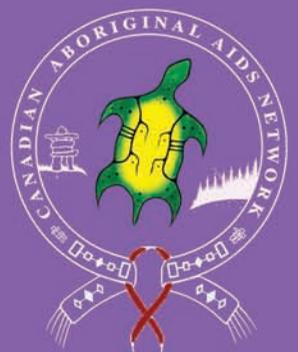


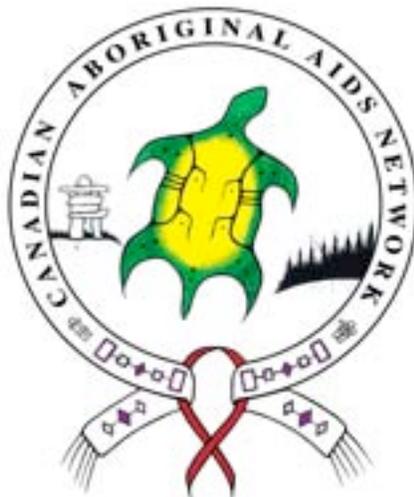
Assessing Community Readiness & Implementing Risk Reduction Strategies

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The Canadian Aboriginal AIDS Network (CAAN)

Mission Statement

As a key national voice of a collection of individuals, organizations and provincial/territorial associations, CAAN provides leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS. CAAN faces the challenges created by HIV/AIDS in a spirit of wholeness and healing that promotes empowerment, inclusion, and honours the cultural traditions, uniqueness and diversity of First Nations, Inuit and Métis people regardless of where they reside.

Vision Statement

A Canada where First Nations, Inuit and Métis people, families and communities achieve and maintain strong, healthy and fulfilling lives free of HIV/AIDS and related issues where Aboriginal cultures, traditions, values and Indigenous knowledge are vibrant, alive, respected, valued and integrated into day-to-day life.

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CAAN Overview

Established in 1997, the CAAN is a national, not for profit organization governed by a thirteen member National Board of Directors and operated by a four member Executive. The CAAN represents over 340 member organizations and individuals, providing a national forum for members to express needs and concerns, and provides relevant, accurate and up to date information on issues facing Aboriginal people living with HIV and AIDS in Canada.

Acknowledgements

We would like to thank the Colorado State University Tri-Ethnic Centre for allowing CAAN to adapt their Community Readiness Assessment Model so that Aboriginal individuals and groups in Canada can use it to assess how ready their communities are to address risk reduction. We would also like to thank the communities that participated in the Walk with Me pilot projects for sharing their experiences.

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Monique Fong, Project Coordinator.

Introduction

Human Immunodeficiency Virus (HIV) is a virus that breaks down the immune system. It can be transmitted by blood and other bodily fluids. Ways of transmission include but are not limited to unprotected sexual activities and sharing needles. HIV, if not treated, will eventually develop into Acquired Immunodeficiency Syndrome (AIDS), a terminal disease that often results in death because it shuts down the immune system completely. There is no cure for HIV but it is preventable.

HIV and AIDS is a growing problem in Aboriginal communities. According to the Public Health Agency of Canada (PHAC), Aboriginal people are overrepresented in the HIV epidemic in Canada. Between 1979 and December 31, 2008, there have been 21,300 AIDS cases reported to the Centre for Communicable Diseases and Infection Control (CCDIC), of which 16,824 (79%) included information on ethnicity. Of these 16,824 cases, 690 were reported to be Aboriginal people (4.1%). Yet, according to Census Canada (2006), Aboriginal people only make up 3.8% of the population.

In 2008, PHAC surveillance data demonstrated that Aboriginal people make up a growing percentage of positive HIV test reports and reported AIDS cases, with

injecting drug use (IDU) being a key mode of transmission in the Aboriginal community. IDU accounts for more HIV infections and AIDS cases among Aboriginal women than Aboriginal men. Between 1998 and the end of 2006, IDU was the exposure category for 53.7% of HIV-positive test reports among Aboriginal men and 64.4% of HIV-positive test reports among Aboriginal women. In reported AIDS cases among Aboriginal people between November 1979 and the end of 2006, injection drug use was the exposure category for 62.3% of reported AIDS cases among Aboriginal women and 32.1% of reported AIDS cases among Aboriginal men.

This draws attention to the need for community based culturally appropriate interventions to reduce the spread of new infections.

In 2007, the Canadian Aboriginal AIDS Network developed a risk reduction service delivery model (previously referred to as harm reduction) and presented the model in the Walk with Me Pathways to Health: Harm Reduction Service Delivery Model guidebook. The model is meant to serve as a resource guide for service providers, communities, policy makers and leaders who would like to learn about risk reduction, implement new strategies or enhance existing services.

The model has been designed to be diverse, meeting the needs of First Nations, Inuit and Métis people, in on-reserve, rural and urban communities. The Walk with Me Pathways to Health: Harm Reduction Service Delivery Model targets Aboriginal women, Aboriginal youth, Aboriginal people who are or have been in prison, and Aboriginal Two-Spirited men as these groups are segments of the Aboriginal population that are specifically vulnerable to contracting HIV. The model aims to make services more available to these groups, reduce stigma and empower these groups to make life choices that will decrease their risk of contracting HIV.

One of the key lessons learned from implementing this model in Aboriginal communities is that communities are at different levels of readiness to implement risk reduction approaches and influence the circumstances that make people vulnerable to unhealthy behaviours. For example, risk reduction approaches are not fully accepted in some communities because of discrimination against chaotic substance use and the favouring of approaches that promote abstaining from risky behaviours rather than making the behaviours safer (CAAN 2007). This guide will present some of these community experiences of preparing the way to implement a risk reduction model while also helping you as a leader, service provider or impacted person to assess where your community is at in addressing the issue.

In 2009, CAAN published the Harm Reduction Implementation Guide that complements and enhances the Walk with Me document by highlighting ways that can best introduce risk reduction in a community. It also introduced the concept of the Community Readiness Model (CRM) developed by the Colorado State University Tri Ethnic Centre. The CRM is the most extensively developed and tested model used in Aboriginal communities and has been used by some Alaska native and Native American communities to assess readiness to address youth suicide and addictions.

In 2009-2011, CAAN piloted community readiness assessments with Aboriginal organizations and First Nation communities. As a result, CAAN documented lessons learned from the pilot projects. What was lacking was capacity to move forward from assessment to planning culturally appropriate intervention approaches and implementing the plans in the communities. Community engagement, momentum, and building trust are key to success.

This guide will bridge this gap by offering a tool to train community facilitators who can then conduct a community readiness assessment, develop culturally appropriate intervention approaches, implement them and evaluate the process and their impacts.

Purpose of Guide

The guide integrates CAAN's key tools and resources into the community readiness model, providing a user friendly, step-by-step Training of Trainers Guide for Aboriginal communities to:

- assess their community's readiness to address risk reduction;
- determine culturally appropriate prevention and intervention approaches;
- implement the approaches to effectively reduce risk and reduce vulnerability for HIV infection; and
- provide wise practices that demonstrate successful application of the community readiness model for risk reduction and features various case studies outlining lessons learned.

What is a community readiness assessment?

It is a model for community change that integrates the community's culture, resources and level of readiness to more effectively address an issue. It brings the community

together, builds cooperation and increases its capacity for prevention and intervention. Readiness is "the degree to which a community is prepared to take action on an issue".

For the purposes of this guide, the issue is risk reduction. A community readiness assessment will provide you with flexible tools to measure how ready your community is to determine risk reduction approaches and address HIV and HCV prevention. Knowing where your community is at before attempting to implement a risk reduction strategy will give you an appropriate starting point.

Community readiness is a concept that recognizes that Aboriginal communities cannot be forced into addressing issues but must be prepared physically, emotionally, mentally and spiritually. It takes into account the broader realities that can make readiness challenging such as colonization, intergenerational trauma, family violence, racism, coping mechanisms (i.e. substance abuse, silence) and shame. Likewise, communities have their unique strengths and resources that can be assessed and included in a strategy such as traditional beliefs and the wisdom of Elders. A community readiness assessment can also bring to light and honour the work that is already being done. An assessment will help your community scope out the problem and define it in your own community's context, help the community take ownership of the problem and increase the community's capacity to move forward. Best of all, the benefits outweigh the costs; conducting the assessment is straight forward and not resource heavy or time consuming.

What is Risk Reduction?

To understand the connection between community readiness and risk reduction, this guide will present risk reduction information (previously referred to as harm reduction).

The idea of risk reduction emerged in the 1990s (Albert 1998), as a reaction to the ineffectiveness of approaches that coercively promote abstaining from injecting drug use and other risky behaviour as well as criminalizing targeted individuals. Risk reduction focuses on reducing the negative impacts of drug use and other behaviour that places people at greater risk of contracting HIV and HCV rather than reducing drug use itself. The main goal is to decrease the transmission of HIV and HCV. Common risk reduction activities include:

- Needle exchange programs;
- Condom distribution;
- Methadone clinics; and

- Education and outreach programs including safer sex education.

Risk reduction is a non judgmental approach that respects an individual's right to make their own choices and therefore encourages individuals to make changes in their lives at their own pace. For example for an individual who uses drugs, learning how to inject safely is an empowering change in their life and subsequent steps could be "controlling when they use and if they use".

A risk reduction model realizes the broader issues that surround injecting drug use. "Due to colonization, poverty and racism, Aboriginal people [in Canada] are overrepresented in the injection drug use population" (Albert, 1998). Therefore a wholistic, culturally appropriate and community specific approach to risk reduction is needed, recognizing the wholeness of the individual and that substance abuse is a coping mechanism rather than a character flaw or bad choice isolated from the social context it is occurring in.

Why apply the model to risk reduction?

Determining the readiness stage of your community will prepare the way for prevention and intervention strategies. The outcomes of the assessment will help you decide what steps need to be taken to reach a stage where your community can take action.

For example, if there is no leadership support, conducting a risk reduction educational seminar with an Aboriginal Band Council or an organization's Board of Directors might facilitate more buy in. In other words, "When the community denies the presence of a crisis despite strong evidence, education should be the path instead of proceeding prematurely to the stage of healing." (Tousignant and Sioui 2009).

Since your risk reduction strategy will be designed to be culturally and community specific, it will help to know the strengths and resources that your community has as well as the challenges that will need to be worked through to get your strategy up and running.

Potential Community Strengths and Resources:

These are some examples identified in the CAAN Walk with Me: Harm Reduction Service Delivery Model (2007) of community assets to put towards a risk reduction strategy:

- Engaging Elders and Medicine people
- Traditional medicines

- Circles
- Incorporation of dance and music which instill pride
- Language
- Healing Ceremonies
- Connection with the land
- Camping and outdoor activities and services
- Incorporation of teachings
- Role clarification
- Extended Family

Potential Challenges

Challenges will surface when assessing readiness but do not get discouraged. Consider it value added because an implementation plan that wholistically addresses the challenges will be more successful in your community. These are some potential challenges/ barriers:

- Myths about HIV AND AIDS and those infected and at risk
- Denial about it being a problem and "because a high percentage of newly diagnosed Aboriginal HIV infections are within injection drug users and sex trade workers, it could seem easy to dismiss the problem as something that affects only a few people who are outside of a general community" (Red Road HIV Network, 5)
- Homophobia
- A sense of shame felt by those infected and silence
- Family violence and high levels of substance abuse to cope
- Too many stressors such as poverty and racism to cope with and therefore HIV and AIDS is a low priority
- Inability of the community to mobilize to address important issues as a result of colonization and other related factors

Who should be involved in determining community readiness?

Part of determining community readiness is conducting interviews and later brainstorming intervention strategies with community members. Figuring out who should be included in your work towards determining readiness will require you to reflect on some questions:

- How would you describe your community?
- Who composes it?
- Who is mostly listened to and who is usually excluded?

