

Little Red River Cree Nation

SAFE COMMUNITIES
DEMONSTRATION PROJECT
Evaluation Report

Prepared for:

Alberta Center for Injury Control and Research (ACICR) &
Project Partners

Prepared by:



A.F.A. Management
& Consulting Ltd.

working towards a healthy injury-free future

***‘If we say there is no solution
then we don’t look for one.’***

*Elder: Alexander Nanooch
Garden River*

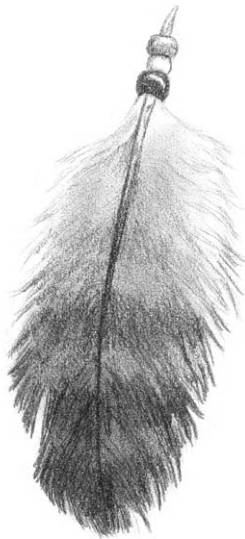


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EXECUTIVE SUMMARY


- ❖ The report was prepared for the Alberta Center for Injury Control & Research (ACICR) and project partners of Little Red River Cree Nation's (LRRCN) Safe Communities Demonstration project.
- ❖ The report, a formative evaluation of the demonstration project focuses on the context and processes involved with the implementation of the project. The approach used relied on three key methods:
 - ❖ a review of project files and documents;
 - ❖ observations during site visits; and
 - ❖ information gained through project discussions.
- ❖ The overall aim of the project was to contribute to the development of sustained community-based injury prevention programming to reduce the problem of injuries in LRRCN. Underlying all project assumptions and objectives is the principle of **CAPACITY BUILDING** focusing on the development of injury prevention, injury surveillance and community mobilization skills.
- ❖ Overall project timelines were met however timeframes consistently required a degree of flexibility. Key factors linked to the need to shift timelines and project activities were identified as being related to:
 - ❖ community access issues;
 - ❖ changing staff/staffing levels;
 - ❖ community events/crises;
 - ❖ skill building requirements;
 - ❖ computer related issues;
 - ❖ lack of project visibility;
 - ❖ staff reporting to multiple authorities; and
 - ❖ staffing shifts associated with the Injury Prevention Coordinator position.
- ❖ Strengths associated with the project were related to capacity building activities and outcomes evidenced by: LRRCN staff training other staff members; injury surveillance issues being addressed by project staff; the emergence of increased dialogue and interaction among the program areas; and the preparation of reports by community members.
- ❖ Aspects of the project that can be improved relate to data collection practices, capacity building, accountability and evaluation processes.
- ❖ Increased awareness about the problem of injuries among health service providers and leadership was expected as was increased capacity in areas of injury surveillance. Unexpected outcomes included the following:
 - ❖ expanded interest in injury surveillance by First Nations communities in British Columbia;
 - ❖ improved partnerships; and
 - ❖ inter-community networking.


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- ❖ A number of specific challenges did arise during the project period related to:
 - ❖ communication;
 - ❖ community access;
 - ❖ staffing levels;
 - ❖ supporting a community-paced approach; and
 - ❖ community readiness.

- ❖ In general project outcomes were met with exceptions being related to much lower levels of community readiness to engage in injury prevention activities than was originally assessed.

- ❖ A key outcome of the project was that communities were able to identify their top 3 injury priorities. The injury surveillance data illustrated that injury priorities by frequency of injury are identical, however, the causes and circumstances associated with these priorities varies significantly by community.

- ❖ ***Lessons learned from the project suggest that:***
 -  *investments in capacity building must be ongoing;*

 -  *a higher level of awareness raising activities should be developed and actively supported; and that*

 -  *Injury Prevention Coordinator positions at the community level should be highly encouraged and supported. They play a critical role in awareness raising, knowledge development and community mobilization efforts.*

- ❖ Future plans are being directed at expanding the injury prevention circle from a core project group to formalized injury prevention teams within each project community whose work will be to raise community awareness, knowledge and involvement in injury prevention.

1.0 INTRODUCTION

The following report was prepared for the Alberta Center for Injury Control & Research and project partners including Alberta Health & Wellness. The report centers on a formative evaluation which considers the CONTEXT and PROCESSES involved in implementing the Little Red River Cree Nation (LRRCN) Safe Communities Demonstration Project. As a result, this report reflects primarily on the STRENGTHS and CHALLENGES associated with the implementation of the project and considers several key questions.

