), data triangulation (multiple sources of data), a high degree of collaboration between participants and the researchers (Curtin and Fossey, 2007) and through the use of a clear data analysis process (Framework analysis).

This study is limited in generalisability having been conducted with a relatively small sample in one rural township. The methodology however may be useful for other health promotion groups seeking to engage the community in research and results may be broadly transferable to low income groups in other communities.

Conclusion

A community-based participatory action research (CBPAR) approach was used to explore the unique issues and challenges associated with healthy eating for families living on low incomes in the Rural City of Wangaratta. This approach and the use of community research volunteers not only enabled the collection of local data but the building of local community capacity to identify issues and develop local actions to facilitate healthy eating. We have identified that community involvement and community cooperation, encouraging social inclusion and up-skilling and training community members in essential skills like budgeting, prioritising and cooking are key mechanisms that can facilitate healthy eating in this community. These findings will form the basis of interventions to address healthy eating in our local community. The next stage of this research will be to implement the identified solutions.

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Appendices

Appendix 1: Focus Group Script

Things to cover in the chat

The green bold script you need to read out for the purpose of the research project if they don't complete the written consent.

1. All other notes are to guide you, not to read out.
2. Welcome everyone, explain where the toilets are and offer tea, coffee and food.
3. Introduce yourself and note taker. Explain we are wanting to find out what makes it easy, hard to eat well, and what might make it easier.
4. Icebreaker (if you feel the group needs one). Everyone introduces themselves - name, how long you have lived in the area, and favourite food
5. Ask the group to set some group rules so people feel comfortable to share.
6. Raffle
7. Feedback: form
8. Summarise the questions which will be asked (in green on next page) to set the scene and put everyone at ease.
9. Any questions or concerns before continuing
10. Ask everyone whether they would prefer written or verbal consent
11. Written- give consent form and draw attention to reading and understanding the statement.
12. Verbal- tell the group that the audio recorder is being turned on and that verbal consent will need to be made before going any further
13. Turn on and test tape (note taker)
14. Turn on new recording (note taker) and Community Research Volunteers to read out the following if doing verbal consent:

"Today's date is XXXX To help us keep good records of what we talk about during the chat today, we are audio recording and note taking this conversation from now onwards. The audio recording will be typed in to written information by a staff member of the research project, and no names will be mentioned. Then the audio recording will be deleted. Please be assured that all your responses are confidential and will only be used for the purpose of this research. Our summary report will make no reference to names.

If you feel concerned about something, please speak to myself or someone else from the research team (contact details are provided on the invitation sheet I gave to you. There are more copies here on the table if you need another one). If anything

discussed today finds that anyone is at risk of harm, it is my responsibility to tell my supervisor. There are support services available which we can help you access.
You are free to leave this chat at any time. If you do leave, what has already been tape recorded will not be able to be deleted, but no information in the written work will identify who you are.

Because the information provided in this chat is going towards research, I need you to agree to take part and for the chat to be audio recorded and note taken. We have [number of people giving verbal consent] people here today. (Only if some written consent was given- state the number of people who gave written consent and how many people remain to provide verbal consent). We will now go around the table and get a 'yes' from you that you are happy to participate. (Go around the room and get them to individually say yes). All [number of people] said 'yes'"

15. Note take to stop recording and start a new recording.
16. Begin discussion:

"Please remember that your answers to the questions I will now be asking you are not to be considered "right" or wrong". Rather, they are information that you can give based on your experiences, observations and feelings."

- **What does eating 'well' mean to you?**
- **What challenges do you face in getting you and your family to eat well? (hard)**
- **Thinking about when you buy food for your family, how do you decide what to buy?**
- **What helps you and your family to eat well now? (easy)**
- **What would make it easier for you and your family to eat well in the future? (solutions)**

Tips: Restate the question you are on if you feel people are going off track or before moving on to the next questions to see if there are any final points to be made.

Say the question in a different way if you think people don't understand or response is quiet.