"Who should be included?" will be different if your community is a Friendship Centre, a correctional facility or a reserve, for example. This also determines who makes up the membership of your community.

It is important to include leaders in any process as things run smoothly with leadership buy in and they can mobilize the community. However it is also important to include

those community members who have less of a voice such as the target groups of the Walk with Me Pathways to Health Harm Reduction Service Delivery Model (women, two spirited men, youth and incarcerated or formally incarcerated people).

With this in mind here are some potential community members that might be important to include in the assessing readiness process. Use this list to brainstorm further:

- Leaders (Band Council, Chiefs, Board Members, Executive Directors). Understanding their perception of risk reduction measures and HIV and HCV prevention in general will give you an idea of whether there is current support, unwillingness to address it or somewhere in between in terms of readiness:
- Elders can highlight the issue as important and can promote acceptance and willingness to address the issue.
- People affected by HIV and AIDS and those at high risk need to be included as they understand from lived experience where their community is at in addressing social issues and what risk reduction strategies are needed.
- Aboriginal community health and social service workers can be strong advocates and break the silence surrounding the behaviours that put individuals at high risk of contracting HIV and HCV. They are also involved with community members on a one to one basis and may be the first point of contact for high risk individuals as well as people living with HIV and AIDS (Red Road HIV Network).
- Anyone else in the community who expresses a willingness to be engaged on the topic.

Values that shape this model

Although some of the values inherent in the community readiness model and subsequent risk reduction strategy are interwoven into the earlier sections, this sub section will highlight some of the key values. This model:

- acknowledges and honours the cultural diversity among First Nations, Inuit and Métis groups in Canada.
- honours the strengths and resiliency of communities through their traditional beliefs and practices and supports mobilizing those protective factors to move forward.
- respects the time needed for communities to move forward in terms of readiness to deliver and support prevention and intervention strategies and understands the healing that will need to occur while facing a community problem head on.
- is flexible and can be culturally adapted to fit your community.
- respects every individual's journey and right to make choices and while offering support through risk reduction

activities, does not force anyone to change their behavior.

- is built on the belief that every individual has the right to confidentiality and to make a choice whether to be open about their HIV AND AIDS status.
- recognizes that building trust is the first step towards outreach.

How to use this manual

The manual presents community readiness from a wholistic perspective. It provides you with:

- **knowledge** required to assess your community's readiness to develop and implement culturally appropriate intervention strategies;
- **skills** needed to conduct a community readiness workshop – informing the community about community readiness and supporting the development of intervention strategies;
- **attitudes** that support you – the Community Trainer or Facilitator – to do the work you need to do in the community; and,
- **values** that shape the model and support you and the people involved in this important community work.

To prepare for the work ahead, take the time to read the information that leads into the “Training of Trainer’s” section of the manual. These sections provide important information about community readiness, the issue that needs to be addressed, and why Aboriginal communities must implement strategies that reduce risk.

The “Training of Trainer’s” section is the step by step training that:

- ❖ informs the participant about the issue (Module 1);
- ❖ informs the participant about community planning as a process, and demonstrating where assessment fits in the plan (Module 2);
- ❖ provides the participant with knowledge needed to conduct and score a community readiness assessment (Module 3 – 4); and
- ❖ provides the participant with knowledge, skills and resources to conduct a community readiness workshop and initiate action plan development (Module 5).

To support the trainer and participant, the manual includes Facilitator Notes and Workshop Templates.

Facilitator Notes: These are for the trainer only – to help facilitate the session. They provide the trainer with information that may be needed to achieve optimal outcomes during the learning;

Workshop Templates: These are for the participants – to help them during an exercise. Make enough copies for the participants prior to the session.

Finally, the manual provides information about evaluation and lessons learned from CAAN's community readiness risk reduction pilot projects. The evaluations section must be read – to inform the community about the importance of evaluation and some information on planning and conducting the evaluation at the initial stages of the community project.

Preparation for the Training Session

Many trainers state that 80% of any training or workshop success will be determined by the extent of the trainer's pre-planning and preparation. In order to support a successful training sessions, a few tips are provided below:

1. Read through the material and be familiar and comfortable with the information and processes that you are about to share;
2. If you can, try to determine the level of knowledge, skill, attitude and values of the participants. Trainers are often amazed at the level of knowledge in the room as they move through the training. Be sure to acknowledge this at the beginning of the training;
3. Training can be an “energy drainer” – so if you are the only trainer, try to keep your audience number between 10 – 15. If more plan to attend, try to have a co-trainer to assist you;

4. Sometimes workshop topics can draw out emotions from the audience. Be prepared for these emotional moments and have a plan to deal with them. Including an Elder is beneficial for counseling the people in these circumstances;

5. Determine the resources needed for the training – audio/visual equipment, copies of materials, including extra copies for unanticipated participants/guests, supportive documentation (ie. Walk with Me and other resources from the CAAN's National Toolkit), flip chart paper, markers, masking tape, etc.;

6. Test the audio/visual equipment ahead of time;

7. As stated above, be sure to have copies of all the “Workshop Templates” that you will need to provide to the participants during the training;

8. Know the training facility (room) and determine the best room setup for learning (ie. chairs in a circle, or table and chairs?). You want to ensure a comfortable, supportive and safe learning environment. Adequate space is needed for comfort but also to facilitate the exercises; and,

9. Remember – your task is to keep the participants focused. Monitor the time and keep them on the agenda. If you find that they are straying off because another issue or concern was raised, put this information onto a flip chart paper titled “PARKING LOT” and assure them that these matters will be addressed at a later time.

Assessing Community Readiness and Implementing Culturally Appropriate Interventions within Aboriginal Communities

Training of Trainers

AGENDA:

Opening

Introductions & Ice Breaker

Purpose and Agenda Review

Pre-Training Questionnaire

Module 1: The Issue: The Need for Culturally Appropriate Interventions in Aboriginal communities

Module 2: Community Planning

Module 3: Community Readiness Model

Defining Community Readiness Model

Reflections on Module 1- 3

Module 4: Conducting Your Community Readiness Assessment

Preparing, Conducting and Scoring your Community's Assessment Interviews

Reflections on Module 4

Module 5: Moving From Assessment to Action Planning

Developing Culturally Appropriate Intervention Strategies and Creating the Action Plan

Reflections on Module 5

Evaluating Your Risk Reduction Action Plan

Final Questions / Answers

Post-Training Questionnaire

Workshop Reflections and Closing

“Let's Begin.....”

Opening

In many Aboriginal cultures, when people gather to share their learning or to conduct business, it is important to bring all hearts and minds together, acknowledging the gifts of Creation and clear the learning path for good thoughts only.

Purpose

A traditional opening will establish a safe and supportive learning environment for the participants and signify the opening of the session.

Method

1. Prior to the session, it is your responsibility to determine the culturally appropriate manner in which to open the session. Once determined, approach the Elder/Traditional Person and if possible, welcome him/her to participate in the training. Full participation will allow the opportunity for the Elder/Traditional Person to offer his/her input and if agreed, counsel a participant if required.

2. Start the session by briefly introducing yourself and welcoming the participants.

3. Introduce the Elder/Traditional Person, briefly explaining his/her role. Invite him/her to open the session (as predetermined).

Time: 15 minutes. The Elder/Traditional Person will ultimately determine the time.

Introductions

When Aboriginal people gather together, it's important that they get to know each other. All peoples, regardless of their culture or position in life, need to have a sense of belonging, purpose and community. Introductions help to establish this sense of community – even if they are just together for the purpose of assessing community readiness and creating culturally appropriate interventions.

Purpose

Introductions will create a sense of team and common purpose amongst the participants, supporting a positive learning environment.

Method

1. Although it is possible that all participants may know each other, ask each participant to briefly state:
-their name,
-their position in the community (ie. health care provider; social worker; Elder; teacher, etc.); and,
-their interest in participating in the training.

2. Welcome each participant to the session and thank them for recognizing the importance of the work they are about to engage in.

Time: 10-15 minutes (allow approximately 2 minutes per participant)

Purpose and Agenda Review

Purpose

By reviewing the purpose and agenda, the participants will reaffirm their sense of purpose – why they are dedicating time to this session – and they will know what to expect during the session.

Method

To prepare the participants for their learning, have them turn to the appropriate pages in their Workbook.

1. Prior to having started the session, you will have set up your laptop and projector, and have your power point presentation ready. Advance to the slide to view the **Purpose**, followed by the **Agenda**.

2. As you read through the **Agenda**, you do not need to explain each module, however you should highlight these agenda points:

- a. The training is one day. State the closing time, and that there will be a 15 minute mid-morning and mid-afternoon break, and a 1 hour lunch;
- b. Explain that there are 5 Modules;

c. Make sure to advise participants that Module 1 – 4 are designed to inform them about the community readiness model and how to conduct the assessment, but Module 5 will give them knowledge and skills to engage the community in a workshop – presenting their community readiness results (including definition of readiness) and to develop their strategies/action plan;

- d. Note that the trainer will conduct a **Reflection** process after the conclusion of each module – to provide an opportunity for participants to share their thoughts about the process, ask questions, or table any concerns;
- e. Advise them that prior to advancing into the modules, they will complete a “confidential” **Pre-Training Questionnaire**. Explain that the intent of the questionnaire is to evaluate the learning process and to determine the change in knowledge, skills and attitudes of the group; and,
- f. After the completion of the Modules, information about evaluations will be presented, followed by a question period and the **Post-Training Questionnaire**.

3. Ask if there are any questions.

4. Next, provide a Pre-Training Questionnaire to each participant. Give them 10-15 minutes to complete and collect the completed forms.

Time: 30 minutes (purpose, agenda and questionnaire)

MODULE 1

The Issue – The Need for Culturally Appropriate Interventions in Aboriginal Communities

The high rates of HIV and HCV infection among Aboriginal people in Canada continue. Over the last few years, HIV, AIDS and HCV awareness has grown and more Aboriginal people have become more aware; however, many who are not working in or involved with health and social service delivery are completely unaware of even the most basic facts.

Purpose

To provide an opportunity for dialogue about HIV and HCV and how some Aboriginal people are at risk for contracting HIV and/or HCV.

Method

1. Advise the participants that:

“The purpose of this module is not to provide HIV and AIDS 101, or an HCV 101 but rather to highlight statistics that will demonstrate the impact that substance use and other high-risk social behaviours has on the incidence of infection among Aboriginal people.”

Provide each participant with the Workshop Template

titled, “The Issue: The Need for Culturally Appropriate Interventions in Aboriginal Communities”. Briefly read through the facts and ask if there are any questions. Please ensure that your power point presentation slide is also on this slide “Module 1 (ex.1): The Issue”. Facilitator Notes are provided to support the next few activities.

2. **Exercise:** Start by stating that:

- Have power point on “Module 1 (ex.2): The Issue”. Ask the group to brainstorm a list of risk factors and risky behaviors. Be sure to point out the difference. As they are stated, record them on flip chart paper. Post on the wall so that all participants can view.

3. **Exercise:** Next, state that:

“Many people are aware how HIV and HCV are transmitted, yet they continue to engage in risky behavior. Sometimes the risk factor is not of their own choosing.”

- Have power point on “Module 1 (ex.3): The Issue”. In the group, ask them to suggest which specific populations they believe are experiencing escalating rates of infection. As they provide their suggestion, ask them to provide their thoughts on the population-specific issues that lead to high risk. As they are stated, record them on flip chart paper. (Walk with Me, pg 13-18). Once complete, post on the wall.

