August 28, 2006

To: Board of Health

From: Dr. David McKeown, Medical Officer of Health

Subject: Peer Nutrition Program Evaluation

Purpose:

The purpose of this report is to inform the Board of Health about the Health Canada funded evaluation of the Peer Nutrition Program and the recommendations and actions stemming from that report.

Financial Implications and Impact Statement:

There are no financial implications stemming directly from this report.

Recommendations:

It is recommended that:

(1) the Board of Health request the Toronto Food Policy Council to undertake activities, including urban gardening, aimed at improving food security for Toronto's ethno-cultural and ethno-racial families and children, in collaboration with the Peer Nutrition Program;

(2) the Board of Health request the Toronto Food Policy Council to work with the Peer Nutrition Program to advocate for capital funding for community kitchens in community recreation centres of priority neighbourhoods;

(3) the Board of Health forward this report to the Ontario Ministers of Health and Long-Term Care, Health Promotion, Children and Youth Services, and Community & Social Services, as well as Toronto Children Services, Ontario Public Health Association, Toronto Food Policy Council, Food and Hunger Action Committee and Medical Officers of Health in the Greater Toronto Area; and

(4) the appropriate City Officials be authorized and directed to take the necessary action to give effect thereto.

Background:

The Peer Nutrition Program, which began in 2000, aims to improve the feeding practices and skills of parents with children ages six months to six years of age within diverse ethno/cultural communities in Toronto. This is a cost-shared program delivered under the Child Health, Chronic Disease Prevention and Access and Equity Mandatory Program Guidelines. The goal of the program is to enhance the nutritional status of children whose parents and caregivers are often missed by traditional nutrition programs. The components of the program include nutrition education, cooking and food skills, nutrition support groups, and food security activities such as community gardens and food budgeting. The program is delivered by Community Nutrition Assistants who are supported by Dietitians and Nutritionists. Through a wide array of partnership arrangements, the Peer Nutrition Program delivers these services in more than 30 different languages at more than 70 locations across the city.

In late 2005, Toronto Public Health received funding through the Health Canada Innovation Fund to conduct an evaluation of the Peer Nutrition Program service model. At its January 2006 meeting, the Board of Health approved the receipt of $35,000 for this purpose. Health Canada acknowledged the unique and innovative approach that Toronto's Peer Nutrition Program uses to access and serve diverse communities; in particular, its approach to engaging community members to assist families, its outreach to ethno-racially diverse populations, its provision of culturally and linguistically appropriate programming and its numerous community partnerships. By evaluating Toronto's Peer Nutrition Program, Health Canada was looking to develop a program evaluation model that could be used to replicate and evaluate other community-based peer programs in Canada.

Through the Request for Proposal process, a consultant was hired to complete the evaluation. A qualitative action research study design that would identify key factors responsible for the success and challenges of the program was developed and approved through Public Health's research and ethics review process.

Comments:

The qualitative action research methodology used in this evaluation included observation of both education and drop-in programs and key informant interviews and focus groups with program staff, program participants, members of the Peer Nutrition Program Community Reference Group and participants of the Peer Nutrition Program community gardens. This provided invaluable insight into the experiences and perceptions of both our community partners and the families that we serve. A review of background documentation and program service statistics was also completed. It should be noted that measurement of actual behaviour change related to nutrition practices of families and the healthy development of children (beyond those self-reported by the participants) was beyond the scope of this evaluation.

In Spring 2006, Toronto Public Health presented the "Peer Nutrition Program: Developing a Model for Peer-Based Program Aimed at Diverse Communities" report to Health Canada. A

copy of the Executive Summary of this Report is attached. A copy of the full report will be available at the Board of Health meeting.

In addition to supplying Health Canada with a detailed description of the Peer Nutrition Program and a program model that outlines defining characteristics, guiding principles, as well as the conditions and process necessary to establish a community-based peer program, the report also includes a number of recommendations directed at both Toronto Public Health and Health Canada.

Community demands for additional programs in certain languages and growing wait lists in some communities and for services in some languages prompted a recommendation regarding the need for additional program funding. The program began in 2000 with eight Community Nutrition Assistants, four Dietitians and one Acting Manager. In 2003, one of the Community Nutrition Assistant positions was changed to a Nutritionist to address the issues of food security among program participants. Due to the success of the program, a permanent program manager and one-time funding was provided in 2004. In 2005, the program doubled in size by adding another Manager, eight more Community Nutrition Assistants, two more Dietitians and one more Nutritionist. Consequently, in order to allow the program to adjust to this rapid growth, no addition funding was requested in 2006 or will be requested in 2007. Additional funding needs will be considered in the 2008 budget cycle.

