## 6.10 Food and education

**Definition**

For the purpose of this report, this section details some of the evidence about models that specifically have a focus on food education or literacy. These can manifest in different ways but can include:

* Community kitchens
* Community food programmes or projects with a specific ‘social making’ motivation e.g., cooking, learning and sometimes then easting together
* Courses and demonstrations that are accessed at community hubs

At their heart, these food education / literacy approaches aim to reduce household food insecurity by teaching skills to people so they can make limited household food budgets stretch further. They can also provide access to places to grow food or provide cheaper access to food, through community shops, market voucher schemes or food box programmes.

In community kitchens participants prepare large amounts of food together and take home the meals prepared, and simultaneously often are taught budgeting and cooking skills.

In practice, there is often an overlap between food models and education, however, the community kitchen is a particular model of focus in this report based on the availability of evidence found in the review. Please also note that a range of funders provide grants to encourage community learning / skills / literacy of this nature (please see section 6.9).

**Evidence**

**Community Kitchens and classes**

Evaluations reviewed suggest that a community kitchen can become highly valued by stakeholders and has a significantly positive effect on people who participate in classes and on partner organisations (defined as public or voluntary sector organisations)[[1]](#endnote-1).

The evidence suggests that community kitchens typically support an increase in reported intake of nutritious foods and increased healthy food access, increased self-reliance and engagement with social services, improved social skills and enhanced social support, and increased skills, confidence and enjoyment from cooking. However, in an evaluation of the experience of people using a community kitchen programme in Canada, Engler-Stringer and Berenbaum noted the tenuous nature of any benefits provided to programme users since programme availability was subject to holiday schedules, funding constraint and time allotment of staff[[2]](#endnote-2)

In an impact assessment of a food insecurity project in the UK[[3]](#endnote-3) which offered cookingclasses, key aspects participants valued about the classes included: learning new cooking skills, sharing their own skills, the information about sauces and spices, communal cooking and eating and the food budgeting tips.

* 75% stated that after the classes they felt more confident about cooking healthily on a budget.
* 72% of participants also stated that their confidence in cooking had either improved or greatly improved.
* 65% of participants stated that they had 'used ingredients which were new to them'.
* 65% of participants reported that they would 'eat more healthily', but 26% did not feel they would.

More than had been expected, classes served as a means for the participants to socialise, share recipes and cooking tips, and to eat together. The social and communal element was important including being out and meeting people. The collective aspect of learning, cooking together and sharing food was highly valued. The value of sharing problems when cooking and eating with other people was also highlighted. Classes had a role in providing a distraction from the participants' everyday problems. There was some evidence that the impact would be longer term for some participants however this was by no means universal. Additional benefits included improved social connectedness and sharing of issues and problems. Some participants reflected on the ways in which coming to the cooking classes felt like they had some control and were making positive changes in their lives.

In another study[[4]](#endnote-4) one food charity operator providing cooking lessons described children who did not know what grapes were because the parents could not afford them. The manager of a surplus food pantry confirmed that people often did not know what the food that was on offer was or what to do with the food they receive because surplus food often includes items that would usually be well beyond the affordability of people on a very low-income (for example asparagus or whole fish). People who were on very low incomes in the communities talked about difficulties with budgeting and being able to access the best deals and the cheapest food. While many organisations offer budgeting advice, it is clear that this advice is not always contextualised for the budgets within which many are operating.

**Cooking skills**

In 2014 Community Food and Health Scotland/NHS Health Scotland commissioned a realist review of community cooking skills activities run by community initiatives and agencies. Cooking activities are a popular activity run by community groups and agencies such as local authorities and NHS teams within low-income communities. They deliver cooking activities in the form of cooking courses, drop in sessions, and as part of activities such as independent living skills programmes or when supporting people on a one-to-one basis. CFHS has provided development funding for 100s of cookery courses and activities since 1997. In recent years, CFHS has focused on improving practice, supporting the development of self-evaluation and developing the evidence base around cooking skills activities. The review explored issues such as how the social circumstances of participants and the approach of the cooking skills activities can affect the outcomes. The researchers analysed 81 sets of reports and evaluation materials or grey literature from community initiatives and agencies, carried out two focus groups with 19 cooking skills course practitioners, and two focus groups with nine cooking course participants. There were limitations in the quality and robustness of the grey literature. The reviewers overcame this challenge by identifying practitioners’ ‘strategies’: what practitioners do and why they do it and linked these to behavioural change theories. The researchers’ conclusions included:

* The cooking activities appeared to be targeting and successfully reaching low-income and vulnerable groups.
* There was evidence of consistent good practice by practitioners.
* Some behaviour change concepts appeared to be used more than others – self-efficacy, salience and social norms were used frequently, and formal goal setting less often.