Trainer Tip:

The intent is to identify the four populations targeted in the Walk with Me manual - Aboriginal women; Aboriginal people who are or have been in prison; Aboriginal 2-spirited men; and, Aboriginal youth — and to educate on the factors that place them at risk.

4. **Exercise:** Finally, state that:

“Although intervention approaches may need to be considered for all individuals along the lifecycle and within various target populations, there are some specific populations which have escalating rates of infection and should be noted.”

- Have power point on “Module 1 (ex.4): The Issue”. Ask the group to state their thoughts on why intervention approaches to reduce risk should be implemented to compliment (or replace) abstinence-based approaches. Record the participant responses on flip chart paper. (HRIG, pg 13)

Time: 45 minutes

WORKSHOP TEMPLATE

The Issue – The Need for Culturally Appropriate Interventions in Aboriginal Communities

HIV and AIDS is a growing problem in Aboriginal communities. According to the Public Health Agency of Canada (PHAC):

- *Aboriginal people are overrepresented in the HIV epidemic in Canada;*
- *Between 1979 and December 31, 2008, there have been 21,300 AIDS cases reported to the Centre for Communicable Diseases and Infection Control (CCDIC), of which 16,824 (79%) included information on ethnicity; and,*
- *Of these 16,824 cases, 690 were reported to be Aboriginal people (4.1%). Yet, according to Census Canada (2006), Aboriginal people only make up 3.8% of the population.*

In 2008, PHAC surveillance data demonstrated that:

- *Aboriginal people make up a growing percentage of positive HIV test reports and reported AIDS cases;*
- *Injecting drug use is a key mode of transmission in the Aboriginal community; and,*
- *Between 1998 and the end of 2006, IDU was the exposure category for 53.7% of HIV-positive test reports among Aboriginal men and 64.4% of HIV-positive test reports among Aboriginal women; and,*
- *Aboriginal youth are diagnosed at a younger age than non-Aboriginal youth.*

In the Walk with Me Pathway to Health document, CAAN wrote:

- *That the number of people with HCV in Canada is increasing at a steady rate; and*
- *PHAC reports that the major mode of contracting HCV is through sharing of contaminated needles and other needle works among injecting drug users; and*
- *that estimates indicate more than 1500 HIV+ Aboriginal people are co-infected with HCV, which presents other health management and outcome complications.*

There are more statistics and life experiences that demonstrate the issue and the need to reduce risk. Many Aboriginal individuals most at risk usually have little or no contact with the health care system, so implementing risk reduction strategies that are non-judgmental are valuable and much needed in the communities. These strategies have proven to successfully engage individuals where they were previously experiencing gaps in service.

FACILITATOR NOTES

The Issue – The Need for Culturally Appropriate Interventions in Aboriginal Communities

Potential Brainstorming Results: Risk Factors and Behaviours;

- *injecting drug use and “Gateway” drugs (tobacco, marijuana, alcohol) – youth get involved in these drugs and the potential is there for them to be drawn into “harder” drugs such as heroin, cocaine, etc.*
- *unprotected sex;*
- *issue of power imbalance and violence – abusive relationships*
- *social determinants of health issues (poverty, low education, etc.);*
- *lack of housing and living on the streets;*
- *survival – women and youth trading sex for survival and perhaps support their drug habit;*
- *being in an unhealthy relationship – partner may be an injecting drug user;*
- *poor self-esteem and self-identity;*
- *lack of education about HIV/HCV and risk reduction strategies;*
- *to get tested or not to get tested (lack of awareness/indecision);*
- *incarceration – high risk environment in prison;*
- *youth in care – foster care. Institutionalization, in many cases, has proven to have a negative impact of a youth’s ability to cope and make healthy life choices;*
- *homophobia / racism / discrimination;*

Abstinence-based Approaches:

- *Programming where the individual is required to “give up” the substance (alcohol, drugs, etc.) completely - common in Aboriginal communities*
- *They are an important aspect of a continuum care of services however they can create access barriers*
Can create policies that exclude people who are not able to be “clean and sober”.
- *By not offering risk reduction intervention programs, the*

most marginalized people in the community may be not get the services they need

-Placing them at greater risk

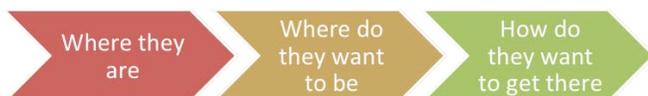
-They will likely only access emergency services when their health issues reach the severe or life-threatening state

Aboriginal communities need a continuum of interventions and strategies to adequately address the diversity of the issue of substance use: interventions that reduce risk can be a part of the community response. (CAAN Harm Reduction Implementation Guide, page 13)

Trainer Tip

Read “Walk with Me Pathways to Health”, pages 13-18, for more detailed information about risk factors and risky behavior.

MODULE 2
Community Planning



When a community recognizes that change is needed to address any issue, one of the first steps in planning is to determine their vision – Where they are; where do they want to be; and, how do they want to get there. These questions must be answered by the community, inclusive of an assessment to determine the community’s readiness. Once the vision and assessment are complete, the community can determine the culturally appropriate interventions needed to address the issue, develop their action plan and evaluate the plan over time.

Purpose:

To envision the process of community planning by using a wholistic, culture based model.

Method:

1. Using the power point presentation, explain to the participants that:

“The primary reason that we are training is to learn about community readiness – teach us how to conduct an assessment in our community. But before we do this, let’s look at and understand the planning process, of which assessment is a key

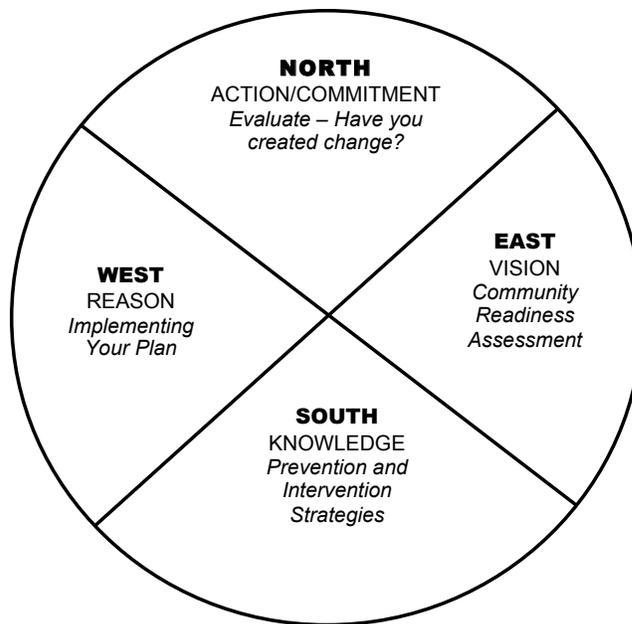
component.”

“One model for community change can be presented using a wheel (Medicine Wheel). Now, let’s start understanding the process for community planning by reviewing the four quadrants of the wheel.”

Trainer Tip

2. Explain to the participants that we will not be creating a Vision for the community, as most communities already have a Vision established.
3. Using the Facilitator Notes on next page, start in the eastern doorway and move around the planning model (Medicine Wheel) clock-wise.
4. Once you have reviewed the planning model (Medicine Wheel), ask if there are any questions.
5. Before you advance to the next Module, reference the CAAN Walk with Me Pathway to Health: Harm Reduction Service Delivery Model. The Walk with Me document is available in the National Toolkit on the CAAN website.

Time: 15 – 20 minutes



FACILITATOR NOTES

Community Planning

PLANNING MODEL

Eastern doorway - Vision:

- The gift of vision sits in the east;
- A strong vision is needed to guide the community in addressing the issue;
- To address the issue, we need to determine the community's readiness - to know the key points, such as resources, people to be engaged; strengths; barriers, and more.

Southern doorway - Knowledge:

- The gift of knowledge sits in the south;
- in order to develop the plan, the issue must be understood;
- In this situation, the issue is reducing the risk that can lead to HIV and HCV infection;
- This is the place on the wheel where those with the knowledge can discuss the types of prevention, intervention and education needs that address the issue.

Western doorway - Reason:

- The gift of reason sits in the west;
- All people have the right to receive culturally appropriate services; to be educated; to have access to health services; and more;
- For this reason, there are many people, many service providers who have committed themselves to address these issues. These are the people and organizations that need to be engaged – to determine the best way to implement the culture based intervention;
- To implement the programs, community people and agencies need to be engaged.

Northern doorway – Action/ Commitment:

- The gift of action and commitment sits in the north;
- To implement the culture based program requires action, it requires the commitment of all those people who have a stake in the success of the program, including the “end-users” – those who will benefit from programs that reduce risk of HIV and HCV infection;
- Like any program or project, it must be evaluated. This is a step that is often forgotten, and if we want to move towards our Vision, we need to know what we are doing well and where the areas for improvement exist.

MODULE 3

Community Readiness Model

“Culturally appropriate intervention strategies to the level of readiness will support a better outcome...”

Community Readiness is a model for community change. All communities are unique and therefore are at different stages of willingness and ability to implement risk reduction approaches to address HIV and HCV prevention. Readiness is “the degree to which a community is prepared to take action on an issue”. Targeting the culturally appropriate intervention strategies to the level of readiness will support a better outcome of the strategies, promoting change in the community.

Purpose:

To understand the assessment process that guides the community towards defining an issue and determining intervention strategies based on the community's capacity and willingness to address the issue.

Method:

1. Using the power point presentation and the Facilitator Notes on the following pages, read the definition.
2. Be sure to state the “What is the Issue” section so that participants are clear on the training's issue.
3. Next, review the process and steps to conducting the community readiness assessment. Use the Process and Steps Wheel on the next page (and on the power point). Start in the east – “Defining Community” and move clockwise.
4. As you move around the wheel, use the Facilitator Notes to explain each step.
5. Next, explain to the participants that the foundational concepts of the Community Readiness model are the dimensions of readiness and the stages of readiness.
6. Using the power point presentation, take them through each dimension. Give them examples of each key factor so they understand better.
7. Explain that the community's status with respect to each of the dimensions forms the basis of the overall level of community readiness.
8. Next, explain the stages of readiness, again using power point and the Facilitator Notes.
9. Mention that in the next training module, the participants will have a “hands-on” opportunity to conduct a mock assessment, and that this presentation was simply to prepare them for the next exercise (modules).
10. Now, before moving onto the next module, complete the Reflections for Modules 1 to 3.

Time: 45 minutes

Definition:

- Community Readiness is a model for community change;
- It integrates its culture, resources and level of readiness to more effectively address an issue, any issue;
- It brings the community together, builds cooperation and increases its capacity for prevention and intervention;
- It recognizes that all communities are unique and therefore are at different stages of willingness and ability;
- Readiness is “the degree to which a community is prepared to take action on an issue”.

What is the Issue: For the purpose of our session, the issue is reducing the risk for HIV and HCV infection. So, the intent is to assess the community and its readiness to address the issue and determine culture based intervention strategies.

The Process and Steps Model:
Explaining the Steps:



Identify your issue. For the purpose of this session, the issue is pre-determined and has been placed “central” to the Model.

Define “Community”

Define “community” with respect to the issue. The community is – any Aboriginal community. Determine who the key people are who are impacted by the issue and are involved in the issue (stakeholders).

Conduct Community Readiness Assessment

To determine your community’s level of readiness to address the issue, conduct a Community Readiness Assessment using key respondent interviews.

Scoring – Analyze the results

Once the assessment is complete, you are ready to score your community’s stage of readiness for each of the six dimensions, as well as your overall score. Analyze the results of the assessment using both the numerical scores and the content of the interviews.

Develop culture based intervention strategies

Develop culture based intervention strategies that are stage-appropriate. For example, at low levels of readiness, the intensity of the intervention must be more low key and personal.