Outreach to Toronto's diverse communities is an essential part of the Peer Nutrition Program and a variety of strategies are necessary to reach different communities. The Evaluation Report identified a need "to research effective outreach strategies for less involved communities such as Aboriginal, Caribbean and African groups." Although Peer Nutrition Program staff from these cultures have been diligent in their efforts to engage these communities, work is currently underway to explore partnerships, mechanisms and funding sources to support research initiatives to further identify effective outreach strategies that could be used. This information will enhance the program's ability to reach more families.

Food security was identified by staff, community partners and participants as a major issue. Despite the fact that many of the women who participate in the program were well educated in their country of origin, more than 40% have an annual take-home household income of under $18,000. Recommendations related to food security included advocating for more community gardens, advocating for funding to establish or upgrade community kitchens in high-needs areas and working with community partners to develop more effective strategies to deal with household and community food insecurity issues. These recommendations are consistent with the "Food Security: Implications for the Early Years" report and recommendations that were approved by the Board of Health at its February 27, 2006 meeting.

The validation and support of individuals, their personal/family circumstances and their cultural practices by respectful and knowledgeable Peer Nutrition Program staff was identified as critically important in building both trust and an increased sense of self-esteem and efficacy. Additionally, the topic of food provides a non-threatening, culturally acceptable forum for women to begin to share their experiences and challenges. It was, therefore, not surprising to learn that the Peer Nutrition Program often provides a gateway to other community and public

health services. This led to a recommendation to strengthen the connection between the Peer Nutrition Program and other public health programs and to increase the understanding of Healthy Families managers and staff about the multidimensional aspects of food and nutrition for different cultures. Through the Healthy Families/Healthy Living reorganization in 2005, the Peer Nutrition Program became an integral part of the Healthy Families Service Area and work is already underway to build stronger linkages between Peer Nutrition Program and other Healthy Families programs such as Healthiest Babies Possible, Healthy Babies Healthy Children, Preschool Speech and Language and other early identification and parent education programming. A Healthy Families Nutrition Co-ordinating Committee has also been established to review and revise nutrition resources so that they are both culturally-sensitive and consistent across the various programs.

The validation and support of program staff was also identified as critical to the success of the Peer Nutrition Program and was named as one of the guiding principles of a community-based peer program. The mixed model of front-line peer facilitators who possess language skills, cultural competence and relevant experience, supported by mentor professionals who have the content expertise is one of the defining characteristics of the Peer Nutrition Program program model. The Peer Nutrition Program currently refers to its front-line peer facilitators as Community Nutrition Assistants. However, given the critical importance of language in shaping people's perceptions, the report recommends changing their name to something that more accurately reflects their expertise and function (e.g. Peer Nutrition Facilitator, Community Nutrition Educator). Toronto Public Health will pursue this change.

As stated above, the report also directs several recommendations to Health Canada. The first one is to apply the proposed model in a variety of programs where diverse communities do not seem to be attending traditional services, such as programs related to parenting, physical activity, sexual health, oral health and chronic disease prevention. Based on the success that Toronto Public Health has experienced with the Peer Nutrition Program, we support this recommendation and have offered our assistance to Health Canada to share this report and Toronto Public Health expertise with other jurisdictions. To support this, the report has also made a recommendation to extend the work of this project by developing a how-to resource kit on establishing a peer-delivered program in diverse communities. Toronto Public Health has much expertise to offer in this regard and is currently in negotiation with Health Canada for additional funding.

The words of program participants from the evaluation focus groups best capture the findings of this evaluation of the Peer Nutrition Program. One Afghani mom said, "We want to know and we don't have any relatives here. So, it's important that we meet and talk with each other. We can solve our problems". An aboriginal mom said "we come because we like the food, we like the environment, we like to sit down at the table with our babies. We're urbanized native people but we're still isolated. So we get to come together with our people, without cultural barriers which is good".

Conclusions:

The Health Canada-funded Peer Nutrition Program Evaluation has benefited both Health Canada and Toronto Public Health. Health Canada now has a model for the development and evaluation

of community-based peer programs. Toronto Public Health looks forward to working with Health Canada to disseminate the findings of the report and to supporting other communities to establish similar peer programs. For Toronto Public Health, the evaluation has clearly named the defining characteristics and guiding principles that have made the Peer Nutrition Program successful, and has provided validation to Peer Nutrition Program staff and community partners who have worked so hard to establish this program in the community. At the same time, it has highlighted some future directions that can be undertaken to assure its continued effectiveness for ethno-cultural communities in priority neighbourhoods within the City of Toronto.