The CFHS cooking skills study group then ran (from 2016) an 18-month long cooking skills study group for eight organisations– NHS, local authority and community initiatives from across Scotland who are supporting people who are vulnerable or from low-income communities. The organisations were Fife Health and Social Care Partnership, NHS Grampian, Edinburgh Community Food, Healthy Valleys, Lanarkshire Community Food and Health Partnership, NHS Greater Glasgow and Clyde, Dundee Healthy Living Initiative and NHS Forth Valley. The group adopted recommendations from the [CFHS review of community cooking skills activities](http://communityfoodandhealth.org.uk/publications/review-practical-cooking-skills-activities-focus-promoting-affordable-healthy-balanced-diet-adults-young-people-families-lowincome-communities-scotland/) and an agreed a list of what outcomes they would evaluate over the next year. CFHS worked with the group to analyse the collective evaluation materials and has reported back on progress since. The study group’s

The [cooking skills study group](https://communityfoodandhealth.org.uk/2016/cfhs-cooking-skills-study-group/)[[5]](#endnote-5) realist evaluation (2016-2018), gathered information from 29 community cooking skills courses (attended by 75 adults -all of whom were managing on low-incomes and the majority were ‘vulnerable’[[6]](#endnote-6)). The results showed that:

* 79% improved their cooking skills (a further 16% could already cook)
* 68% made steps to improve their diet

As part of our realist evaluation, CFHS wanted to find out more about ‘why’ these positive results occurred. Including the different ways the courses were run which all:

* ran flexibly, were led by experienced practitioners, with people attending the course helping to shape it, and practitioners adapting to people’s needs.
* planned activities that were targeted to suit the participant groups attending them.
* asked participant groups what recipes they would like to learn.
* ran for small groups – the ratio of staff to participants was three participants or fewer to each member of staff.
* used recipes that made generous amounts of food – enough to eat a meal at the end of the course and often enough to take a family-sized meal home too.

**What course activities made a difference and how can practitioners do these?**

There were just two course activities that only some of the practitioners offered and that seemed to make a positive difference for all those who took part in them. These were:

* offering (and people taking up) food-related activities after the course had finished (e.g., attending an additional course, such as a food hygiene course, or taking up volunteering opportunities at lunch clubs or cafes).
* providing ‘give aways’ during or at the end of the course e.g., recipe ingredients or cooking equipment.

Offering and taking up additional activities made a positive difference across a range of outcomes but had the biggest impact on improving people’s diet.

It’s not surprising that people having an opportunity to reinforce what they have learned on a course improves their outcomes. But this might be difficult for some practitioners to arrange, particularly if they are not part of a community or team that continues to have contact with people and/or can signpost them to other opportunities. Other tips and learning are found [here](https://www.communityfoodandhealth.org.uk/2019/reasons-to-be-cheerful-part-2-cfhs-cooking-skills-research-what-did-we-learn-about-the-best-ways-to-run-a-cooking-skills-course/) and [here](https://www.communityfoodandhealth.org.uk/our-work/research-evaluation/)[[7]](#endnote-7). Check out CFHS’s [Chopping and Changing](http://communityfoodandhealth.org.uk/publications/chopping-and-changing/) report for further information about what seems to work in cooking skills courses, why and who for.

**Outcomes**

Key sources where these outcomes were evidenced for this section of the report.