Evaluate the efforts

After a period of implementation, evaluate the effectiveness of your efforts. You can conduct another assessment to see how your community has progressed – has it changed?

Reassess community readiness – move forward

As your community’s level of preparedness to address an issue increases, you may want to gather your people back together and, based on the new level of readiness, develop more advanced culture based intervention strategies.

Foundational Concepts: Dimensions and Stages of Readiness

The level of community readiness is founded on two key factors:

- A. *The dimension of readiness of six key factors that influence community preparedness; and,*
- B. *Based on the status of these dimensions, the nine stages of readiness.*

Dimensions

Dimensions of readiness are key factors that influence your community’s preparedness to take action on an issue. The six dimensions identified and measured in the Community Readiness Model are very comprehensive in nature. They are an excellent tool for diagnosing your community’s needs and for developing strategies that meet those needs.

A. Community Efforts: To what extent are there efforts, programs, and policies that address the issue? For example: needle exchange, HIV workshops.

B. Community Knowledge of the Efforts: To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

C. Leadership: To what extent are appointed leaders (Chief and Council, Board Members, etc.) and influential community members (Elders, Youth Councils, Mentors, etc.) supportive of the issue?

D. Community Climate: What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment? For example: Do people think that individuals who use needles are irresponsible and therefore, deserve to get sick?

E. Community Knowledge about the Issue: To what extent do community members know about the causes of the problem, consequences, and how it impacts your community? For example:

Do they understand the factors that influence a person’s decision to use a substance? Do they know the benefits of needle exchange programs? How it can support an individual to change their life?

F. Resources Related to the Issue: To what extent are local resources – people, time, money, space, etc. – available to support efforts?

Your community’s status with respect to each of the dimensions forms the basis of the overall level of community readiness.

Stages

See next page for stage descriptions.

Stage Description

1. No Awareness: Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).

2. Denial / Resistance: At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.

3. Vague Awareness: Most feel that there is a local concern, but there is no immediate motivation to do anything about it.

4. Preplanning: There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.

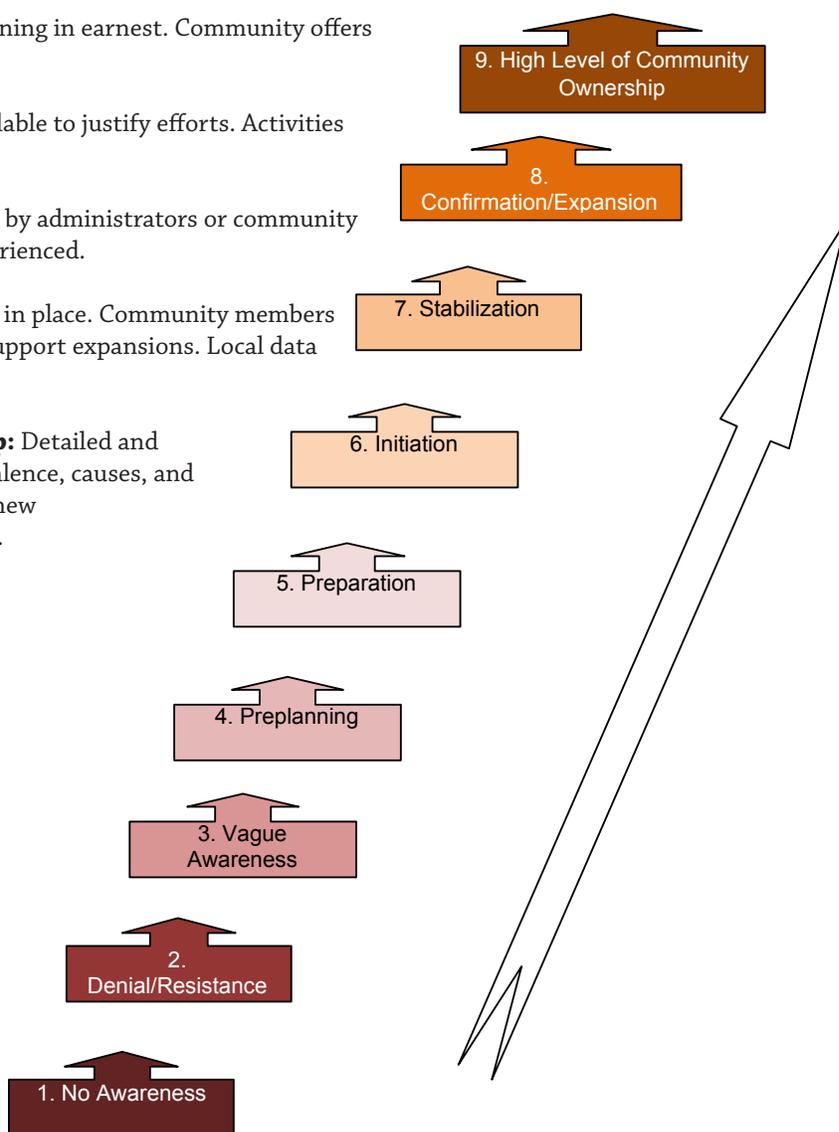
5. Preparation: Active leaders begin planning in earnest. Community offers modest support of efforts.

6. Initiation: Enough information is available to justify efforts. Activities are underway.

7. Stabilization: Activities are supported by administrators or community decision makers. Staff are trained and experienced.

8. Confirmation/ Expansion: Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.

9. High Level of Community Ownership: Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.



REFLECTIONS ABOUT THE TRAINING PROCESS

In many Aboriginal cultures, we are taught that it is hard to move forward without taking the time to look back – to reflect on where we have come from and the lessons the journey provided for us. This CR assessment is a tool that can be used when reflecting what has happened, what needs to take place to help the healing process and what tools/services are needed to get to the ideal place for that individual community.

Purpose

To provide an opportunity for the participants to process what they learned and how the learning applies to the community readiness model.

Method

1. Explain to the large group that we will brainstorm and process the learning through a series of questions listed below. Starting with Experience, read out the questions. As participants respond, write down the responses on the flip chart paper.

Experience:

- What did you learn from the module(s)?
- What did you need to know in order to prepare for community readiness?
- Identify: How was the experience significant to you? (Personally or as a Community Facilitator)
- What do you understand better about yourself? Your role?

Analyze:

What helped you to learn?
What do you feel about what you learned?

Generalize:

How will you apply what you learned to being a Facilitator of Community Readiness?
Is there anything that you would change about the process?

2. Before moving onto Module 4, ask if there are any additional comments? Concerns?

Time: 15 minutes

MODULE 4:

Conducting Your Community Readiness Assessment

Conducting a Community Readiness Assessment is the key to determining the community's readiness by dimension and by overall stage. To perform a complete assessment, the participants must have the knowledge, skills and tools to achieve this task.

Purpose

To demonstrate to the participants how to prepare, conduct and score for the results of their community's readiness to develop and implement culturally appropriate intervention strategies that reduce risk for HIV and HCV infection.

Method

1. Advise the participants that conducting an assessment is a three step process:

- a. Prepare/Plan;
- b. Conduct interviews; and,
- c. Score the interview results.

2. First, advise the participants that in order to prepare for conducting the interviews, they will need to do three things:

- a. Identify Key Respondents to interview;
- b. Have a thorough understanding of the questions and be able to address any question that the interviewees may ask;
- c. Contact the identified Key Respondents and arrange the interviews.

3. **Exercise:** To support this learning, take 15 minutes and complete this exercise:

- a. Ask the participants to brainstorm potential Key Respondents that they believe are connected to the issue. Remind them again what the issue is and as they call out their suggestions, write them on the flip chart paper.
- b. Once you have a list, ask the group to explain why these individuals would be appropriate Key Respondents. (Suggested Key Respondents are listed in the Facilitator Notes)

4. Presentation: Advise the participants that there are 22 questions that have been developed to assess readiness for implementing culturally appropriate intervention strategies designed to reduce risk of HIV and HCV infection in Aboriginal communities.

a. Ask the participants to turn to the questions in their Workbook – also listed on the Workshop Template.

b. As the Trainer, take 15 minutes and read through the questions, answering any questions that may arise. Also – read from the Helpful Hints listed in the Facilitator Notes and in their Workbooks.

5. Exercise: To practice interviewing, pair up the participants, designating one as the Interviewer (Community Facilitator) and the other as the Interviewee (Key Respondent). Using the Workshop Template – Community Readiness Interview Questions - provide 30 minutes to complete the interview. Be sure that they keep record of the responses.

a. Be sure to walk around and check in with each pair – to monitor progress and answer any questions.

b. After the 30 minutes, have the participants gather back as a large group.

c. Ask for feedback from the group. In general, you want them to share how the interview experience was and get any suggestions that may be helpful. It is also an opportunity to share ideas on process.

d. If you feel it would be helpful, records their comments on flip chart paper and post.

6. Presentation: Ask them to turn to their Workbook section – the Workshop Template called “Process for Scoring the Interviews” - and the other associated workshop templates. Guide them through the scoring process – step by step –referencing the other workshop templates where relevant. Answer any questions that may arise.

7. Exercise: Once everyone is clear on scoring, ask them to gather back into their pairs.

a. Instruct them to use their Workshop Template “Community Readiness Assessment Scoring Sheet” and the “Anchored Rating Scales for Scoring Dimension” to score the interview results and determine their overall readiness. Give them 20 minutes to complete this exercise.

b. Be sure to walk around and check in with each pair – to monitor progress and answer any questions.

c. After 20 minutes, have them return to the larger group. Ask a few pairs to share their results. Record on flip chart and post.

8. Before moving onto the next module:

a. Point out the “Important Facts” listed on the Scoring Sheet.

b. Note that there are generic strategies appropriate for each stage of readiness to assist them in developing culturally

appropriate interventions in the community. These are noted on the workshop template in this guide and their workbook.

9. Finally, present the power point presentation called, “Dimensions and Stages: Sample Risk Reduction Strategies”. This presentation will give the participants more information to demonstrate how strategies can be developed based on lining up the stages with dimensions.

10. Take the time to discuss a few that line up with some of the readiness results/stages posted on the flip chart paper.

11. Answer any final questions.

12. Finally, before moving into Module 5, complete the Reflections of Module 4.

Time: 120 minutes (2 hours)

FACILITATOR NOTES: Conducting Your Community Readiness Assessment

Suggested Key Respondents:

Identify four to six individuals in your community who are connected to the issue of reducing risk and changing risky behaviours associated with HIV and HCV infection. In some cases it may be “politically advantageous” to interview more people. However, only four to six interviews are generally needed to accurately score the community. Try to find people who represent different segments of your community.

Trainer Tip: Although 4-6 are generally all you need to interview, it would be advisable to schedule 7-8 in case a few have to cancel.

In the Aboriginal community, suggested respondents are:

- People engaged in the high risk behavior – for example, “people injecting drugs”*
- Health and Social Service Workers:*
 - Community Nurses / Nurse Practitioners*
 - Community Health Reps*
 - Drug and Alcohol Workers / NNADAP*
 - Mental Health Workers*
 - Outreach Workers*
 - Health and Wellness Workers*
 - etc,.....*
- Youth and Youth Workers*
- Chief and Council / Traditional Council*
- Board members and Executive Directors (urban Aboriginal non-profit organizations, such as Friendship Centres)*
- Local law enforcement*
- Local health agencies (Aboriginal and non-Aboriginal involved in the issue / providing services)*
- Mental health & treatment service providers*
- Spiritual community – Elders, Traditional Healers, Grandmothers*
- Teachers or guidance counselors*
- Community at large*

FACILITATOR NOTES: Conducting Your Community Readiness Assessment

Helpful Hints for Preparing to Conduct Interviews:

- 1) The questions in **bold** are mandatory and must be asked.
- 2) Questions for Dimension A and B have been combined for better flow to the interview.
- 3) If translating from English to another language, ask someone very familiar with the language and the culture to translate. Then “back-translate” to English by someone else, just to ensure that original content of the question is maintained;
- 4) Test your questions with a friend or family member just to make sure they are easy to understand.