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List of Attachments:

Attachment: Health Canada Evaluation Report Executive Summary

Attachment

PEER NUTRITION PROGRAM:

DEVELOPING A MODEL FOR PEER-BASED PROGRAMS AIMED AT DIVERSE COMMUNITIES

Prepared for Toronto Public Health
and Health Canada

by

Arlene Moscovitch

Spring, 2006

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Finally, to all the focus group participants who were so ready with a welcome, so willing to share their opinions and so eager to learn whatever might benefit their children, their families, themselves and their communities, thank you.

Executive Summary

The Peer Nutrition Program delivers culturally and linguistically appropriate nutrition programs to parents, grandparents and caregivers of children aged six months to six years in diverse underserved communities. The program is currently offered in 32 different languages and at more than 70 locations across the City of Toronto. Program participants receive direct education from 16 peer facilitators, called community nutrition assistants, with the support of six dietitians, two nutritionists and two managers who both have a nutrition background.

The program consists of three main components: nutrition education and food skills workshops that last for six to ten sessions, ongoing follow-up drop-ins (support sites), and a community garden initiative. The Peer Nutrition Program uses a partnership model that currently involves a collaborative relationship with 78 community agencies and organizations.

A qualitative research study was undertaken February-March 2006 to identify the key factors responsible for Peer Nutrition's success, with a view to developing a program model for other peer-delivered programs aimed at diverse ethno-cultural, ethno-racial and Aboriginal communities. In addition to identifying the key factors, the research also focused on the lessons learned and challenges encountered by those implementing the program.

The qualitative action research methodology used in this study included observation, key informant interviews and focus groups with program staff, program participants from a range of diverse communities, members of the Community Reference Group and participants in Peer Nutrition's community garden initiative. Relevant program documents, literature reviews and quantitative program data collected since November 2000 also informed the development of an extensive case study and ensuing model. The report has been written in a style that is intended to add a human dimension to useful information.

Based on program statistics, interviews with community partners, and focus groups with program participants, it is clear that a wide variety of ethno-cultural, ethno-racial and Aboriginal communities in the GTA highly value the Peer Nutrition program. Participant feedback also suggests that the program has helped improve the nutritional status of young children (and their families) in at-risk groups that were not using existing mainstream or multicultural programs offered by Toronto Public Health. Peer Nutrition delivers its nutrition-based education to diverse underserved communities with a firm focus on the social determinants of health; the ready acceptance by those communities

of its culturally responsive services has helped to reduce health disparities, in accord with Toronto Public Health's strategic directions.

The Peer Nutrition Program has much to offer other community-based peer-delivered programs to diverse communities in terms of effective program delivery as well as information about research, protocols, strategies, processes, and so forth. Other peer-delivered programs do exist but this one is notable for several reasons which the research shows are intrinsic to its success: it is language and culture-specific; the tailored program is delivered by a mixed team of front-line peer facilitators supported by mentor professionals; community involvement is ongoing and includes collaborative relationships with host partners.

Key Findings

- The linguistic and cultural specificity of the program creates a supportive initial environment for participants who feel safe and respected, and therefore better able to voice concerns and absorb new information and skills. Participants who continue on to the program's second phase are usually comfortable enough by then to enjoy mixed ethno-cultural and ethno-racial settings.

- The mixed team model is particularly effective because it combines the language skills, cultural competence and relevant experience of the peer facilitators with the content expertise and specialized support of the certified professionals, thereby providing quality assurance.

- The program develops and delivers culturally appropriate content in a culturally appropriate way. The validation and support of cultural practices and individual experiences by respectful and knowledgeable staff is critically important in building both trust and an increased sense of self-esteem and efficacy. Having developed trust, participants then use the program as a gateway to access other resources and services within Public Health and the larger community.

- Ongoing community involvement and input through community consultations and an advisory Community Reference Group are essential for advocating for the program, recruiting partners and testing resource materials. Community ownership of the program has grown as the program has proved itself to be both knowledgeable about and responsive to community needs and concerns.

- The Peer Nutrition Program is community-driven, with the bulk of its referrals coming from community sources. Internal referrals to the program from Toronto Public Health are low.

- The nutrition education offered by the program is seen as important by participants but the reduction in social isolation, as well as the community engagement and skills development the program offers are almost equally valued.

- Food functions as a non-threatening, culturally acceptable entry point into other community services and resources. Consequently, when developing programs, it may be useful to look for linkages between food and other topics that are considered more controversial by some communities, such as HIV/AIDS.