* Evaluation of Fife's Community Kitchen (2012)
* An independent evaluation of Food for Life cook and eat courses, Shoreditch Trust (2017)
* Social policy and embedded evaluation: Assessing the impact of a food insecurity project in the United Kingdom
* Interventions to address household food insecurity in high-income countries (2018)
* A review of practical cooking skills activities which focus on promoting an affordable healthy balanced diet for adults, young people and their families within low-income communities in Scotland (2015)
* Chopping and changing: Evidence and ideas to improve the impact of your cooking skills courses (2018)

The most notable outcomes referenced in the literature include:

* Increasing awareness, knowledge, skills, experience and confidence around healthy eating through classes on topics including:
	+ What constitutes a healthy diet
	+ The importance of eating healthily
	+ How easy it can be to prepare healthy food
	+ How to prepare affordable healthy food
* Increased intake of nutritious foods/reduced barriers to healthy eating / significant improvements to participants’ diets e.g., in Fife Community Kitchen nearly two-thirds
	+ eat more fruit and vegetables
	+ make meals using fresh ingredients more often
	+ add less salt to food; and
	+ eat less food that is high in fat and/or sugar
* Improved ability to plan, shop for and prepare healthy meals for themselves and their families
* Increased healthy food access
* Improved knowledge of selection and preparation of more highly nutritious food
* Improved eating habits and consequent health benefits
* Improved social connectedness / socialising / meeting new people
* Increased self-reliance and engagement with social services
* Improved social skills and enhanced social support
* Increased skills, confidence and enjoyment from cooking
* Budgeting skills
* Life and employability skills (where this forms art of the education model) e.g., in Fife 80% of survey respondents said they had learned new skills from the Community Kitchen, 31% said it had helped them get into education or training and 20% said it had helped them find a job
* Introduction to college (n.b. some community kitchens are able to attract a younger target group / young families and with the Fife model participants who had become comfortable and familiar with the college environment as a result of going to the Community Kitchen and had since enrolled in college courses)
* Sense of achievement
* Increase in confidence
* Choice and empowerment
* Reduced isolation
* Feel valued
* Have fun / have a laugh / a sense of pleasure.

**Examples**

**Fife Community Kitchen**

In a 2012 evaluation in Fife, the study aimed to identify the health and social impact of the Community Kitchen on participants, including any changes in the way they shop, cook and eat, as well as investigating long-term sustainability and funding options. Success would be judged against the aims of the Community Kitchen “to improve the skills and knowledge of vulnerable groups in Fife by providing groups of participants with an opportunity to cook together simple healthy meals made from raw ingredients, thus enabling and empowering them to make informed choices about the food they buy and eat.” The project’s specific aims were to:

* reduce barriers to healthy eating and increase awareness, skills and knowledge around healthy eating for targeted individuals, families and communities.
* increase the quality of life and mental wellbeing of local people engaging with the Community Kitchen; and
* develop team building through practical activities.

*How it works (in Fife)*

The Community Kitchen aimed to improve the health of the local population by delivering cookery courses including theory and practical elements. These aim to improve the skills, knowledge and confidence to shop for and prepare healthy meals among vulnerable groups in Fife. A range of partner organisations used the Community Kitchen to deliver group-based cookery courses to their service users. The Community Kitchen was available for partner organisations to use with any of their service users, but the main target groups were disadvantaged or vulnerable members of the community including young families, teenage parents, homeless and low income groups. Delivering healthy eating sessions: a development worker or one of two sessional workers from the Fife Community Food Project and/or a member of staff from the partner organisation organising the session, tend to deliver the healthy eating classes in the Community Kitchen.

*Who used the Community Kitchen?*

Where the age of the participant is known, **most were young**. 46% of participants were aged 16-24 years and 31% were under 16. This is perhaps not surprising as two of the Kitchen's target groups were teenage parents and young families, but the results suggested scope to widen the Community Kitchen's use among people aged 25 years and over. The evaluation concluded that the Community Kitchen is perceived to be largely successful in its aims to reduce barriers to healthy eating and increase awareness, skills and knowledge around healthy eating for targeted individuals, families and communities; increase the quality of life and mental wellbeing of local people engaging with the Community Kitchen; and develop team building through practical activities. The Kitchen primarily services a young demographic but other vulnerable groups are also targeted - it has largely missed engaging homeless people. The study identified a number of key areas where service could be improved for future expansion but that there would be significant financial implications of developing additional Community Kitchen(s).

**Shoreditch Trust Food for Life cook and eat courses**

In a 2017 evaluation of this community organisation’s cook and eat courses run as part of their Food for Life Health and Wellbeing programme, found strong evidence to support the idea of introducing community-based 'cook and eat' initiatives particularly in disadvantaged areas and in Caribbean and South Asian communities where residents tend to have the least healthy diets.