WORKSHOP TEMPLATES:

Conducting Your Community Readiness Assessment

Community Readiness Interview Questions

A. COMMUNITY EFFORTS (Programs, Activities, Policies, etc.)

B. COMMUNITY KNOWLEDGE OF EFFORTS

1. In your community, how much of a concern is providing services that reduce risk and risky behavior associated to HIV and HCV infection? To answer the questions, use a scale from 1 to 10, with 1= “not at all” and 10= “being a very large concern”? Please explain.
2. Please describe the efforts that are available in your community to address reducing risk and risky behaviors?
3. How long have these efforts been going on in your community?
4. Using a scale from 1 to 10, how aware are people in the community of these efforts? (1= “being no awareness” and 10= “being very aware”) Please explain.
5. What does the community know about these efforts?

C. LEADERSHIP

6. For the “leaders” in your community, how much of a concern is reducing risk? Use a scale of 1 to 10, with 1= “not at all” and 10= “a very large concern”. Please explain.
7. How are the “leaders” involved in efforts regarding providing services that reduce risk and risky behaviours? Please explain. (For example: Are they involved in a committee, task force, etc.? How often do they meet?)
8. Would the leadership support additional efforts? Please explain.

D. COMMUNITY CLIMATE

9. Are there ever any circumstances in which members of your community might think that denying services to individuals who are “under the influence” or who practice other risky behaviours should be tolerated? Please explain.
10. How does the community support efforts to reduce risk?
11. What are the primary obstacles to efforts to reduce risk in your community?
12. Based on the answers that you have provided so far, what do you think is the overall feeling among community members regarding efforts to reduce risk?

E. KNOWLEDGE ABOUT THE ISSUE

13. How knowledgeable are community members about risk reduction. Please explain. (Such as: dynamics, signs, symptoms, statistics, effects on family and friends, etc.)

14. What type of information is available in your community regarding risk reduction?
15. What local data on risk reduction is available in your community?
16. How do people obtain this information in your community?

F. RESOURCES FOR PREVENTION EFFORTS (time, money, people, space, etc.)

17. On a scale from 1-10, what is the level of expertise and training among those working on providing services to reduce risk? With 1 being “very low” and 10 being “very high”. Please explain.
18. Do efforts that address providing services to reduce risk have a broad base of volunteers?
19. What is the community’s and/or local business’ attitude about supporting efforts to address reducing the risk for individuals, with people volunteering time, making financial donations, and/or providing space?
20. How are the current efforts funded? Please explain.
21. Are you aware of any proposals or action plans that have been submitted for funding to address reducing risk in your community? If yes, please explain.
22. Do you know if there is any evaluation of these efforts that are in place to address reducing risk? If yes, using a scale from 1 to 10, how sophisticated is the evaluation effort, with 1 being “not at all” and 10 being “very sophisticated”?

Process for Scoring the Interviews

Important: On the Anchored Rating Scales for Scoring Dimension pages, you will notice that there are “bulleted” spaces between the numbered comments. These are to indicate “half points”, meaning that you believe the rating falls somewhere between the two ratings.

- 1) Score the interviews one at a time. Start by reading through each interview record (answers/notes to questions) before you begin to score to get a general feeling and impression from the interview. Pick out statements and references that refer to specific dimensions.
- 2) Using the Anchored Scoring Sheet Guide and recording on the Assessment Scoring Sheet, create a score for each of the six dimensions according to the anchored scoring scales. So, for each interview record, there will be a resulting score for each of the 6 dimension (in other words.... interviews are scored by dimensions and not by individual questions). The score per dimension will range from 1 to 9.
- 3) To record the results, use the Assessment Scoring Sheets. Under the section titled “Individual Score”, you are to fill in your scores for each dimension of each of the interviews. Please note: There may be more than 6 key informant interviews in a community. If this is the case simply add #7 and #8, handwritten to this form.
- 4) Next, if there is more than one person scoring, you will need to discuss each of your individual scores, then decide on a combined score. It is important that there be consensus on the scores by both scorers. Remember different people can have slightly different impressions and it is important to explain how you arrived at your decision. These combined scores will be recorded in the section “Combined Score”. Enter your agreed upon score on one of the scoring sheets for each dimension and each interview (see sample).
- 5) Once the Combined Score table is filled in, total each line (dimension) by adding across the table. Now, you will need to determine the “mean” score for each dimension. So, under the Calculated Scores section, take each dimension TOTAL and record on the corresponding dimension line and record in the number of interviews. This equation will give a “calculated score” for each Dimension.
- 6) Add up the calculated scores and mark this number on the line called, “TOTAL Calculated Score”.
- 7) Transfer this number onto the next section called “Stage of Readiness” on the appropriate line in the equation. You divide the “TOTAL Calculated Score” by 6 (the number of dimensions).
- 8) This number is the **stage of readiness** – use the table on the Assessment Scoring Sheet to determine your communities’ readiness result.
- 9) Finally, under comments, write any impressions about this community, any unique outcomes, and qualifying statements that you wish to make regarding the score of the community.

Important: The scoring process is not an evaluation, or a report card of what is not succeeding in the community. It is a process to help meet the community members where they are at...

Alternative Scoring Approach (only 1 Scorer)

If there is only 1 scorer, complete # 1 to #3, but skip the #4 and follow the instructions below.

You need to determine the “mean” score for each individual dimension. So, under the Individual Scores section, take each dimension score and add up the TOTAL and mark it on the paper (even though there is no record on the corresponding dimension line).

Move these totals into the chart featured under the Calculated Scorers and write in the number of interviews. This equation will give a “mean” for each Dimension.

Add up the “mean” scores and mark this number on the line called, “TOTAL Calculated Score”.

Now continue with # 7 to #9.

Community Readiness Assessment Scoring Sheet

Scorer: _____ Date: _____

Individual Scores: Record each scorer’s independent results for each interview for each dimension. The table provides space for up to 6 interviews.

<i>Interviews</i>	#1	#2	#3	#4	#5	#6
<i>Dimension A</i>						
<i>Dimension B</i>						
<i>Dimension C</i>						
<i>Dimension D</i>						
<i>Dimension E</i>						
<i>Dimension F</i>						

Combined Scores: For each interview, the two scorers should discuss their individual scores and then agree on a single score. This is the combined score. Record it below and repeat for each interview, in each dimension. Then, add across each row and find the TOTAL for each dimension. Use this TOTAL to find the calculated score below.

<i>Interviews</i>	#1	#2	#3	#4	#5	#6	<i>Total</i>
<i>Dimension A</i>							
<i>Dimension B</i>							
<i>Dimension C</i>							
<i>Dimension D</i>							
<i>Dimension E</i>							
<i>Dimension F</i>							

Calculated Scores: Use the combined score TOTAL in the table above and divide by the number of interviews conducted. Add the calculated scores together, enter it under Total Score.

Scores

TOTAL Dimension A _____ ÷ # of interviews _____ = _____

TOTAL Dimension B _____ ÷ # of interviews _____ = _____

TOTAL Dimension C _____ ÷ # of interviews _____ = _____

TOTAL Dimension D _____ ÷ # of interviews _____ = _____

TOTAL Dimension E _____ ÷ # of interviews _____ = _____

TOTAL Dimension F _____ ÷ # of interviews _____ = _____

Total Score: _____ (continued on next page)

Overall Stage of Readiness:

Take the total calculated score and divide by 6 (the number of dimensions). Use the list of stages below to match the result with a stage of readiness. Remember: round down instead of up.

Total calculated score _____ ÷ 6 = _____

Score	Stage of Readiness
1	<i>No Awareness</i>
2	<i>Denial / Resistance</i>
3	<i>Vague Awareness</i>
4	<i>Preplanning</i>
5	<i>Preparation</i>
6	<i>Initiation</i>
7	<i>Stabilization</i>
8	<i>Confirmation / Expansion</i>
9	<i>High Level of Community Ownership</i>

Comments and/or Impressions about the community:

Important:

- Look carefully at the distribution of scores across the dimensions. Are they all about the same? Are some lower than others?
- To move a community forward on the issue, readiness on all dimensions must be at about the same level:
- If you have one or more dimension with lower scores than the others, you should focus your efforts on strategies that will increase the community's readiness on dimension(s) first.
- Be sure that the intensity level of the strategy is consistent with (or lower than) the stage score for that dimension.

Anchored Rating Scales for Scoring Dimension

DIMENSION A: Existing Community Efforts

-
-
-
- 1 No awareness of the need for efforts to address reducing the risk.
-
-
- 2 No efforts addressing the issue of reducing risk.
-
-
- 3 A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.
-
-
- 4 Some community members have met and begun a discussion of developing community efforts.
-
-
- 5 Efforts (programs/activities) are being planned.
-
-
- 6 Efforts (programs/activities) have been implemented.
-
-
- 7 Efforts (programs/activities) have been running for several years.
-
-
- 8 Several different programs, activities and policies are in place, covering different age groups and reaching a wide range of people. New efforts are being developed based on evaluation data.
-
-
- 9 Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.
-
-
-

DIMENSION B: Community Knowledge of the Efforts

-
-
-
- 1 Community has no knowledge of the need for efforts to address reducing the risk.
-
-
- 2 Community has no knowledge about efforts addressing the issue of reducing risk.
-
-
- 3 A few members of the community have heard about efforts, but the extent of their knowledge is limited.
-
-
- 4 Some community members know about local efforts.
-
-
- 5 Members of the community have basic knowledge about local efforts (ie. purpose).
-
-
- 6 An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.
-
-
- 7 There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.
-
-
- 8 There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.
-
-
- 9 Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.
-
-
-

DIMENSION C: Leadership (includes appointed leaders & influential community members)

-
-
-
- 1 Leadership has no recognition of the issue.
-
-
- 2 Leadership believes that this is not an issue in their community.
-
-
- 3 Leadership recognizes the need to do something.
-
-
- 4 Leader(s) is/are trying to get something started.
-
-
- 5 Leaders are a part of a committee or group that addresses the issue.
-
-
- 6 Leaders are active and supportive of the implementation of efforts.
-
-
- 7 Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.
-
-
- 8 Leaders are supportive of expanding/improving efforts through active participation in the expansion/improvement.
-
-
- 9 Leaders are continually receiving evaluation results of the efforts and are modifying support accordingly.
-
-
-

DIMENSION D: Community Climate

-
-
-
- 1 The prevailing attitude is that its not considered, unnoticed or overlooked within the community. “It’s just not our concern.”
-
-
-
- 2 The prevailing attitude is “There’s nothing we can do.” Or “Only those people do that” or “We don’t think it should change”.
-
-
-
- 3 Community climate is neutral, disinterested, or believes that the issue does not affect the community as a whole.
-
-
-
- 4 The attitude in the community is now beginning to reflect interest in the issue. “We have to do something, but we don’t know what to do”.
-
-
-
- 5 The attitude in the community is “We are concerned about this” and community members are beginning to reflect modest support for efforts.
-
-
-
- 6 The attitude in the community is “This is our responsibility” and is now beginning to reflect modest involvement in the efforts.
-
-
-
- 7 The majority of the community generally supports programs, activities, or policies “We have taken responsibility”.
-
-
-
- 8 Some community members may challenge specific programs, but the community in general is strongly supportive of the need for reducing the risk efforts. “We need to keep up on this issue and make sure what we are doing is effective”.
-
-
-
- 9 All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.
-
-
-

DIMENSION E: Community Knowledge About the Issue

-
-
-
- 1 Not viewed as an issue.
-
-
-
- 2 No knowledge about the issue.
-
-
-
- 3 A few in the community have some knowledge about the issue.
-
-
-
- 4 Some community members recognize the signs, symptoms and implications of the issue, but information is lacking.
-
-
-
- 5 Members of the community know that the signs, and symptoms of this issue occur locally, and generally information is available.
-
-
-
- 6 A majority of community members know the signs and symptoms of the issue and that it occurs locally, and local data is available.
-
-
-
- 7 Community members have knowledge of, and access to, detailed information about local prevalence.
-
-
-
- 8 Community members have knowledge about prevalence, causes, risk factors, and consequences.
-
-
-
- 9 Community members have detailed information about the issue as well as information about the effectiveness of local programs.
-
-
-

DIMENSION F: Resources Related to the Issue (People, money, time, space, etc...)