- Though generally well educated, the majority of Peer Nutrition participants are dealing with extreme poverty, and household food access and insecurity are pressing concerns for many.

Recommendations

- **Continue to advocate for increased funding** for the Peer Nutrition Program
  (a) to meet community-based demands for additional programs and to address the waiting lists in some communities
  (b) to research effective outreach strategies for less-involved communities, such as Aboriginal, Caribbean and African groups.

- **Advocate for funds for more Peer Nutrition community gardens** to address food security issues, encourage the growth of cultural foods and promote cultural sharing and physical activity.

- Given the high rate of poverty among Peer Nutrition Program participants, **develop more effective strategies to deal with household and community food insecurity issues.**

- Given the integrative and social development aspects of community kitchens**,** advocate for funds for **capital grants to establish or upgrade more community kitchens** in high-needs areas, with a particular emphasis on social housing and neighbourhood community centres.. This is in line with health promotion strategies stressing social and skills development.

- **Strengthen the connections between the Peer Nutrition Program and other Toronto Public Health programs.**

  a) The low rate of Toronto Public Health referrals into the Peer Nutrition Program causes a break in what would seem to be a natural flow in

services, e.g., from the Healthiest Babies Possible Program which ends at six months into the Peer Nutrition Program which begins at six months. Establish and implement an automatic referral process within Toronto Public Health to ensure that this flow occurs.

b) Implement cultural sensitivity training for TPH managers and staff around the multidimensional aspects of food and nutrition for different cultures. This includes the social, emotional and ceremonial aspects of the food consumed by diverse groups.

- Given the critical importance of language in shaping people's perceptions, the **term "Community Nutrition Assistants" should be reframed** to more accurately reflect the peer workers' expertise and function. Some suggested terms are ""Peer Nutrition Facilitators" (as used in this report), " Community Nutrition Facilitators", "Community Nutrition Educators" or "Peer Nutrition Educators".

- **At a national level, apply the proposed model** in a variety of programs where diverse communities do not seem to be attending in significant numbers. This may include parenting programs, health programs such as diabetes, cancer prevention and heart health, physical activity programs and sexual health programs.

- **Develop a how-to resource kit** on establishing a peer-delivered program for diverse communities for other interested organizations and agencies. Such a kit would include guiding principles and templates to be adapted to local cultures and circumstances: e.g., protocols for developing culturally appropriate resources, how to identify community connectors, hiring criteria and appropriate training for the peer facilitators as well as the support structures required.

Introduction

At a Wigwamen Housing building in Scarborough, an Aboriginal group in the Peer Nutrition Program prepares for a feast. Wanina, the Community Nutrition Assistant, sets out all the dishes she has prepared for the grand sum of only $30.

There's soup swimming with corn and beans and turnip, a variation on the "three sisters"; wheat crackers topped with cream cheese laced with crushed pineapple; two kinds of salad; tiny rolls stuffed with smoked turkey and mozzarella cheese; a fruit plate that glows with jewel colours: green kiwi, wine-red grapes, chunks of straw-coloured banana. "You see," Wanina says, as she sprinkles the last of the red pepper strips onto the fresh green salad, "the best way to get people to want to eat your food is to prepare it with lots of colour."

Taking a tip from Wanina, this report aims to capture the flavour of Toronto Public Health's Peer Nutrition Program, an innovative undertaking to improve the nutritional status of young children in diverse ethno-cultural, ethno-racial and Aboriginal communities in the Greater Toronto Area. It does so with the hope that readers, having experienced what the program has meant to all who have participated in it, will be inspired by the blend of ingredients – in particular, the mix of peer facilitators and mentor professionals, supported by ongoing community input and partnerships –to create recipes for other offerings intended to nourish communities on many different levels.

Objectives

The objectives of this report are three-fold:

1. To present a detailed examination of Toronto Public Health's Peer Nutrition Program as the basis for developing guidelines for those who wish to create community-based, peer-delivered programs serving culturally and linguistically diverse populations.

2. To answer the Key Question: Which critical factors have been responsible for the Peer Nutrition Program's success?

3. To present the "flavour" of the program in an accessible and engaging way which intensifies user involvement.

Report Structure

The report is divided into three main sections:

A. Case study of the Peer Nutrition Program
B. Critical Factors for a Program Model
C. Appendix of Culturally Appropriate Resources

Approach and Methodology

The qualitative action research methodology used in this study included observation, conversation, key informant interviews and focus groups. In-depth interviews were done with program managers, the community health officer and several community partners. Focus groups were conducted with program participants from various communities; with program staff, including front-line peer facilitators and mentor professionals; with members of the Community Reference Group; and with participants in the community garden initiative.