17. Once discussions are finished, check if there are any other questions or comments.
18. Raffle and feedback form

Appendix 2: Evaluation/feedback questionnaires undertaken by participants of the KTCs

Local People, Local Food Solutions- Kitchen Table Chat Feedback

1. Age in years (circle or tick)

18-25

26-35

36- 50

50+

2. Gender (circle or tick)

Male

Female

Choose not to provide

3. What is your town or postcode?

4. Background (circle or tick all that apply)

Aboriginal/Torres Strait Islander

Australian citizen

Born overseas

Choose not to provide

5. How many children aged 0- 12 years do you have or care for?

6. Employment (circle or tick all that apply)

Working full-time

Working part-time

Not working- looking for work

Home duties

Studying

Other

7. Main Source of Income

Salary or wages

Centrelink

Other- please specify

8. Do you have a Health Care Card (circle or tick)?

Yes No Choose not to provide

9. Do you feel that your attendance and input today was valued?

Yes No Why?.....

10. Are you glad you attended the chat?

Yes No Why?.....

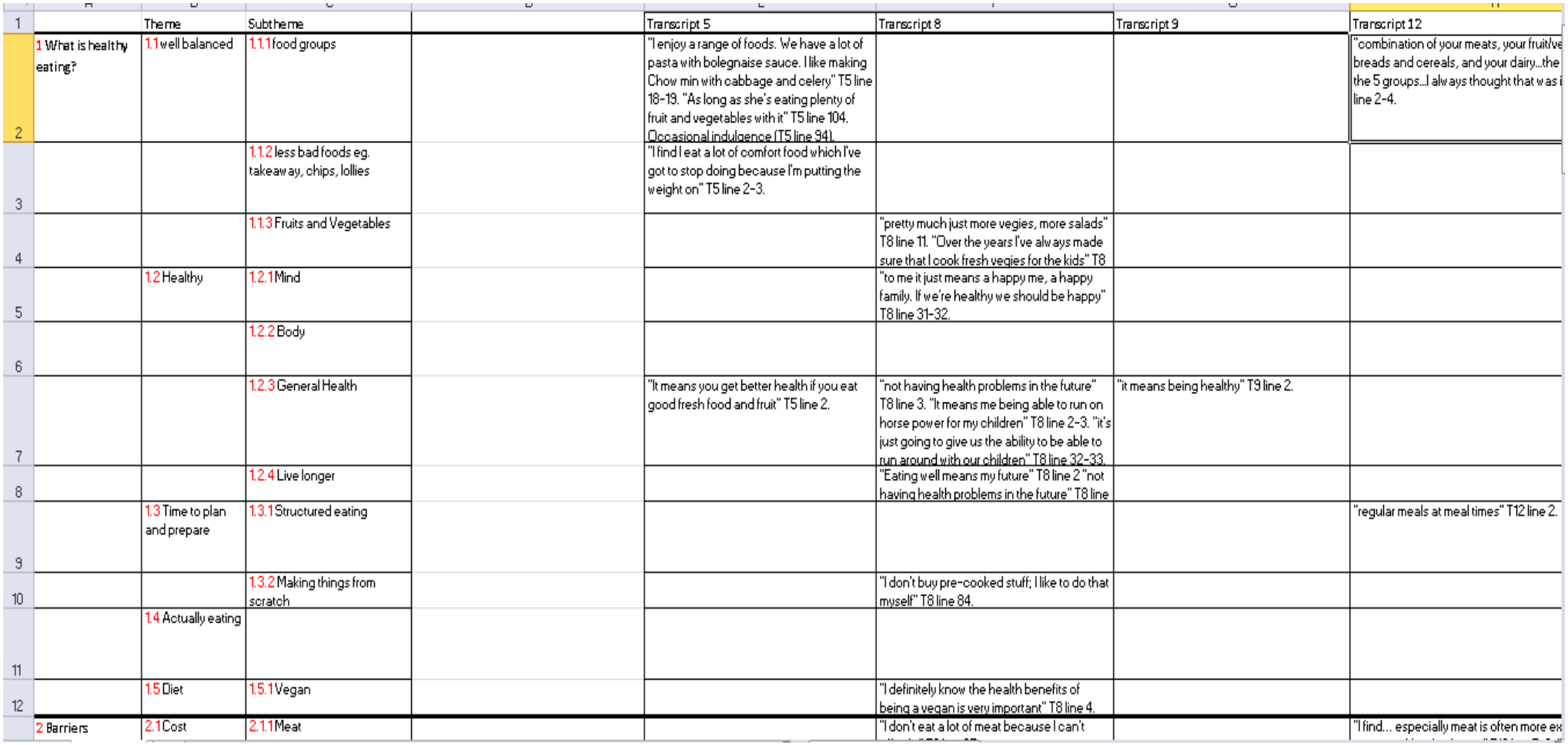
11. Would you be interested in attending a Community Celebration Event at the end of this research project?