- *Did the implementation of the project occur as planned?*
- *What aspects of the project are strong?*
- *Which aspects of the project are challenging?*
- *What can be improved?*
- *What expected and unexpected outcomes are evident to date?*
- *Did specific challenges arise?*
- *How were challenges managed?*
- *How are lessons learned being applied to future planning?*

The report begins with information about LRRCN's communities and background information about the planning processes undertaken prior to the launch of the demonstration project. The background information is followed by an overview of the demonstration project as outlined by a Project Logic Model. Subsequently a discussion of evaluation questions, project assessments and outcomes are provided. Background information contained in this report is intended to provide project partners with both contextual and historical reference points for the project. It is also intended to support reflection on the challenges, benefits, and realities of working with communities.

2.0 APPROACH TO EVALUATION

The approach used to evaluate the project relied on three key methods, a review of project files and documents, observations conducted during visits to the project communities, and information gathered through individual and group discussions.

- **A review of project files and documents:** was used to provide impressions of how elements of the project were conducted and handled. Specific emphasis was placed on reviewing information related to project timelines, implementation related issues, and progress notes.

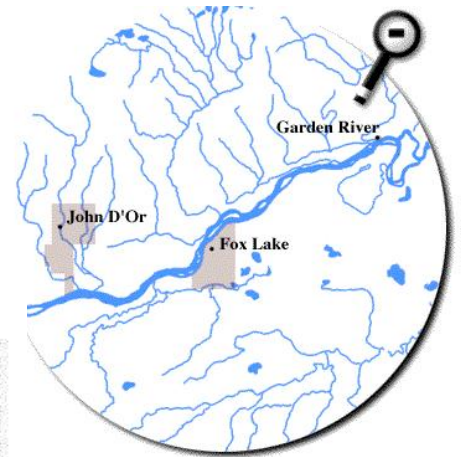
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- **Field observations:** were utilized to gather information about how the project was actually operating within each of the three project communities.
- **Individual and group discussions:** were held with LRRCN staff actively involved in project activities in order: to monitor and assess project implementation issues; to reflect on project challenges; and to reflect on emerging lessons learned.

3.0 BACKGROUND

3.1 Location and access to LRRCN communities

LRRCN is comprised of three communities, these being Fox Lake (Reserve # 162), John D’Or Prairie (Reserve # 215) and Garden River (Indian Settlement). Fox Lake is the largest of the three communities with a population of approximately 1775 residents. The community is situated on the south side of Peace River, 180 km east of High Level. John D’Or Prairie commonly referred to as John D’Or is located about 125 km east of High Level and houses the administrative center of the Nation.



Its population is approximately 1060 residents. Of the three communities, Garden River is the smallest community with a population of approximately 500 residents. It is situated 200 kms east of High Level in Wood Buffalo National

Park. Access to all three northern communities is influenced by their natural location, available means of travel and seasonal weather conditions.

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Of LRRCN's three communities, John D'Or is the most accessible by road due to its closeness to Highway 58 and its general proximity to the cities of High Level and Fort Vermillion.

Road access to the communities of Fox Lake and Garden River are more severely restricted due to being located a greater distance from major centers as well as geographic characteristics associated with their location.

For example, road access to Fox Lake involves a river

crossing as the community is situated on the south side of the Peace River. Travel prior to winter conditions setting in, requires crossing of the river by use of a barge which can only transport one vehicle per river crossing or alternatively crossing the river by boat. During the winter months, road

***Boat travel prior to winter conditions
October 2002***



***Ice bridge leading to Fox Lake
December 2004***



travel relies on the establishment of an ice bridge for river crossings.

Road access to the community of Garden River is also impacted by its natural location.

Access to the community involves travel on a stretch of dirt road leading into the community which is

particularly impacted by boggy terrain and muskeg.

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This means that as seasonal transitions occur during late fall and early spring, road access to Fox Lake and Garden River shuts down for a period of time.