*How it works (London Borough of Hackney)*

The courses are mix funded by the local authority within their **Community Kitchens programme**, Hackney and City Wellbeing Network, Shoreditch Trust and private donations (McQuarrie). The study reviewed the six week courses designed for adults run in five community kitchens on housing estates in Hackney and open to anyone in the community over the age of 18 years, and courses ran as part of the Wellbeing Network for people with mental health issues and held in the Healthy Living Centre owned by Shoreditch Trust. The purpose of the cook and eat courses were to increase participants' knowledge, skills, and confidence in meal planning, budgeting, healthy eating and cooking, and anticipated that home cooking would improve their diets. Other intended outcomes include increased confidence to work as a group, to engage socially, and a reduction in social isolation.

*Who attended the courses and what were their motivations?*

200 participants attended the adult classes in 2015 and 2016. Most were women (72%), aged between 36 and 55 years old (62%), and 20% aged 26-35 years, with few under 26 years and none over the age of 66 years. Attendance was voluntary and free of charge and the cook and eat courses are a good example of local people taking up an opportunity to improve their own lives. Several reasons explained participants' motivations to attend. Some were clustered around cooking and healthy eating; to learn how to cook (63%), they like cooking (58%), and to learn how to buy and eat healthy food (55%). Other reasons were social, and the courses provided an opportunity to meet local people (73%). Loneliness motivated almost a quarter of respondents to attend and for them the course was 'something nice to do' (23%), or participants were worried about their health in the future (23%). A few who attended were unable to cook at home (4 respondents). Others were not motivated by outcomes, they came 'for something to do' and a few came for free food. Every participant gave several reasons for attending and said that they benefited in several ways. Attending due to experiences of ill-health and anticipating worsening health was a recurring reason for attending.

Survey results suggested positive results for those taking part in the classes

* 98% felt that the courses were warm and welcoming
* 95% said they had learnt about healthy foods
* 88% felt more confident about cooking
* 88% enjoyed cooking with others
* 68% enjoyed eating a meal together (68%).
* 70% said they had improved their diet including
* 80% cooking using more ingredients
* 73% eating less salty and/or sugary foods
* 69% eating more fresh fruit and vegetables

The majority of respondents made improvements in their eating habits:

* 80% cooked more for themselves, family and friends
* 74% ate less processed or ready to eat meals
* 58% ate fewer takeaways

The majority felt more optimistic about the future (63%), better about themselves (55%) and many felt more able to chat to other people (50%) and some felt more confident about making friends (40%). The target outcomes did not capture the full impact of the initiative, particularly for those in poor health, those anxious about their future health and those struggling to live on low incomes and in poverty. For these attendees classes enabled them to feel valued, to have fun and to laugh, and gives them a great deal of pleasure.

**Learning**

**Community Kitchen (Fife)**

Strengths / effective aspects

* A domestic, homely environment
* Well-equipped
* Facilitates the delivery of healthy eating sessions
* Staff who deliver courses at the Community Kitchen
* The Community Kitchen has social benefits for participants
* The management model of the Community Kitchen minimises on-going costs and overheads.

Challenges

* Barriers to accessing the Community Kitchen - a small number of survey respondents said that it was sometimes difficult to find a parking space and a few others said they found it difficult to get to the Community Kitchen using public transport.
* Participants and stakeholders identified a few areas for improving the Community Kitchen: extend sessions and programmes; extend opening times to include evenings and weekends; increase capacity of the Community Kitchen
* Income generation - The Community Kitchen is available for use free of charge to partner organisations and service users from the 20% most deprived SIMD neighbourhoods. It charges a fee for other use of the Community Kitchen and aims to use 25% of its time for income-generating work and 75% as non-income generating activity. However, it appears that this aim was not achieved in that there has been less income-generating activity than expected.
* There are several barriers that hinder individuals' ability to eat healthily, including: a lack of awareness of what constitutes a healthy diet; a lack of skills, confidence and knowledge to shop for and prepare healthy meals; a lack of available and affordable healthy produce, particularly among low income communities; and cultural habits and traditions.