Yes No

12. Any other comments?

Appendix 3: Data Analysis

Figure 1: The data analysis template Combined spreadsheet example



		Theme	Subtheme		Transcript 5	Transcript 8	Transcript 9	Transcript 12
2	1 What is healthy eating?	1.1 well balanced	1.1.1 food groups		"I enjoy a range of foods. We have a lot of pasta with bolegnaise sauce. I like making Chow min with cabbage and celery" T5 line 18-19. "As long as she's eating plenty of fruit and vegetables with it" T5 line 104. Occasional indulgence (T5 line 94).			"combination of your meats, your fruit/ve breads and cereals, and your dairy...the the 5 groups...I always thought that was i line 2-4.
3			1.1.2 less bad foods eg. takeaway, chips, lollies		"I find I eat a lot of comfort food which I've got to stop doing because I'm putting the weight on" T5 line 2-3.			
4			1.1.3 Fruits and Vegetables			"pretty much just more vegies, more salads" T8 line 11. "Over the years I've always made sure that I cook fresh vegies for the kids" T8		
5		1.2 Healthy	1.2.1 Mind			"to me it just means a happy me, a happy family. If we're healthy we should be happy" T8 line 31-32.		
6			1.2.2 Body					
7			1.2.3 General Health		"It means you get better health if you eat good fresh food and fruit" T5 line 2.	"not having health problems in the future" T8 line 3. "It means me being able to run on horse power for my children" T8 line 2-3. "it's just going to give us the ability to be able to run around with our children" T8 line 32-33.	"it means being healthy" T9 line 2.	
8			1.2.4 Live longer			"Eating well means my future" T8 line 2 "not having health problems in the future" T8 line		
9		1.3 Time to plan and prepare	1.3.1 Structured eating					"regular meals at meal times" T12 line 2.
10			1.3.2 Making things from scratch			"I don't buy pre-cooked stuff; I like to do that myself" T8 line 84.		
11		1.4 Actually eating						
12		1.5 Diet	1.5.1 Vegan			"I definitely know the health benefits of being a vegan is very important" T8 line 4.		
	2 Barriers	2.1 Cost	2.1.1 Meat			"I don't eat a lot of meat because I can't		"I find... especially meat is often more ex