In general seasonal weather conditions impact access to all three communities. For instance, dry weather can improve road conditions making graded dirt roads more passable while wet and rainy conditions can create extremely muddy and boggy conditions. Any number of harsh weather conditions associated with rain, snow, cold, or fog impact safe access and travel by road.



These same extreme weather conditions also limit community access by air travel. Small

aircrafts operate under Visual Flight Rules (VFR) and are subject to conditions of operation based on weather and visibility. Flights are also subject to cancellation due to poor runway conditions within the communities also resulting from bad weather conditions.

3.2 PRE-Demonstration project phases and timelines

August of 1997: LRRCN initiated a process for the transfer of responsibility for health services from the federal government to the Nation. A significant step in this process involved conducting a health needs assessment of the communities. The assessment was prepared by KPMG Consulting under contract to LRRCN. The report produced entitled *Little Red River Cree Nation: Preparing for a Healthier Nation (March, 1998)* involved: looking at the health needs of the population; describing the Nation's vision for a healthier future; establishing priorities; and developing a health plan with an operational component leading to the transfer of health services.

Within the context of this health needs assessment the most frequent cause of death during (1983-1995) was identified as being INJURIES associated with motor vehicle collisions and homicides, followed by injury deaths associated with fire and drowning. Following injuries, diseases involving

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the cardiovascular and respiratory systems were the next leading causes of death. Injury related deaths were associated with the younger aged community members, while disease related causes of deaths were associated with those aged 35 years and older. The identification of INJURIES as a priority health issue affecting the Nation, led to LRRCN initiating discussions with the Alberta Centre for Injury Control and Research (ACICR) which initially took place in **March of 1999**. Several subsequent discussions took place during the course of 1999 and early 2000.

Early 2000: Discussions undertaken at this time focused on identifying potential strategies for enhancing safety and community wellness. As a basis for project planning it was agreed that a literature review examining causal factors associated with injuries and their inter relationship among Aboriginal communities would be useful. The review had two components, one being an examination of the literature and the other being interviews conducted with LRRCN health service providers. The final report entitled ***Injury in Aboriginal Communities: A Subject Review (July 2000)*** recommended the establishment of injury surveillance (IS) as a next step to establishing injury prevention programming.

April of 2001: A planning partnership was struck involving the Alberta Centre for Injury Control and Research (ACICR), a designated Support Centre for the International Safe Communities Network of the World Health Organization (WHO), the political leadership of LRRCN, and members of LRRCN's Health portfolio. Concurrently, planning activities were undertaken by LRRCN to hire an Injury Prevention (IP) Coordinator and to initiate the development of an action plan on the problem of injuries. Plans for the ***LRRCN Safe Communities Demonstration Project (May, 2001)*** were initiated as a key step to long term injury prevention programming. A funding proposal was submitted to the Aboriginal Health Strategy Fund in **September of 2001** and subsequently approved in **December**.

It should be noted that the basis of the LRRCN's vision of safe communities is guided by principles of practice associated the World Health Organization's (WHO) Collaborating Centre on Community Safety Promotion. The long term vision of LRRCN is admission to the International Safe Community Network. The manifesto for safe communities states that ***'All human beings have an equal right to health and safety.'*** This principle has led to community action around the world leading to the development of safer communities.

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As **APPENDIX 1-PRE-Project Timeframe** (p.29) illustrates the partnership dialogue and activities leading to the establishment and funding of the Safe Communities Demonstration Project evolved over a period of time and can be described as having three phases.

- **Exploratory Dialogue & Consultation Phase:** This first phase represents the timeframe between LRRCN's initial consultation with the ACICR and the establishment of a Memorandum of Understanding (MOU) to engage in a subject review. This period of time represents *13 months* of telephone contacts and informal meetings.
- **MOU-Literature Review & Needs Assessment Phase:** The second phase, a *12 month* period, was marked by the discussion, planning, negotiating and undertaking of an injury specific literature review and needs assessment.
- **Project Proposal Phase:** The third and final period of *9 months* focused on activities associated with the successful submission of a funding proposal. Six of the nine months were dedicated to the actual development of the proposal while the remaining three months represent the elapsed time pending notification of the status of the submission.