-
-
-
- 1 There is no awareness of the need for resources to deal with reducing risk.
-
-
- 2 There are no resources available for dealing with the issue.
-
-
- 3 The community is not sure what it would take, (or where the resources would come from) to initiate efforts to reduce risk.
-
-
- 4 The community has individuals, organizations, and/or space available that could be used as resources.
-
-
- 5 Some members of the community are looking into the available resources.
-
-
- 6 Resources have been obtained and/or allocated for the issue.
-
-
- 7 A considerable part of support of on-going efforts are from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.
-
-
- 8 Diversified resources and funds are secured and efforts are expected to be ongoing. There is additional support for further efforts.
-
-
- 9 There is continuous and secure support for programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.
-
-
-

WORKSHOP TEMPLATES: Conducting Your Community Readiness Assessment Goals and General Strategies Appropriate for Each Stage

1. No Awareness

Goal: Raise awareness of the issue

- *Make one-on-one visits with community leaders/members.*
- *Visit existing and established small groups to inform them of the issue.*
- *Make one-on-one phone calls to friends and potential supporters.*

2. Denial / Resistance

Goal: Raise awareness that the problem or issue exists in this community

- *Continue one-on-one visits and encourage those you've talked with to assist.*
- *Discuss descriptive local incidents related to the issue.*
- *Approach and engage local educational/health outreach programs to assist in the effort with flyers, posters, or brochures.*
- *Begin to point out media articles that describe local critical incidents.*
- *Prepare and submit articles for church bulletins, local newsletters, club newsletters, etc.*
- *Present information to local related community groups.*

(Note that media efforts at the lower stages must be lower intensity as well. For example, place media items in places where they are very likely to be seen, e.g., church bulletins, smaller newsletter, flyers in post offices, etc.)

3. Vague Awareness

Goal: Raise awareness that the community can do something

- *Get on the agendas and present information at local community events and to unrelated community groups.*
- *Post flyers, posters, and billboards.*
- *Begin to initiate your own events (pot lucks, potlatches, etc.) and use those opportunities to present information on the issue.*
- *Conduct informal local surveys and interviews with community people by phone or door-to-door.*
- *Publish newspaper editorials and articles with general information and local implications.*

4. Preplanning

Goal: Raise awareness with concrete ideas to combat condition

- *Introduce information about the issue through presentations and media.*
- *Visit and invest community leaders in the cause.*
- *Review existing efforts in community (curriculum, programs,*

activities, etc.) to determine who the target populations are and consider the degree of success of the efforts.

- *Conduct local focus groups to discuss issues and develop strategies.*
- *Increase media exposure through radio and television public service announcements.*

5. Preparation

Goal: Gather existing information with which to plan strategies

- *Conduct school drug and alcohol surveys.*
- *Conduct community surveys.*
- *Sponsor a community picnic to kick off the effort.*
- *Conduct public forums to develop strategies from the grassroots level.*
- *Utilize key leaders and influential people to speak to groups and participate in local radio and television shows.*
- *Plan how to evaluate the success of your efforts.*

6. Initiation

Goal: Provide community-specific information

- *Conduct in-service training on Community Readiness for professionals and paraprofessionals.*
- *Plan publicity efforts associated with start-up of activity or efforts.*
- *Attend meetings to provide updates on progress of the effort.*
- *Conduct consumer interviews to identify service gaps, improve existing services and identify key places to post information.*
- *Begin library or Internet search for additional resources and potential funding.*
- *Begin some basic evaluation efforts.*

7. Stabilization

Goal: Stabilize efforts and programs

- *Plan community events to maintain support for the issue.*
- *Conduct training for community professionals.*
- *Conduct training for community members.*
- *Introduce your program evaluation through training and newspaper articles.*
- *Conduct quarterly meetings to review progress, modify strategies.*
- *Hold recognition events for local supporters or volunteers.*
- *Prepare and submit newspaper articles detailing progress and future plans.*
- *Begin networking among service providers and community systems.*

8. Confirmation / Expansion

Goal: Expand and enhance services

- *Formalize the networking with qualified service agreements.*
- *Prepare a community risk assessment profile.*
- *Publish a localized program services directory.*
- *Maintain a comprehensive database available to the public.*
- *Develop a local speaker's bureau.*

- *Initiate policy change through support of local city officials.*
- *Conduct media outreach on specific data trends related to the issue.*
- *Utilize evaluation data to modify efforts.*

9. High Level of Community Ownership

Goal: Maintain momentum and continue growth

- *Maintain local business community support and solicit financial support from them.*
- *Diversify funding resources.*
- *Continue more advanced training of professionals and paraprofessionals.*
- *Continue re-assessment of issue and progress made.*
- *Utilize external evaluation and use feedback for program modification.*
- *Track outcome data for use with future grant requests.*
- *Continue progress reports for benefit of community leaders and local sponsorship. At this level the community has ownership of the efforts and will invest themselves in maintaining the efforts.*

REFLECTIONS ABOUT THE TRAINING PROCESS

In many Aboriginal cultures, we are taught that it is hard to move forward without taking the time to look back – to reflect on where we have come from and the lessons the journey provided for us. This CR assessment is a tool that can be used when reflecting what has happened, what needs to take place to help the healing process and what tools/services are needed to get to the ideal place for that individual community.

Purpose:

To provide an opportunity for the participants to process what they learned and how the learning applies to the community readiness model.

Method:

1. Explain to the large group that we will brainstorm and process the learning through a series of questions listed below. Starting with Experience, read out the questions. As participants respond, write down the responses on the flip chart paper.

Experience:

What did you learn from the module?

What did you need to know in order to prepare for

community readiness?

Identify:

How was the experience significant to you?
(Personally or as a Community Facilitator)

What do you understand better about yourself? Your role?

Analyze:

What helped you to learn?
What do you feel about what you learned?

Generalize:

How will you apply what you learned to being a Facilitator of Community Readiness?

Is there anything that you would change about the process?

2. Before moving onto Module 5, ask if there are any additional comments? Concerns?

Time: 15 minutes

MODULE 5: Moving from Assessment to Action Planning

All the learning up to this point has provided knowledge needed to conduct the community readiness assessment.

Once the assessment is complete, the community will be ready to develop culturally appropriate intervention strategies. This will likely be done in a small group or workshop format, lead by a Community Facilitator, and involve a variety of community members.

Not only will the community members participate in developing the interventions, they will also be informed about the community readiness process and the resulting level of readiness for their community.

“Never depend upon institutions or government to solve any problems. All social movements are founded by, guided by, motivated and seen through by the passion or individuals.”

-Margaret Mead

Purpose:

To provide the knowledge, skills and tools needed to facilitate a community workshop for the purpose of developing intervention strategies that are appropriate to a community's stage of readiness.

Method:

1. Inform the participants on the purpose of this module (see purpose statement above). State:

- a. That we will be presenting a power point presentation that they (as Community Facilitators) can use to inform their community about the community readiness model and its process, as well as presenting the results of their community's assessment result.
- b. However, since they, as the training session participants, have already learned about the model and its process, we will not take much time on this review.
- c. The power point presentation contains **Notes** that they can use to present the information to their community members – basically there is a script for them to follow.

2. Ask the participants to turn to the section in their Workbook with the power point presentation and notes. Take 15 minutes and present the power point presentation. Inform the participants that if their community does not have a projector (in-focus machine), they can print out the presentation and use as a Hand-out for their workshop participants to follow along with. As the Community Facilitator, they should use the print out with the Notes - their script to guide the workshop.

3. When you present the last slide “Our Community’s Readiness Score”, the workshop takes a turn from being a presentation to an interactive workshop – Moving from Assessment to Action Planning. The next several exercises are to teach the training participants how to facilitate their community workshop segment that moves beyond assessment into action planning.

4. Community Workshop Exercise:

- a. Ask the workshop participants what stage they believe the community falls into for the targeted issue – reducing risk to prevent HIV and HCV infections. Have participants briefly explain their answer. Allow participants to have a brief discussion about their opinions. Don't take more than 5 minutes on this discussion
- b. Present the community readiness scores for each of the dimensions, for your community (you can type in

the number on the slide Our Community's Readiness Score) and the overall stage. Remind participants exactly what that readiness score means. For example, if your community scores a “3”, describe the Vague Awareness stage of readiness. You can show the slide that describes this stage of readiness (from the “Stages of Readiness” slides).

c. Allow for a brief discussion and answer any questions from the workshop participants. If people take issue with the score, simply explain that differing viewpoints provide the richness in the strategy development and this score reflects the perceptions of those who were interviewed.

However, avoid discussion of intervention strategies at this time; you can let the participants know that you will soon move on to actually discussing and developing intervention strategies for their community.

d. Move to the slide that presents the general strategies for that particular readiness score. This slide states the goal of this stage of readiness, and the general types of strategies that are appropriate for this stage of readiness. Read the goal and sample strategies to the participants and ask if these make sense to them? Discussion.

e. Now, state that it is time to move into discussing culturally appropriate interventions for their community, based on their stage of readiness.

5. Community Workshop Exercise: “Brainstorming Intervention Strategies”

Before moving into the exercise with the training participants, quickly explain to them what “brainstorming” is and some helpful hints to support success. These are noted in the Facilitator Notes.

Trainer Tip

Be sure to have this information written on flip chart paper prior to this exercise and post on wall.

a. Advise the participants once again that we have now identified our issue and we know our community's readiness stage for each dimension, as well as the overall stage.

b. Advise them that in order to support their thinking on appropriate intervention strategies, we will brainstorm what our community's strengths, concerns and resources are. This will happen quickly and with NO discussion. Discussion comes later.

c. On a flip chart, write “Strengths”. Before you ask the question, ask for a volunteer to record (or maybe you already have a co-facilitator that can help). Ask the question: **“What strengths does our community have**

that will help reduce the risk of HIV and/or HCV infection?” Give them an example, such as Traditional Elders, or teachings. Participants can state their ideas and the recorder can write them on the flip chart. Give them only 5 minutes to brainstorm. Post the flip chart on the wall.

d. On a flip chart, write “Concerns”. Ask the question: **“What are the concerns or obstacles to implementing strategies focused on reducing the risk?”** Again, give them only 5 minutes to brainstorm, writing down all their ideas as they are stated. (See Facilitator Notes for some potential Concerns/Barriers/Obstacles – from Walk with Me Pathways to Health) Post the flip chart on the wall.

e. On a flip chart, write “Resources”. Before asking the questions – advise the participants that resources are slightly different from strengths (although they may sometimes be the same). They are things that are already in established or in place – such as the Community Centre, the school. Ask the question: **“What are our resources that support strategies for reducing the risk for HIV and HCV infection?”** Give them only 5 minutes to brainstorm. Post on the wall.

f. Now, here’s where the discussion comes in. Keep a time limit (whatever you decide is appropriate) and keep the group focused.

i. Once again, point to the flip chart on the wall – your community issue and the readiness scores.

ii. Ask them to set the **priorities** - focusing on the dimensions with lowest readiness scores. Be sure to have consensus on these priorities. Record their priorities on flip chart.

iii. If more than one, ask which ones they wish to focus on in the short term and in the long term. Once complete, post on wall.

iv. Focusing on only **one priority at a time**, refer back the general types of strategies on the slides, ask the group **“Knowing that our readiness score for this dimension is _____, and using the strengths and resources, what strategies can we use to best meet our concerns/obstacles?”** Allow the group to formulate some specific and reasonable strategies for each of the priorities. Write these on flip chart and post. (See Facilitator Notes for Strategies that Reduce Risk – from “Walk with Me

Pathways to Health”)

5. Community Workshop Exercise: “Creating the Action Plan”

a. Ask the participants to turn to the section in their Workbook demonstrating the “Action Plan”. Explain the layout of the template: 1) Intervention/Strategy, 2) Actions/Activities, 3) Person(s) Responsible 4) Target date for completion 5) Expected Outcome. Use a sample template to assist you (see Facilitator Notes).