Focus Group Selection

With input from the program managers, 12 participant focus groups were selected. They included nine program sites and three follow-up support or drop-in sites. Sites were chosen according to several criteria. Programs for Aboriginal participants, teen mothers and the African-Caribbean community were selected because these groups are often the most difficult to reach. The remaining groups were chosen to reflect the geographical

spread and ethno-cultural and ethno-racial range of the communities served by the Peer Nutrition Program.

The education program groups were: Aboriginal (2), Filipino, Afghani, mixed South Asian, teen mothers, Spanish-speaking, Caribbean and participants from Ghana. The drop-in sites were Tamil, a mixed group with emphasis on the Middle East and Eastern Europe and another mixed group with emphasis on Portuguese, Filipino, Tibetan and Vietnamese.

In almost every case, the evaluator visited each education group twice. The first visit was solely for observation purposes and to create a comfort level for the participants by meeting them and explaining the reasons for the study.

Translation/Interpretation

Six focus groups were conducted in languages other than English. In concert with the managers and with input from the peer workers, it was decided that the peer facilitators, usually known as , should function as translators/interpreters for those six groups. This was done because of their familiarity with the content and context of the Peer Nutrition Program and because of the comfort and trust level they had already established with the participants. The peer facilitators translated the consent letters and photo release forms into the appropriate language when needed, acted as interpreters for the evaluator and participants, asked the focus group questions and translated and transcribed the taped sessions into English.

The peer facilitators had already had several meetings with the evaluator, had taken part in their own focus group and had contributed to the framing of questions for the participants. This familiarization process with the evaluator was an important factor in facilitating an easy flow of information and a sense of comfort with their crucial role in the participant focus groups.

Story Snapshots

Innovative projects beg for innovative modes of presentation. Models are skeletons, highlighting the structural/anatomical features of a program. Stories put flesh on the bones so that the model then has a life of its own. With a nod to the work of Labonte and Feather (*Handbook On Using Stories in Health Promotion Practice, 1996)* "story snapshots" and photographs are used to document the human interactions unfolding within the program. "Story snapshots" illustrate the principles/criteria/indicators which they exemplify, so as to provide the context necessary to understand which factors lead

to success or failure and why. These are supplemented by a liberal use of quotes to convey the immediacy of people's experiences in regard to the program.

Almost all the photographs used in the report were taken by the evaluator and the participants who used disposable cameras. The participants who wanted to take pictures were asked to record what was most important to them about the program. Copies of all the photos were given to the participating groups.

Finally, relevant program documents, literature reviews and quantitative program data collected since November 2000 also informed the development of the case study and ensuing model.

Overarching Metaphors

The Peer Nutrition Program is about food. It is about other things as well but food functions as the connector and vital entry point for the people who attend the program. At a certain level of abstraction, we may wish to strip away the food component and take a generalized look at Peer Nutrition's structures, processes, attitudes and understandings so as to possibly adapt them to other health-promoting programs for diverse communities. Even so, we would be wise to remember the food connection, not least because it offers two resonant metaphors – **nourishment** and **hospitality** – which help to explain the program's appeal and effectiveness. Nourishment, like health, is a multi-dimensional word. People can be nourished on many levels and clearly by far more than the nutrients in their food, important as those may be. So it's helpful to ask, "What does nourishment include?" and "How is it taken into account when designing health-promoting programs?" It's worth noting that the dictionary definition of "nourish" flags "encourage" and "support" as synonyms.

For writer John Berger, the notion of hospitality is central to the way he uses language. There are, he claims, hospitable and inhospitable writings, and clarity and hospitality go together. Beyond the goal of clear, inviting and friendly language, there lie further questions: What factors create a hospitable environment? What helps to make people feel welcome and at ease when attending programs?

These and related matters are explored in the following case study.

A. Peer Nutrition Program: The Case Study

The Peer Nutrition Program is like a big banyan tree. It gives shelter to everyone.
Tamil participant

This program values people's culture. You are not here to break them and build something new, you are building on already existing values and customs. You are respecting cultures and finding tools.
Peer Nutrition facilitator

Program Description

The Peer Nutrition Program delivers culturally and linguistically appropriate nutrition programs to parents, grandparents and caregivers of children aged six months to six years in diverse underserved communities. The program is currently offered in 32 different languages and at more than 70 locations across the City of Toronto. Program participants receive direct education from 16 peer facilitators, called community nutrition assistants, with the support of six dietitians, two nutritionists and two managers.