In summary, *13 months* of informal and ongoing dialogue passed before formalized partnership activities were undertaken. A combination of factors was identified as delaying progress towards formalized project planning these being:

- scheduling challenges among potential partners;
- administrative changes occurring at the Alberta Center for Injury Control and Research; and
- technical communication issues within the communities associated with unreliable phone, fax and intermittent availability of satellite e-mail communication.

Once formalized activities were initiated a *21 month* period of planning discussions and activities took place prior to achieving project funding. Within this time period eight of the twenty-one months were dedicated to sharing the results of the subject review in various meetings while another six months was needed to prepare the actual funding submission.

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The initial consultation by LRRCN with ACICR occurred in March of 1999 with the successful submission of a funding proposal being achieved in December of 2001. This pre-funding period represents a total of **34 months**.

4.0 DEMONSTRATION PROJECT OVERVIEW

4.1 Aims and objectives

The aim of the project is to contribute to the development of sustained community-based injury prevention programming to reduce the problem of injuries in LRRCN. Sustained programming efforts will support LRRCN's long term goal to achieve designation as a Safe Community within the WHO International Safe Communities Network. The key objectives of the project are to: 1) to build capacity in the three communities of LRRCN to take on the challenge of intentional and unintentional injuries; 2) to demonstrate an effective process for Aboriginal community mobilization in injury prevention and control; and 3) to pilot test a 'community development' model that may be replicated in other Aboriginal communities in Alberta and beyond.

4.2 Project Logic Model

The ***Project-Logic Model*** illustrated in ***Figure 1*** (p. 13) outlines the basic assumptions underlying the project, as well as key factors likely to affect the implementation of the project which are categorized as key INFLUENCES and RESOURCES. Key project activities and outcomes also outlined in the model are detailed later in the report's discussion of challenges.

Underlying all project assumptions is the fundamental principle of CAPACITY BUILDING. It is assumed that investments in the community in terms of skill building in the areas of injury prevention, injury surveillance and community mobilization will result in increased awareness and capacity to act on the problem of injury at the individual, family, community, and Nation levels.

Aspects likely to INFLUENCE the project as strengths were considered to be the recognition of injuries as a major health concern by LRRCN's leadership, along with the long term vision of working towards creating safer communities, and the presence of a committed Injury Prevention Coordinator. Challenges were considered to be community-

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based staff with limited injury prevention training, and community services predominately focused on treatment and emergency services rather than prevention.

Significant RESOURCES associated with the project were considered to be access to injury prevention knowledge and pre-existing working relations between the Health Director of LRRCN and the ACICR. Given the northern location of the project communities mutual access between the communities and external resources was identified as a challenge.

4.3 Project timelines and planned activities

YEAR 1 (January -December 2002): Planned activities associated with the first year of the project included: the delivery of an injury prevention workshop to the communities of LRRCN to create awareness about the problem of injuries at the community level; the promotion of injury prevention activities at the community level; and the delivery of injury surveillance training in preparation for initiating data collection.