Figure 2: Wall chart example

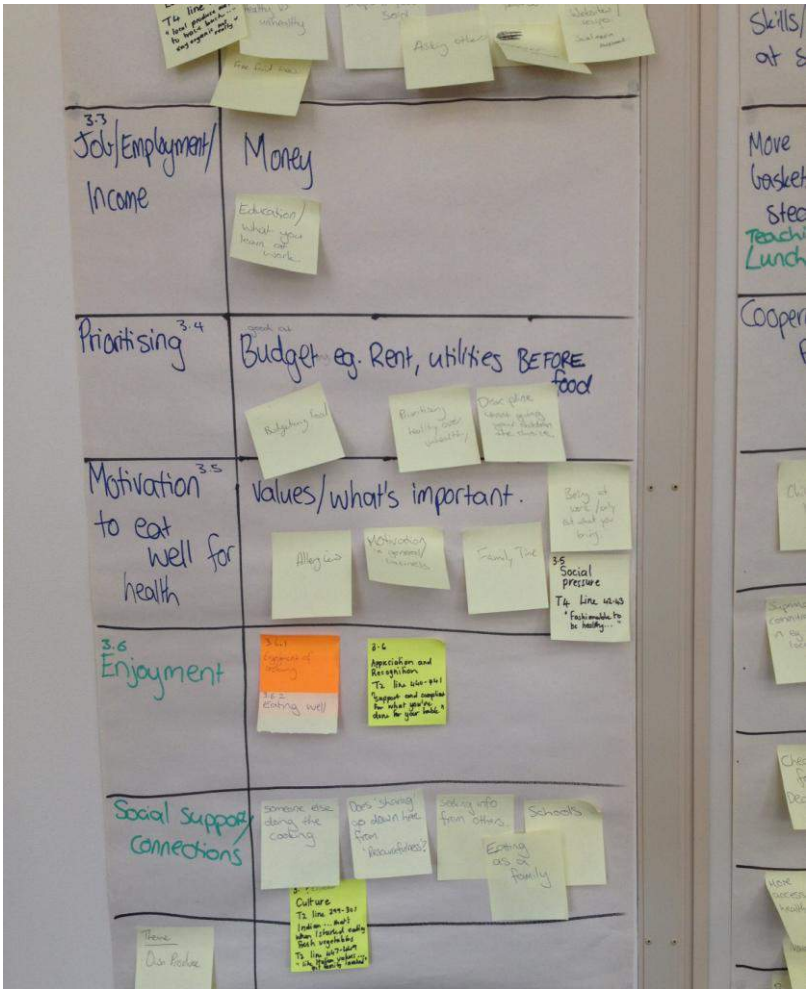


Figure 3: Mapping wall chart example

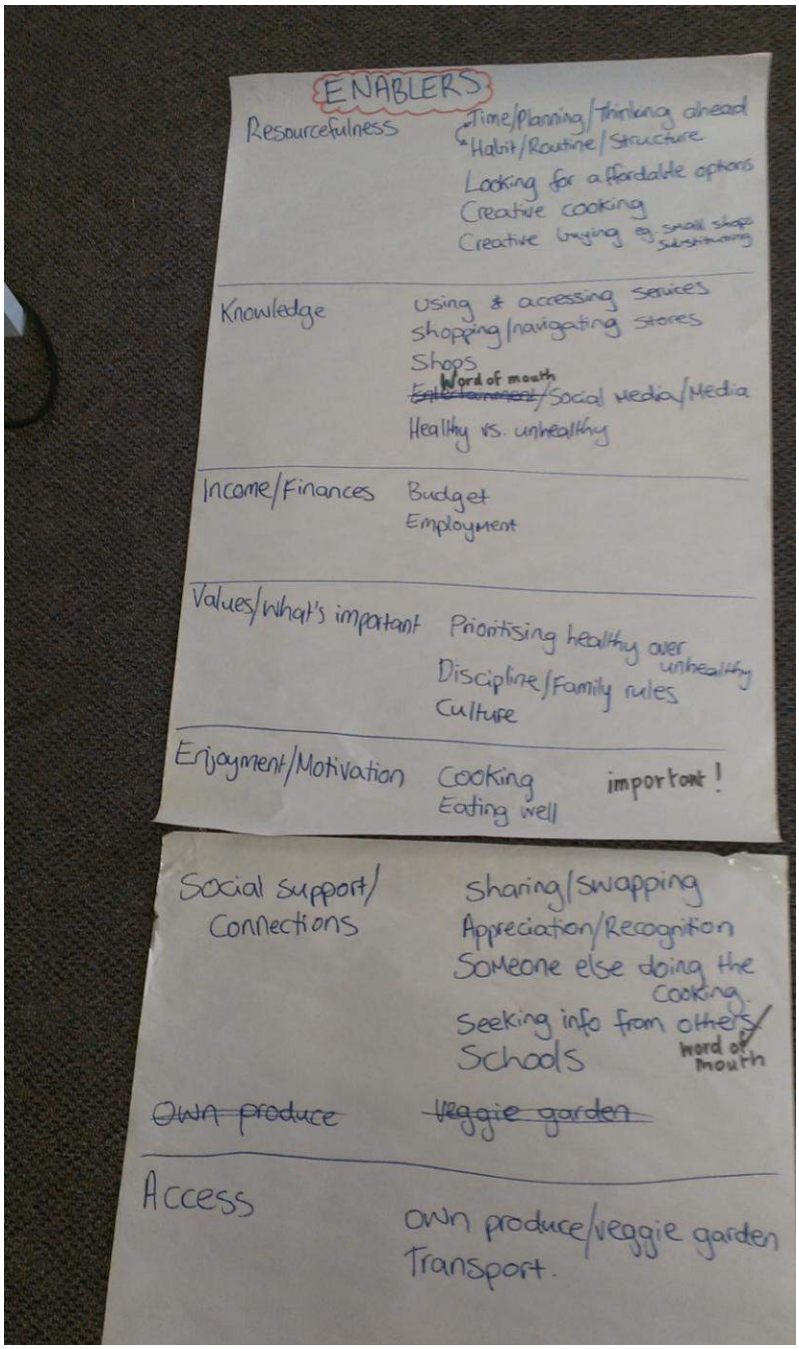


Figure 4: Mapping poster example