**Cooking courses (in Hackney)**

Strengths

* By understanding how to work closely with residents, and listening to them, Food for Life staff have designed an initiative that meets their needs and wishes.
* As a well-run organisation Shoreditch Trust are able to use their community connections to reach out to those with poor diets, although statutory and voluntary agencies could make better use of cook and eat by referring those with poor diets, who are overweight or obese.
* Staff have the confidence to show leadership by organising courses which extend the knowledge of participants to show them what is possible and what options are available to develop a healthy habits.
* Key to the high quality provision and its success is the use of knowledgeable and committed sessional staff sensitive to working with those on a limited income and with an ability to incorporate those with disabilities and with long-term health issues into a group.
* The cook and eat initiative model provides opportunities for developing a more integrated system of commissioning. Complimentary projects could be run at the same centres to capitalise on the additional motivations of cook and eat participants to make further improvements to their lifestyles.
* The findings show that the courses were well run, participants learn, found them pleasurable and many enjoyed them socially. They show a synergy between motives for attending and the course itself, indicating the relevance of cook and eat classes to residents' needs.

Challenges

* Implementing community-based programmes in low income stressed neighbourhoods is difficult and requires skill, dedication and hard work over a long period of time.
* The courses were oversubscribed indicating a demand for the courses.
* The challenge for staff is, however, to sign up residents who live locally and who have low socio-economic status.
* It was difficult to recruit people living within a short walk of the kitchens (in Hackney) for reasons including a lack of confidence to try something new, associating a course with school that 'never did anything for me', shift work, chronic illness or an unwillingness to be out-and-about in the early evening.
* How to motivate local people with poor diets to attend may require 'extra' encouragement from GPs, nurses, voluntary organisations or housing officers.

**Other examples in the literature**

**Crafternoons, cooking lessons and others.** As a result of putting on a craft activity, which included a cup of tea and a snack, it was reported that the number of medical visits by older people in the village went down. Crafternoon sessions facilitate social connections and a sense of purpose for older residents in the community, which has the outcome of enabling them to live longer and better lives but also makes them available as a motivated resource for community self-organisation. **Cookery lessons**. One model comprised a six-week cook and eat session called 'healthy, wealthy, and wise' where participants do five weeks of different recipes, mostly fake-aways because that is what people like to eat. This is all done with basic equipment. Participants play icebreaker games and are given a choice of recipes to decide what they are going to cook – providing choice and a sense of empowerment. Participants sit together and eat. They try to get kids involved as well. The aim behind these courses is to find a fun way for people to learn to cook healthy options within a tight budget. Residents (primarily women) talked about the difficulty of getting family members to eat fruit and vegetables but reported that when trying the recipes at home, they were able to "hide" these items in food that looked familiar. Many spoke with a sense of pride at being able to provide healthy foods for their families that they would eat and enjoy. By enabling new ways of cooking, these sessions also reduce stress associated with trying to find low-cost food that families will eat that are also at the same time healthier options. Building on existing food skills participants began to be more confident and have more positive relationships with their food. This intervention also expanded the reach of their services to a wider range of age groups in the community thereby enhancing the communities capacity to build resilience.

**The case for community kitchens?**

The investment case for the Fife Community Kitchen was oriented around **public health challenges**, specifically data relating to obesity, being overweight, links to type 2 diabetes, hypertension, heart disease, some cancers and premature death. The total cost to Scottish society of obesity was estimated at £457 million including approximately £175 million in direct NHS costs back in 2012. Obesity was also recognised as affecting employment, production levels, and mental health. The case for healthy food was made by providing evidence that lower income families in the UK were reducing their consumption of fruit and vegetables. Statistics released by DEFRA showed that lower income families in the UK reduced their fruit and vegetable consumption by nearly a third to an average of 2.7 portions per day and that recession and rising food prices contributed to this trend. Before the Community Kitchen was developed, NHS Fife and the Fife Community Food Project had identified a lack of suitable facilities to meet the significant need for basic cookery classes for people in deprived areas of Fife to help them develop the awareness, knowledge and skills to prepare healthy meals. The Community Kitchen was led and funded by **NHS Fife** and was run in partnership with **Adam Smith College, Fife Council and Fife Community Food Project**. The **Food and Health Strategy Group** contributed a one off amount of £20,000 to develop the Community Kitchen and Fife Community Food Project contributed £11,500 in 2010 to purchase a Smartboard, to upgrade the equipment and work surfaces, and to purchase light equipment. Any items that were lost or broken were replaced by Fife Community Food Project and this was absorbed in their core budget. On-going costs such as electricity, cleaning, equipment maintenance and booking administration were met by Adam Smith College's main budget. The important thing to note is that the Community Kitchen aligned with numerous national and local policies, strategies, priorities and ambitions – across public health, but also at a local level it would contribute to the achievement of several Fife-wide priorities linked to its 2011-2020 Community Plan. The most direct link was to the aim to reduce inequalities which included an outcome to ‘improve the health of Fifers and narrow the health inequality gap.’ The Plan noted the importance of improving the health of Fife’s most deprived and vulnerable households, an aim which the Community Kitchen shared. The Community Kitchen also aimed to help participants to improve their skills, including cooking and life and employability skills such as teamwork, thereby helping to move participants closer to work, education or training and contributing to targets related to increasing employment. The Community Kitchen was also directly linked to several national and local outcomes identified in ‘A Stronger Future for Fife – Single Outcome Agreement between Fife Partnership and Scottish Government 2009-2012’.