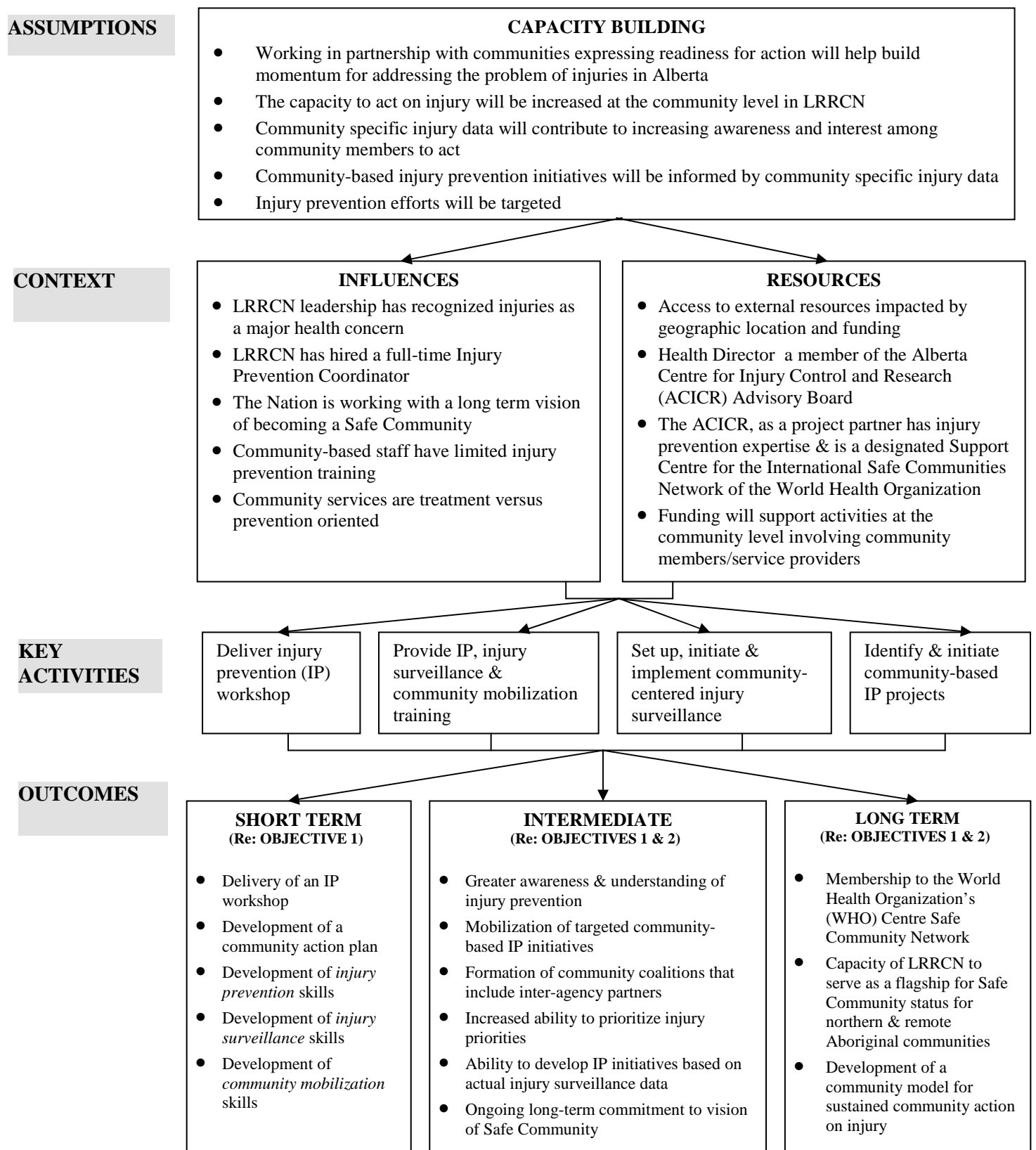
YEAR 2 (January -December 2003): Planned activities associated with the second year of the project focused on: supporting data collection and analysis; the preparation of an initial injury data report (12 month period); and identifying injury priorities emerging from community-based injury data; and supporting community level injury prevention activities.

YEAR 3 (January -December 2004): Planned activities associated with the final year of the project were: to support ongoing surveillance activities; to assist with the preparation of a second data report; to support ongoing injury prevention activities and to prepare a final project report.

In each of the three project years injury prevention activities were to take on the form of a specific community-based injury prevention project. From a long term perspective plans for **Years 4 (2005-2006) & 5 (2006-2007)** are to continue with surveillance activities; implement targeted community initiatives informed by community-based injury data; to continue to monitor efforts; and to disseminate learnings about a community model for sustained community action.

Figure 1:

LRRCN Safe Communities Demonstration Project-Logic Model



5.0 EVALUATION QUESTIONS AND OUTCOMES

5.1 Did the implementation of the program occur as planned?

APPENDIX 2-Project Implementation Timeframe (p.30) outlines the key objectives as related to each project year. The Gantt chart outlines timelines illustrating activities as they were originally scheduled or planned and compares them visually to timelines as they actually unfolded within the project period. Although overall implementation objectives were met, timeframes consistently required a degree of flexibility.