Intervention/.....
 Strategy/Actions/.....
 Activities.....
 Person(s).....
 Responsible.....
 Target date for completion.....
 Expected
 Outcome.....

b. Depending on group size and the number of strategies, break them into groups of three or four. The best way to organize them into groups is with respect to their preferred dimension. Be sure that all dimensions are now assigned to a group.

c. Give each group a few flip chart papers and markers. Ask them to recreate the template format on their paper and to assign someone in the group to be a recorder and someone else to be a presenter. Remind them to always keep referring back to the types of strategies that are used at that level of readiness consistent with the dimension they are working on.

d. Instruct them to create an Action Plan for their priority dimension, listing the strategies determined in the last exercise. Follow the flow of the template – determining the action steps needed to achieve that strategy.

e. Be sure to move amongst the groups, checking in to make sure that they are following the instructions and that they understand their task – that they are on track!

f. Give them 30 minutes to complete. Once they are done, have them regroup to present their Action Plans. Allow time for questions. Post all Plans once presented.

5. Now that the Action Plans are complete, you will need to set up a date for the group to reconvene and get an update on the tasks completed and what is outstanding. At this meeting, the group can also address any obstacles and concerns.

6. Finally, complete your Reflections exercise for Module 5.

Time: 120 minutes

FACILITATOR NOTES:

Moving from Assessment into Action Planning

Brainstorming

Brainstorming is a quick and fast approach to developing creative ideas - it allows participation from all - it works within a specific set time limit and it allows no time for discussion of ideas - that comes later.

Helpful Hints for Effective Brainstorming

- Allow the team to “brainstorm” as many ideas as possible.
- Point out that during this next twenty minutes, there will be no in-depth discussion but just random ideas thrown out. If someone begins what could be a lengthy discussion, tell the group you will hold up two fingers to signal them to hold that thought until the discussion time later and move on.
- Consider all suggestions and be creative, there are no right or wrong answers.
- Use a flip chart to write down all ideas.
- Get creative, outlandish, consider all ideas.
- Never brainstorm on one topic for more than five minutes, remember you’re going for quantity of ideas at this point, not quality.

Common Concerns / Barriers / Obstacles (selection from “Walk with Me Pathway to Health” – CAAN)

- Belief that risk reduction approaches condone and even encourage risky behaviors that are immoral;
- Stigma and discrimination – homophobia, sex workers, injection drug users, etc.
- Abstinence-based addictions treatment philosophies that exist in community;
- Limited access to services and programs;
- Concerns about confidentiality;
- Youth not attending school or participating in prevention/ education activities;
- Women becoming isolated in their homes and not being able to attend meetings;
- Community Leaders and members in denial about risky behaviours occurring in their community;

- Communication problems in the community. ie: people not attending meetings;
- Lack of risk reduction initiatives in the community;
- Fear – if people provide the risk reduction service, it may be viewed that they are promoting the behavior/activity that places people in risky situations.

Strategies that Reduce Risks (broad-based and specialized) (selection from “Walk with Me Pathway to Health” and “Harm Reduction Implementation Guide” CAAN)

- Education and information approaches about reducing risk – workshops, one-on-one session, social marketing/media;
- Testing for injection drug users – to determine early diagnosis and facilitate treatment;
- Health promotion activities to minimize negative health outcomes – ie. educating people about nutrition, getting them involved in physical activities ;
- Outreach services – providing food and water to those who have not eaten in days;
- This builds trust between the “end-user” and service provider;
- Needle Exchange programs;
- Condom Distribution and safer sex education;
- 12 step and Anonymous programs;
- Medical marijuana (part of a comprehensive treatment program for people with chronic illnesses (ie. HIV, cancer, HCV);
- Provision of pamphlets that provides information about testing for HIV;
- Methadone Clinic / “Wet” Shelters ;
- Policy development.

For a thorough outline of “Actions For Change” in addressing and reducing risk, go to CAAN’s Walk with Me Pathways to Health: Harm Reduction Service Delivery Model, pages 31 – 35.

SAMPLE: Record of Community Strengths, Concerns and Resources

Community Name: Friendly First Nation

Workshop Date: July 15, 2011

Community Facilitator: John Doe

Overall Readiness Stage and Score: 4, "Pre-Planning"

STRENGTHS	CONCERNS	RESOURCES
<ul style="list-style-type: none"> -Community pride -Caring for one another -Strong family unit -Strong religious background -Education is important -Has everything (self-sufficient) -Strong work ethic -Self policing -Cultural heritage -Low crime / safe -Honesty -Low cost of living -Lake -Recreation (baseball, track, golf) -Education and sports achievements 	<ul style="list-style-type: none"> -Negative attitude -Clique-ish / exclusive -Powerful and inaccurate gossip -Nosy -Self righteousness -Focus on negatives -Tough to challenge -Elderly population ignored -Lack of program buy-in from general community -Low socio-economic status -Too competitive -Lack of youth input -Lack of high paying jobs in community 	<ul style="list-style-type: none"> -School -Traditional lodge -Community groups -Good healthcare -Volunteer EMS -Street Outreach -Lake -Neighbors -Family -Finances -Volunteer fire department -Police on reserve -Local paper -Local community channel

Record of Community Interventions and Strategies: Action Plan

Community Name: _____ Workshop Date: _____

Community Facilitator: _____

Overall Readiness Stage and Score: _____

Intervention / Strategy	Actions / Activities	Person(s)
Responsible	Target Date for Completion	Expected Outcomes

Intervention / Strategy	Actions / Activities	Persons (s) Responsible	Target Date for Completion	Expected Outcomes

SAMPLE: Record of Community Interventions and Strategies: Action Plan

Community Name: Friendly First Nation

Workshop Date: July 15, 2011

Community Facilitator: John Doe

Overall Readiness Stage and Score: 4, “Pre-Planning”

<i>Intervention / Strategy</i>	<i>Actions / Activities</i>	<i>Persons (s) Responsible</i>	<i>Target Date for Completion</i>	<i>Expected Outcomes</i>
<i>1. Educational Presentations to Adult Groups</i>	<i>What: When: Where: How:</i>	<i>Who:</i>		
<i>2. Information Dissemination</i>				

REFLECTIONS ABOUT THE TRAINING PROCESS

In many Aboriginal cultures, we are taught that it is hard to move forward without taking the time to look back – to reflect on where we have come from and the lessons the journey provided for us. This CR assessment is a tool that can be used when reflecting what has happened, what needs to take place to help the healing process and what tools/services are needed to get to the ideal place for that individual community.

Purpose:

To provide an opportunity for the participants to process what they learned and how the learning applies to the community readiness model.

Method:

1. Explain to the large group that we will brainstorm and process the learning through a series of questions listed below. Starting with Experience, read out the questions. As participants respond, write down the responses on the flip chart paper.

Experience:

What did you learn from the module?
 What did you need to know in order to prepare for community readiness?

Identify:

How was the experience significant to you?
 (Personally or as a Community Facilitator)

What do you understand better about yourself? Your role?

Analyze:

What helped you to learn?
 What do you feel about what you learned?

Generalize:

How will you apply what you learned to being a Facilitator of Community Readiness?
 Is there anything that you would change about the process?

2. Before moving onto discussing some general points about evaluation, ask if there are any additional comments? Concerns?

Time: 15 minutes

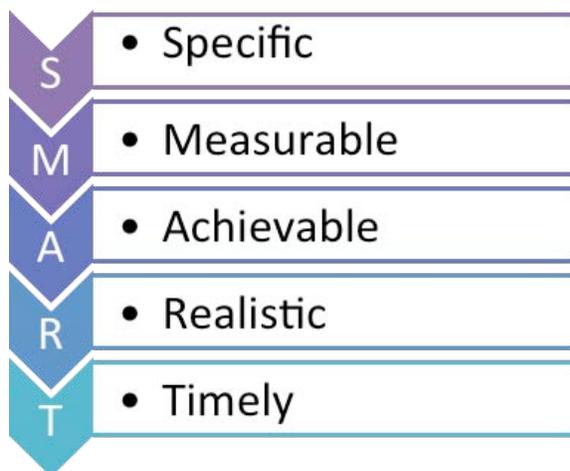
EVALUATING CULTURALLY APPROPRIATE INTERVENTION STRATEGIES

Evaluation is more than just a completion stage of a program or policy. Evaluation can be factored in from the beginning of any project. After assessing your community's stage of readiness, the next step is coming up with culturally appropriate intervention strategies that address the issue in your community.

Developing a Logic Model

An easy way to map out your plan is to make a logic model. A logic model illustrates how and why a program or strategy works by showing "...how all the program goals, activities, and expected outcomes link together" (Shackman, 2010).

The first step to building a logic model is to identify your overall goal(s). Goals describe future expected outcomes or states. They provide programmatic direction. They focus on ends rather than means. For example, your goal may be to reduce the spread of HIV and HCV in your community by delivering programs and services that effectively reduce and/or change risky behaviours.



Step two is to consider your **objectives**. Objectives are **SMART** statements of action which when completed will move towards goal achievement. Objectives tell how to meet a goal. Examples of objectives are:

- To raise community awareness about risky behaviours that may lead to HIV infection; and,
- To reduce risk by promoting safer sex practices.

Next, you will have to identify the **inputs**. What are the resources that will go into accomplishing your goal? Since you have completed your assessment, you will have gone through the exercise of identifying the resources. Resources can be funds, people, capital items, etc.

The next step is to come up with **Activities** (including services, products, and more) that serve your goal and are clearly linked to the objectives. Examples of activities are:

- To raise community awareness about risky behaviours that may lead to HIV infection (objective)
- Series of workshops; and,
- Information brochures about HIV and HCV.

Activities can also be classified as outputs in some logic models.

Now that you have objectives, inputs and activities to try and accomplish that goal, you can plan the short term, intermediate and long term outcomes you would like the activities to accomplish. Outcomes are the preferred consequences of achieving the set out goals of your culturally appropriate intervention strategy. Your short term outcomes may be more practical such as distributing a certain number of condoms to community members or delivering a sexual education class to a certain number of youth. These are called quantitative measures which mean they are measured in numbers. With proper data tracking it can be determined if you have reached your intended outcomes. It is also a possibility to use a qualitative (a descriptive) short term outcome such as increased acceptability of practices that reduce risk in your community. Qualitative outcomes cannot be counted - they are people's verbal or written accounts of their experiences or their feelings about their experiences.

Intermediate and long term outcomes are accomplished over a longer period of time when your strategy has had time to develop and take root in your community. These outcomes may be more qualitative in nature such as decreased stigma around injection drug use or HIV in the community.