Other similar initiatives that have made effective use of income generating activity reported in the Fife Community Kitchen Evaluation. Durham Community Kitchen runs a community cafe and plans to deliver training for hospitality businesses; Community Training Kitchen in Inverurie charges a fee to organisations using the Kitchen but ensure that the classes are free for the service users. Initiatives such as Knowle West Health Association Community Kitchen and Community Kitchens Northwest (USA) run classes for members of the public, for which there is a nominal charge, on various topics including: one pot meals; food on a budget; and diabetes and weight control. [London Community Kitchen](https://londoncommunitykitchen.co.uk/) has a mixed revenue model, offers learning, qualifications, training into employment and has obtained an independent community café.

**The case for food education / cooking classes**

Evaluations suggest that attending cook (and eat) classes represents a moment in time when participants are motivated to improve their lifestyles, it is a time of heightened awareness about their health, and they learn that they can make a difference to their own health. This situation presents an opportunity to develop an integrated set of interventions alongside cook and eat sessions to support participants sustain these improvements such as exercise. A range of health, wellbeing and wider social benefits are in evidence, and they can be targeted and or inter-generational in their approach depending on the desired outcomes. These classes can affect behaviour change for participants around how they shop, cook and eat. For those people struggling or seeking to stretch their budgets, skills can provide greater confidence to provide healthier food for their families or households that they might not otherwise try.

**Questions arising**

1: Do we have any / enough community kitchens?

2: Are these interventions attractive for Public Health / Adult Learning / Community investment in York and North Yorkshire?

3: What opportunities are there for building on existing community assets to develop community kitchens and classes where they will help people that are struggling, stressed or having to stretch their budgets?

4: How viable are community kitchens in rural or sparse communities?

5: What can we learn from the ongoing work of [Community Food and Health Scotland](https://www.communityfoodandhealth.org.uk/our-work/research-evaluation/) with their innovative approach to evaluating the efficacy of these kinds of food and education models, as well as the new research and evaluation commissioned to build the evidence base on the nature and extent of community food activity in Scotland; identify the contribution of this work in reducing health inequalities and barriers to healthy and affordable food; explore new ideas for improving food and health work.

1. Evaluation of Fife's Community Kitchen (2012) [↑](#endnote-ref-1)
2. Interventions to address household food insecurity in high-income countries. 2018 [↑](#endnote-ref-2)
3. Social policy and embedded evaluation: Assessing the impact of a food insecurity project in the United Kingdom [↑](#endnote-ref-3)
4. More than Just Food: Food Insecurity and Resilient Place Making through Community Self-Organising [↑](#endnote-ref-4)
5. [CFHS cooking skills study group | Community Food and Health (Scotland)](https://www.communityfoodandhealth.org.uk/2016/cfhs-cooking-skills-study-group/) [↑](#endnote-ref-5)
6. for example: they had mental health support needs; a learning disability or were on the autistic spectrum; had experienced homelessness or were in recovery from addiction or a combination of issues [↑](#endnote-ref-6)
7. [Research and evaluation | Community Food and Health (Scotland)](https://www.communityfoodandhealth.org.uk/our-work/research-evaluation/) [↑](#endnote-ref-7)