2002: The first key activity involved the delivery of an injury prevention workshop to the project communities. This was held as scheduled in January of 2002. Shortly thereafter all project activities were suspended for a period of six months. This delay was associated with significant LRRCN staffing changes. In January the Health Director resigned and the Injury Prevention Coordinator position was left vacant as the staff person was reassigned to another portfolio. In addition, the staff member delegated to act as the Data Collection Coordinator for the 3 communities was identified as being on leave. As a result the official community launch of the project, staff training and data collection were postponed until such time as the positions were recruited. Subsequent to the positions being filled a period of time was required for the Health Director: to become familiar with their responsibilities; to reaffirm commitment to the project with community leadership; and to begin coordinating project staff.

2003: The key activities in this project period related to training, data entering and monitoring of the data collection processes in each community. Although the planned timeline and actual timeframes appear to be on track, it should be noted that the activities were undertaken at different times with each of the 3 communities. Attempts were made to mirror timelines and activities in the communities, however, each community moved at its own pace based on individual circumstances. The generation of the first data report was delayed by one month. Given the delay with launching the project and starting up data collection the report reflected 3 months of injury data rather than 12 months.

2004: In last year of the project as in the second a significant focus involved maintaining injury surveillance activities. Once again timelines were community-paced. Another significant activity slated for January was the generation of a second report. This timeline,

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however, was cascaded into February 2005 to allow for an analysis of the maximum number of injury cases.

2005: Site visits were conducted in January and February of 2005 in line with supporting ongoing data analysis training and report generation. Strategic planning sessions planned for January were delayed by one month and occurred in late February.

Generally, implementation objectives and timelines were met; however, several key factors were clearly linked to overall project delays. The need to shift timelines and project activities are listed and discussed below.

Access: By virtue of their geography travel to the northern based project communities was impacted by weather. Poor weather conditions and seasonal transitions resulted in a number of travel plan cancellations.

Changing Staff / Staffing Levels: As previously noted the launch of the project was delayed due to the resignation of the Health Director and the reassignment of the Injury Prevention Coordinator. In addition to these vacancies, changes were also taking place at the Chief and Council level and among front line health staff. The change of personnel at the leadership level was a key issue that impacted the launch of the project while staff changes involving health personnel impacted timelines during the course of the project. The latter usually resulted in project activities being unattended for a period of time. In turn, this required new personnel to attend to a back log of work, however, before any back log of activities could be addressed additional orientations and training sessions were required. The three year project period has involved three Health Directors. The first Health Director departed in March of 2002 and the second departed in October 2004. The third Health Director came on board in January 2005.

Community Events / Crises: Events such as holidays, elections and crises situations usually involving the death of a community member played a significant role in managing timelines. The death of an Elder would result in the general shut down of community events and a scale back of services for a period of traditional mourning. There were a number of injury related deaths during the project period which would impact staff in various ways by

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virtue of their role and relationship to the deceased. First and foremost staff members could be related to the deceased and therefore personally impacted. Further, staff often was involved in the administrative handling of the death, providing support to others, or assuming an additional workload due to the absence of staff impacted at a family level.

Skill Building: The need for skill building was identified as a significant factor affecting timelines and resources. Considerable investments of time are needed when skill levels vary among staff members to ensure and promote skill development in the areas of injury prevention, computer use, and injury surveillance.

Treatment Orientation: The treatment orientation of health services in the community appears to influence the attitudes and beliefs of the community and health service providers. Numerous discussions with health staff suggest that the notion of injuries being preventable is relatively unfamiliar. Knowledge about injuries is focused on their treatment rather than their preventability. Given this point of reference, time and attention was placed on increasing awareness and sharing knowledge about how injuries could be prevented.

Computer Related Issues: Unanticipated issues were encountered related to the use of computers. This resulted in a significant amount of time being dedicated to problem solving, a key issue related to gaining access and use of the computers. Computers used by the project communities are networked and therefore set up with security protocols which prevent unauthorized usage and system modifications. Permission to use the computers for data entry purposes and the addition of software were required. As a result the start up of electronic data entry was delayed.

Lack of Project Visibility: Injury surveillance activities involved a small core group of health staff members actively engaged in data collection, data entry and analyses activities. Discussion of these activities tended to be limited to other health and social services staff. Until such time as a sufficient number of injury cases were documented, analyzed and reported, it was difficult to engage others in discussions about the project. Once information was available in visual form through reports and PowerPoint presentations discussions were facilitated and served to expand interest and project visibility.