The program consists of three main components: nutrition education and food skills workshops that last for six to ten sessions, ongoing follow-up drop-ins (support sites), and a community garden initiative. The Peer Nutrition Program uses a partnership model that currently involves a collaborative relationship with 78 community agencies and organizations.

Program Goals

- To enhance the nutritional status of children six months to six years in diverse communities by improving food selection, purchasing and preparation skills among participating families

- To deliver multicultural and multilingual healthy eating messages that are appropriate and sensitive to culture, faith and literacy levels

- To encourage activities that integrate food-related beliefs and practices from diverse cultures into Canadian guidelines for healthy eating

- To share information with participants about the influence of nutrition on various stages of child development

- To share information about different stages of development and cultural practices, such as the early introduction of solid foods, in a way which is both culturally sensitive and grounded in the most up-to-date research

- To deal with food insecurity issues by showing participants alternatives to being funneled into the culture of food banks

- To provide additional "nourishment" by offering social supports and building leadership skills among participants from underserved diverse communities so as to increase their participation within society

Genesis and Initial Challenge

The impetus to create the program came from several sources. Chief among them were the Children and Youth Action Committee's *1999 Toronto Report Card on Children* and the 2000 *Ornstein Report on Ethno-Racial Inequality in Toronto*, based on 1996 Census data. The existence of underserved communities with high needs was underscored, as well as the imperative to create programs there that would support child development and parenting.

One challenge identified was how to design a program that would improve the nutritional status of children in diverse ethno-cultural, ethno-racial and Aboriginal communities that were not accessing existing mainstream or multicultural Toronto Public Health programs. As part of the CYAC Action Plan, a Peer Nutrition Worker Program was established and

with initial funds of $459,000 began operations in November 2000. The projections were that it would serve about 720 parents per year and involve over 1200 young children. Five years later, the program annually reaches almost three times the number of parents originally projected and about 2.5 times the number of children. In some communities, there are long waiting lists to get into the workshops.

Who Comes? Participant Profiles

The Peer Nutrition Program has clearly been successful in attracting parents and caregivers of children aged six months to six years to its program, but who exactly has been coming? Systematic data has been collected since the program began in November 2000. The most current statistics – January to December 2004 – that were available at the time of this study paint the following picture.

Numbers Served

In 2004, the Peer Nutrition Program with a budget of one million dollars served 1904 clients and reached 2864 children in its education sessions. An additional 900 adults attended the drop-ins. More than eighty childcare workers were trained in nutrition and 6000 people were also reached through promotional workshops.

Cultural Groups

The three most strongly represented groups were of East and South East Asian origins (38%), South Asian origins (23%) and African, Black and Caribbean origins (15%). Those of Aboriginal origin made up 1.6% of the total.

Languages

33% of the participants chose English as their preferred language for a workshop; 69.7% chose another language.

Age

55.4% of the participants were between the ages of 19-35. A substantial 44% were 36 years or older.

Participant's relationship to child

Mothers made up 79% of the total participants, followed by grandmothers at 8.8%, caregivers at 7.35 % and fathers at 2.6%.

Years in Canada

Though the largest percentage of participants (55.4%) had been in Canada 0-5 years, substantial numbers had been here far longer: 21.3% for 6-10 years, 12.4% for 11-15 years and 10.8% for longer than 16 years.

Education level

23.8 % of all participants have finished high school, 12.3% have attended some college or university and 31.6% have completed college or university. In other words, more than 40% of all participants have post-secondary education.

Family income

40.4% of all participants have a take-home household income of less than $18,000. Another 26% fall between $18,000-$28,000. 25% are on social assistance.

Major expenses

Housing (for 87.5% participants), groceries (for 84.7%), transportation (for 63.3%)

Food security issues

- 8.9% of participants use a food bank or other food access service.
- Of the clients who use a food bank, 58% found the food bank adequate, 41% did not.
- Of those who did not find the food bank adequate, the clear majority (66.7%) was of Arab or West Asian origins. This most likely ties into those communities' concerns about halal food.
- Of the 10% who go without food sometimes, 1/3 do so because of lack of money.

Other food-related data

- 46% of participants prepare meals for up to three people, 48% for four to six people.
- 34% of participants worry about the way their family eats.
- 83% of participants' children were breastfed, with a clear majority (67.6%) breastfeeding for 4 months or longer.
- The majority (57.4%) introduced solid foods at 4-6 months, with another 29.8% doing so between 6-8 months.