Once you have your logic model, you will have a better idea of what you are trying to achieve and how you are planning to achieve it. Measuring your outcomes along the way will allow you to grasp whether you are moving in the right direction or not. This is called process evaluation. Questions in your evaluation should gather information on:

- Whether your plan is well suited for your community and at what stage of readiness they are;
- Whether your activities are suited for meeting your outcomes/goals;
- Whether you are reaching the target community members (e.g. Aboriginal women, youth, two-spirited men and individual who have been or are in prison);
- How external factors are influencing the delivery of the activities; and

- How well the intervention activities are being implemented.

Collecting the information that addresses these areas could help you decide how to move forward with the strategy. You may find that you need to improve on some areas, make some minor adjustments overall or maybe continue the work as status quo because the strategy is going as intended. In short, before conducting your evaluation decide what needs to be collected and how to be useful to your community.

Process and Outcome Evaluation

The World Health Organization defines Process Evaluation as being “.aimed at enhancing your current programme by understanding it more fully. Process evaluations measure what is done by the programme, and for whom these services are provided” (WHO 2000 p.8). In short, process evaluation informs about the functioning of the program and whether it is being implemented as designed while outcome evaluation measures the outcomes of the program. Process evaluation for your purposes can be beneficial to conduct at any point and Outcome Evaluation can be conducted to measure the short term impacts and later the long term impacts once the strategy has been around for awhile. Evaluation in general is good to improve the strategy and for accountability purposes if there is funding involved. The following are potential questions that you can include in your evaluation. To get the most useful questions reflect on what you want to evaluate. Is it process or outcome oriented or both? Are questions to be general to the strategy or are there questions that need to be asked about specific activities? Etc.

Potential questions: Process

- How does the intervention strategy look on the ground?
- What are the strengths? What are the challenges of the strategy?
- Are the activities appropriate for achieving the goals originally set out?
- Is the strategy suited to the goal? Are there alternatives that would work better?
- Are the intervention activities planned and carried out according to the core values of risk reduction (e.g. everyone deserves care, being non judgmental)
- How could the strategy be improved?

Potential questions: Outcome

- Is the strategy having a positive impact on the community and reaching targeted members of the community?
- What activities were responsible for having an impact (if any)?
- Are there unintended consequences?

Choosing a method to collect data

The questions you are asking and the data you are trying to collect will determine your method of data collection. Some options are quantitative in nature while others are qualitative. Usually a mixture of methods is worthwhile so that you get an in-depth understanding and also a larger scope of data. Some options include:

- *Surveys*
- *Key informant interviews*
- *Focus Groups*
- *Analysis of Available Data*

Surveys: a set of questions asked of everyone in the same way. They address the questions about how many and how often. For example “How many community members have received HIV awareness education? How often are these sessions held? When doing a survey it is likely that you will only ask a sample which is a small group of the population you want to collect data from. The population may include service providers, community members, community leaders, those community members that the HR strategy is meant to reach etc. The best way to choose your sample is to randomly select. This way you can make generalizations about the larger population the survey results is supposed to describe. An easy way to randomly select is to put names in a hat and pull out a certain number.

Key Informant Interviews: “are qualitative in-depth interviews of 15-35 people selected for their first-hand knowledge about a topic of interest” (Shackman 2010). To conduct interviews, choose a variety of stakeholders who have in-depth knowledge and decide on the best questions to ask them to produce the data that is meaningful to your evaluation. Interviews might be useful for collecting sensitive information that would not be comfortably shared in a focus groups (Shackman 2010).

Focus Groups: are discussions among a small group of people about selected topics and planned questions. A facilitator leads the discussion while being flexible to allow discussions that were not predicted. Focus groups are a good way to bring the community together.

Analysis of available data: If data pertaining to the strategy is collected from the planning stages of the strategy and then continued, there will be data available to analyze and feed into the evaluation. For example you may collect data on a spreadsheet about the amount of awareness sessions you held or how many people have accessed a needle exchange clinic. When collecting data keep in mind what you would like to know in the future such as how successful the strategy has been or where it needs to be improved.

Considerations for Conducting an Evaluation

Ongoing data collection can be extremely useful. Consider collecting data on HR activities from the beginning of implementing the strategy so that data is already available and does not need to be collected later. Using the rest of this section come up with some ideas of what data you may want in the future and then organize excel spreadsheets or other means to collect that data on a regular basis in a simple fashion.

The process of carrying out the evaluation is just as important as the evaluation outcomes. Consider an approach that is inclusive of as many people involved or impacted as possible to get a wide range of ideas of what’s important to evaluate and how to carry it out. Also consider ways to build capacity such as training sessions and splitting up the work - working as a team. Finally its beneficial to share results with everyone involved to validate what was found but also to show gratitude for everyone’s dedication and involvement.

LESSONS LEARNED AND WISE PRACTICES

In 2009-2011, CAAN assisted First Nations and agencies to assess their stage of readiness taking a risk reduction approach to service delivery using the Community Readiness Model developed by the Tri-Ethnic Centre for Prevention Research. Various agencies within three cities participated, and three First Nation communities. The agencies provide services to the identified target groups: Aboriginal women; youth; two spirited men; and individuals that had or are in the correctional system.

After interviewing the frontline service providers involved in the project, certain promising practices and lessons learned became clear. This section will discuss those lessons learned so that communities mobilizing to implement culturally appropriate intervention strategies that address and reduce risks for HIV and HCV know the potential challenges and can strategize on how to meet those challenges. The following are lessons learned organized into overarching themes:

- *Capacity in terms of time and resources to implement intervention strategy(s);*
- *Resistance to change within institutions and among service providers;*
- *Vicarious trauma experienced by service providers working within their own communities;*
- *A need to set the ground work;*
- *Delivering services in different settings;*
- *Assessing community readiness in culturally appropriate ways;*
- *Communicating new concepts in applicable terms; and*

- *Reaching at risk populations.*

Capacity building is an important component of working with communities to set up an intervention strategy:

- *The difficulty of conducting a community readiness assessment when these are direct front line service providers already overworked and dealing with crisis on a daily basis. They might want to dedicate themselves in some way, but don't have the capacity to actually do it; and,*
- *There was not enough time after scoring for community readiness for the Coordinator to sit down and work on community readiness specific activities to move forward; and,*
- *For organizations already working towards a risk reduction approach, the project was a motivator but for organizations that were doing things differently it felt like duplicating efforts of current services; and,*
- *Not reinventing the wheel - 2-spirits (Toronto) was successful because they turned to already created resources to improve what they were already doing for their risk reduction strategy' and,*
- *Coordinating with other services (referring) is really important because an organization can only stretch their resources so much; and,*
- *Having the organizational space to start new activities – appropriate space for at risk populations. For example a private space to meet with street involved people who are high when receiving services at a women's shelter that is separate from where women and their children are living and receiving services; and,*
- *Some services providers don't have the skills to provide certain services, such as needle exchange (ie. how to dispose of used needles). So training might be necessary. There will be resistance to change within Institutions and among service providers.*

There will be resistance to change within institutions and among service providers:

- *Service providers may be used to the abstinence approach and find it difficult to work from a risk reduction approach.*
- *The stigma of community assessments.*
- *The risk reduction approach recognizes that two different types of problems result from illegal drugs. One set of problems results from the negative effects of the drug on an individual's health, another from society's efforts to eliminate drugs. These two are often confused. Much of the risk that occurs is blamed on drugs themselves, while the negative consequences of efforts to eliminate them are not recognized. Risk reduction isn't solely about change in individual behavior, but about societal change. It challenges us to rethink how we see drugs and recognize that many of the risks associated with drug use are caused by prejudice and a "war on drugs" approach to drug policies.*

- *It might not align with the primary goals set by the organization. For example, at a women's shelter they did not tolerate drug use and did not provide needles. Their main goal was to get the shelter residents off drugs not preventing HIV. So it's also the challenge of mobilizing around the issue and how important it is to address.*
- *Some risk reduction approaches may be more accepted than others such as condom distribution and education but not accepting the choice to use drugs among clients.*
- *Might not meet mandate and resistance at funding level.*

Given that service providers work with their own communities, Vicarious Trauma can be an unintended consequence and must be considered:

- *When delivering a workshop, prepare to spend time working through the issues on a personal level. Aboriginal service providers, unlike mainstream service providers, experience a lot of vicarious trauma because they do not have the privilege of separating themselves from the issue when their lives have been personally touched in such a way.*
- *What is the general feeling in Aboriginal agencies around risk reduction? Is there a difference in how people feel about risk reduction depending on if they are male/female, older/younger, Aboriginal/non-Aboriginal, target group/service provider, etc? Aboriginal service providers often come from the target population. When we speak of the risks from substance use, many Aboriginal people have first-hand experience with the issue, it is not just a theoretical subject studied at school. This is the climate within which we are asking people to consider change.*

There is a lot of ground work that must be done before setting up a risk reduction strategy such as community mobilization around the issue of HIV:

- *Very ambitious goals set when they had to take a step backwards and consider community mobilization first.*
- *Identifying where a community is at in terms of community readiness can be stigmatizing.*
- *How aware are community members that they can receive services when they are high or under the influence? How would community members learn about risk reduction services at the agency?*
- *Communities at different stages. Some are still learning about HIV, AIDS and HCV before moving onto risk reduction. Risk Reduction Strategies must be tailored to the needs and context of the community to be successful:*
- *Risk reduction will look different in different environments. Consider that women's shelters are residential, and their children may be present, so it's hard to imagine handing out needles. It may not be appropriate).*
- *What's out there? Often all the space is being used in an agency and there is no room or space to start new risk reduc-*

tion services. There was a feeling that there is a need to protect those clients or community members who were abstinent, especially youth and women. New space would have to be secured in order to start up new and separate programming for those who are actively using. Do the agencies/communities already have the resources to address risk reduction? Or are there major resources missing? Delivering in a community centre versus outreach centre (example).

In every community there is work to be done. In every nation, there are wounds to heal. In every heart there is the power to do it.

- Marianne Williamson

Community Readiness must be assessed in a Culturally Appropriate Way:

- *Someone wrote to the tri ethnic centre that community readiness assessments would be more culturally appropriate if more qualitative – oral focus groups.*
- *Following community protocols to build trust and rapport is important. This was a success.*

Before moving forward with a risk reduction strategy it is important to ensure that the main concepts are clear to all involved:

- *The definition of Community was an issue. People who took the survey had to be constantly reminded that when we say “community” we’re talking about the agency as defined by the “sectors of community”, ie. board, staff, volunteers, Elders, etc.*
- *The definition of Risk Reduction was an issue (previously referred to as Harm Reduction). Even after the presentation, some key respondents were not on the same page on risk reduction. Some people constantly went back to needle exchange as being the full definition of risk reduction. In order to conduct the Community Readiness Survey (questions), it is very important that each key informant has a similar understanding of the definition of Risk Reduction before being asked about 6 dimensions of community readiness.*
- *Early in the process, when defining community with the main contact person at each agency sometimes the board member or “leader” is chosen to do the survey because they are viewed as “safe” in that they are already “in support” of risk reduction. This is not necessarily desirable.*

More time has to be dedicated to reaching at Risk Populations:

- *The hardest group to reach is the Aboriginal incarcerated population. Prison walls are a major barrier, more resources and time must be given to reaching this population.*
- *Engaging Youth has to be done whole heartedly, not just a token piece of the larger work. Youth are more on board to implement risk reduction than the workers who are entrenched in the abstinence approach.*
- *Risk reduction for two spirited men: behavior based rules rather than abstinence based, if you are intoxicated and can function, then fine. If you are aggressive and threatening, then no.*
- *Prisons: Must investigate and research the conditions within prisons before suggesting a way to implement things*

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