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Multiple Authorities: The data collection process was developed in consultation with LRRCN health staff. The process was considered relatively clear and straightforward with modifications emerging as needed. As the data collection process unfolded it was noted that the quality and level of data captured varied significantly based on personnel assignments. Discussions with project personnel including the nurses revealed that they are employed by different authorities. Some are employees of the Band Council while others are employees of the First Nations and Inuit Health Branch of Health Canada. Entered into this mix are nurses that come to the community as relief nurses who would largely be unaware of the need to capture information on injury cases. In addition there was no formalized agreement for staff regardless of their hiring authority to carry out data collection and as a result would lose priority whenever work loads increased. Consequently data collection relied on voluntary practices influenced significantly by workload and staffing configurations. Tensions were experienced when expectations varied among team members. Data collection practices were negotiated over time and discussions have been initiated to ensure that data collection on injuries will become standard practice. The data collection process brought to light that project members were being asked to work as a team and to work through jurisdictional issues.

Dedicated Injury Prevention Coordinator: The role of the IP Coordinator is central to project coordination, promotion and community mobilization. The presence, availability and assistance of the coordinator consistently facilitated meeting project timelines and enhanced project implementation outcomes.

5.2 What aspects of the project are strong?

Key strengths associated with the project related to *capacity building* activities.

Investments made in developing skill sets among staff were evidenced by:

- LRRCN staff training other staff members;
- injury surveillance issues being addressed by project staff;
- the emergence of increased dialogue and interaction among the program areas; and
- the preparation of reports by community members.

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Despite staff changes involving key positions, LRRCN remains committed to moving injury prevention forward.

5.3 Which aspects of the project are challenging?

The project envisioned increased awareness about the injury problem at the grass roots level. It also envisioned specific injury prevention projects being developed each year in each of the project communities. Reflections by project members suggest that this was ambitious for the project period given the level of capacity building required to undertake the project. Aspects of the project that were considered weak centered on low project visibility and altering levels of dedicated injury prevention staffing.

Project Visibility: Injury surveillance related activities had low levels of visibility.

Communication tools only emerged as injury data became available through the generation of community specific reports. Grass roots awareness and involvement is low and needs to grow beyond the core project group.

Injury Prevention Staffing: Although the communities currently have an Injury Prevention Coordinator position the responsibilities of that position are not fully dedicated to injury prevention. As long as multiple program responsibilities are being carried out under the umbrella of one position it will remain difficult to bring focused attention to injury prevention.

Ongoing support will be critical to continuing the community mobilization process. Specifically a *dedicated injury prevention coordinator* position would be needed to continue to support awareness raising and to support community-based activities originating from injury prevention planning which developed and emerged at the end of the project period.

5.4 What can be improved?

Aspects of the project that can be improved relate to data collection practices, capacity building, accountability and evaluation processes.

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Data Collection Practices: Volunteer data collection practices have demonstrated the potential to compromise the consistency, quality and comprehensiveness of data being collected. The establishment of standardized and required data collection among Band and First Nations and Inuit Health Branch nurses would contribute to improving the overall quality of injury data being collected.

Capacity Building: By and large the coordination of project activities improved in relation to the development of various skill sets. Given that regular site visits were significant in supporting staff development, improving the consistency and regularity of visits could further improve capacity building efforts.

Accountability: The ability to track and report on community-based work, such as awareness raising activities was difficult to carry out within an environment of changing staff and staff levels. Accountability could be improved through dedicated staffing.

Evaluation Processes: As the Safe Community Demonstration Project moves into its next phase, evaluation parameters will need to evolve. Structured outcome measures and processes consistent with the maturation of the project will require development. The development of evaluation indicators among project partners will help to advance evaluation processes.

5.5 What expected and unexpected outcomes are evident to date?

Increased awareness about the problem of injuries among health service providers and leadership was expected as was increased capacity in areas of injury surveillance.

Unexpected outcomes included the following.

Expanded Interest in Injury Surveillance: Information about the project was shared by the ACICR and interest was generated in the province of British Columbia. Staff from the First Nations and Inuit Health Branch of British Columbia visited LRRCN and has proceeded to partner with 13 First Nations communities to engage in community-centered injury surveillance.