Snapshot: Aboriginal Food Issues

People of Aboriginal descent make up 1.6% of PNP participants.
According to program statistics, they have proportionally

- the highest rate of worry about how their family eats (61.3%),
- the second highest rate of food insecurity issues for self or family (19.4%),
- the highest rate of food bank use (77.4%),
- the highest rate of early infant feeding (less than 2 months) of all the cultural groups surveyed.
- Of all the cultural groups surveyed, Aboriginal adults are least likely to take vitamins themselves but most likely to give them to their children.

70% of all participants do physical activity at least once a week or more. This breaks down into 35% daily, 18.5% three times a week, 16.2% at least once a week.

How Participants Heard about PNP

- 67.8% of referrals came from community sources. Of these, 49.2% of participants heard about the program from friends and relatives; 11.3% came through a community centre; and 7.3% through a cultural centre, group or agency.

- 7.9% of referrals came from Toronto Public Health. Of these, 3.1% of participants were referred by a Public Health home visitor; 2.5% by a Public Health nurse; and 1.8% by other Public Health personnel. The lowest rate of internal referrals came from Public Health dietitians at 0.5%.

Involvement in Other Toronto Public Health Programs

12.4% of Peer Nutrition participants were currently involved in other TPH programs. For the 87.6% who were not involved, the main reasons cited were lack of knowledge (58.3%), lack of time (26.6%) and lack of availability in their language/culture (17.3%).

Involvement in Other Community Programs

41.5% of participants were currently attending other community programs, For the 58.5% who were not, the main reasons cited were lack of knowledge (52.7%), lack of time (32%) and lack of availability in their language and culture (12.2%).

Conclusions

- The majority of program participants are a highly educated population who are nonetheless facing multiple stresses in their lives. Poverty is especially acute, with almost 50% bringing home less than $18,000 annual income.

- The peer workers' outreach efforts seem to have borne fruit: the Peer Nutrition Program is obviously community-driven, with the bulk of referrals coming through word-of-mouth or other community contacts. Internal referrals from Toronto Public Health are low.

- Program availability in other languages seems an important feature with approximately 2/3 of all participants requesting that option.

- This is a population with a high rate of breastfeeding. Most participants introduce solid food to their infants between four to six months but a third do so between six to eight months.

Getting Started

Once the Children and Youth Action Plan was approved by City Council of Toronto in November 1999 and adopted by the Board of Health in January 2000, funds to implement the Peer Nutrition Program became available in July 2000. The first staff members were hired in August 2000 and the program began operations in November of that year.

Early Stages

Initial planning stages began with **a literature review**, which also included an examination of different peer-led programs. The review focused on nutrition-related issues in young children as well as cultural influences on health and nutrition. One conclusion reached was that multicultural nutrition programs had had limited success. Reasons advanced for this outcome included the predominant emphasis on the scientific aspects of nutrition practice, an undervaluing of the art of service delivery and little attempt to adapt interventions to specific ethnic groups.

The **scan of peer programs** generated a list of critical factors, which help make such programs successful. Among the most noteworthy were the need to recast professionals' role from that of experts who define needs and provide solutions to that of consultants who mobilize the peer leaders and help them grow, the need to provide ongoing support for peer leaders and maintain regular contact, and the need to provide comprehensive and multi-faceted training.

The community development model used by Toronto Public Health in 1992/1993 to create a heart health program delivered by trained peers in the South Asian, Portuguese, African-Canadian/Caribbean and Chinese communities was very influential in shaping the way in which Peer Nutrition was conceived. That training had been organized and implemented by dietitians from various cultures, a community development officer and a public health nurse. However, all peer facilitators in the ethno-cultural heart health programs were seen as volunteers and were paid honoraria to cover their transportation expenses.

Two defining characteristics of the new Peer Nutrition Program were that it would be a **mixed model delivery system** and that **all the peer facilitators would be Public Health employees who were paid salaries and received benefits.** The latter decision was made as a way of properly acknowledging the critical contribution of the peer facilitators to the success of the program and encouraging staff stability. The mixed model was chosen because it provided quality assurance by combining the peer facilitators' cultural knowledge, skills and relevant nutrition background with the expertise of certified professionals.

A **needs assessment** was undertaken, using data from the 1996 Census and working with a social epidemiologist. The resulting **selection model** projected how many people needed services and in which particular areas. This information helped determine how many staff needed to be hired and from which communities.

Community Input

Establishing a **community connection,** based on community research, was essential to the program's success. **Community consultations** were held with grassroots community members, as well as with 40 agencies and organizations. These included representatives from ethno-cultural and ethno-racial agencies, other agencies serving mothers and children such as Children's Aid and shelters, school boards, Parks and Recreation and community health centres. Using an appreciative inquiry approach, the consultations asked community members to define and articulate needs and make suggestions for program design.

Out of the consultations, a **Community Reference Group** was formed and continues to this day. Having helped to develop the program framework, the CRG acts as an ongoing advisory group, recruits people for community consultations, suggests new program partners (e.g., community centres and schools) through its network of contacts and advocates for the program on behalf of the community.

One specific instance of very concrete feedback came when the Peer Nutrition staff was trying to understand why members of the African-Caribbean communities were not responding to their flyers. "You've got to change the design", members of the group advised. "It looks too mainstream, people don't feel that it has anything to do with them." Acting on their feedback, a new flyer was produced using exactly the same content but with a black-and-white kente cloth border. The positive response showed that producing culturally appropriate materials involves not only relevant content but extends to graphic symbols and even the colours chosen.

The Community Reference Group also had input into the development of the **program goals and logic model**, which were completed, by the program manager and Peer Program dietitians.

Recruiting the Team

Peer facilitators were recruited through advertisements in the ethnic press and fax-outs to various community and ethno-cultural organizations. There were 700 applications for 16 part-time positions. All applicants went through a written interview, an oral interview and a hands-on cooking demonstration. Key qualifications included:

Language Skills

Peer workers need to be able to fluently speak and write their first language, as well as English. Since they are required to develop materials in their own language, translate

English materials into their language of origin and act as interpreters for people with varying degrees of schooling, only candidates with post-secondary training in their country were considered.

Cultural Competence
Peer workers need to know the history, background, practices, fears, norms and values of their community, particularly as they relate to food. They have to have the ability to connect, build trust and work with the community.

Group facilitation skills, knowledge of nutrition and working parents, and food preparation skills were also deemed essential.

As of August 2005, enhanced program funding made it possible for the community nutrition assistant positions to become permanent and full-time.

Four **dietitians** were hired in summer 2000. Original qualifications included a degree in food and nutrition or equivalent program from a recognized university, membership in the College of Dietitians of Ontario, and completion of a year-long internship approved by the College. The internship requirement has since been changed because it constituted a barrier to foreign-trained dietitians who are now able to complete a practicum instead. Experience working in diverse communities was also important. At a later date, two **nutritionists** were hired, both of whom had begun working in the program as community nutrition assistants. Their focus was to look at food security issues and do research with a focus on policy.

Training the Team
Both the mentor professionals and peer facilitators were given extensive training. For the peer workers, this included nutrition education developed by the Peer Nutrition dietitians in line with Toronto Public Health policies and goals. Other important components were cultural sensitivity training given by experts from the community, as well as group facilitation training and sessions about working in multidisciplinary teams. These workshops, intended to build trust in one another, were done first with the dietitians and then with the peer facilitators and finally in mixed groups.

Finding the Partners and Participants
Multiple strategies were used to find the partners and participants.

- The Community Reference Group identified organizations, community centres, and places of worship, as well as the gatekeepers in various organizations and agencies who would want to co-sponsor the program.

- Four **implementation work groups** were established at the beginning of the program. Each group consisted of a dietitian, a community health officer and

agencies from the east, north, west and south respectively. The groups, which lasted for a year, helped with the outreach. The dietitian from each group would come back to the main resource group and report on what was happening in terms of recruitment.

- Advertisements were taken out in the ethnic media and hundreds of faxes were sent to community organizations.

- Three kinds of promotional workshops were developed:
  a) a 20-minute presentation to a board to learn about the program
  b) a 45-minute presentation for front-line staff who would refer clients
  c) a 2-hour presentation for parents and PTA groups, including a cooking demonstration to give the flavour of the workshop

With 40 partners providing space and covering part or all of the associated childcare costs, the program got underway in 24 different languages in late 2000.

Funding

Through the Child Youth and Action Committee, the program received an initial grant of $459,000 in July 2000 for six months worth of operations. In 2001, the same amount was annualized by Toronto Public Health, which allowed the staff to remain at full complement for the whole year.

The Ontario Ministry of Health paid fifty percent of the funding because Peer Nutrition qualified under three different mandatory programs: Child Health, Chronic Disease Prevention and Equal Access. The latter, according to Ministry Guidelines, "may require…developing special programs including special educational materials, tailored service delivery and active outreach".

In 2005, as a result of the program's success, funding was enhanced. This allowed the 16 peer facilitators to become permanent full time employees and paid for the employment of another six temporary part-time Peer Nutrition facilitators. The complement of dietitians was increased to six, another nutritionist was hired and a second program manager joined the program.