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Improved Partnerships: The project has provided a platform for partnerships to grow. The First Nations and Inuit Health Branch (FNIHB) has shown interest and support to standardize data collection among staff. Two meetings have been held to date to move towards formalizing the process, while fire services available to LRRCN are now partnering to increase safety promotion activities within the communities.

Inter-community Networking: The communities of Fox Lake, John D'Or and Garden River are networking regarding their respective injury issues examining both their similarities and differences. In addition, as skill sets have grown (general computer skills & injury surveillance) staff is commuting among communities to share their knowledge.

5.6 Did specific challenges arise?

A number of specific challenges did arise during the project period related to communication, community access, staffing levels, supporting a community-paced approach, and community readiness.

Communication: Communication among project staff and the communities was considered challenging at a number of levels. For example, the communities rely on a satellite server system for e-mail communication. It is often assumed by external partners that the system is reliable and functions as would a system housed in a major centre. In reality it can take 30 minutes or more to send an e-mail message. This deters community-based staff from using the system regularly as it can be time consuming.

Staffing Levels: Another issue relates to staff within the community often assuming multiple job roles and responsibilities. In the event of a community crisis the ability to reach staff becomes limited as they often have to defer various commitments to assume more urgent responsibilities.

Community Pace: Although timelines among the 3 communities was identical, each community had its own pace based on individual circumstances and events. The community of Garden River was particularly challenged over the course of the project for a number of reasons. In particular the construction of a new Nursing Station offered a unique set of challenges for staff. Staff was pre-occupied with maintaining health services during the

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construction phase and subsequent moves between old and new facilities. The additional responsibilities of the project were challenging for staff to assume. Critical events unfolded during the project period such that at several points Garden River was at risk for opting out of the project. Both data collection and entry was delayed due to construction. Once data collection was initiated and underway it was terminated prematurely due to a miscommunication among staff. Staff was then required to make a decision as to whether they were prepared to invest in retrospectively identifying injury cases and collecting data. Adding to these challenges, travel to Garden River was restricted by weather conditions which delayed computer installations from the old building to the new, which in turn created a domino effect delaying training, data entry and report generation.

Community Readiness: During the project planning phase it was determined that each community would identify and initiate an injury prevention initiative in each year of the project. As the project unfolded, however, it was the assessment of the project team that that awareness levels within the communities was low and that a culture of safety was limited.

5.7 How were challenges managed?

Flexibility had to underlie all project activities requiring ACICR to learn flexibility from a community perspective. Challenges were handled by exploring alternative communication strategies when site visits were rescheduled or postponed. Phone contacts were increased, and teleconferencing was conducted as required. Scheduling flexibility was increased among the 3 communities and ACICR when weather prohibited travel to one community or another or when staffing levels in the community were critical. Any community missed during a site visit was given priority during the subsequent site visit. This supported an equitable system of capacity building which enabled communities to catch up on any delayed activities. At the end of the project period, Garden River which had come close to withdrawing from the project was helping the remaining 2 communities with project work. These strategies were found to be supportive of improving communication practices and working around staffing related issues. This in turn supported the individual pace of the project communities.

With regards to community readiness, a strategic decision was required to support the needs of the community. It was identified that community residents were limited in their safety practices not only due to low levels of awareness about the preventability of injury but also

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due to the limited availability of safety equipment. As a result a strategy was developed to support a two pronged approach to enhance community readiness for injury prevention activities. Rather than focusing on individual projects, support was provided for a ***Safety Equipment Access Program*** that provided for the purchase of helmets, child safety seats and personal floatation devices. Facilitating access to needed equipment would be used to raise awareness and promote a culture of safety. At the same time resources would be directed to supporting the activities of the Injury Prevention Coordinator to promote activities in the communities such as developing injury prevention messaging in Cree for radio broadcast and promoting injury prevention at a community gathering.

6.0 PROJECT OUTCOMES IN SUMMARY

Project objectives are summarized below and rated qualitatively using the following rating scale.

The scale is applied only to short and intermediate outcomes.

(+2)	much more than expected
(+1)	more than expected
(0)	expected
(-1)	less than expected
(-2)	much less than expected
P	premature

<i>Table 1: Short Term Outcomes</i>		
Outcome	Rating	Progress
Deliver an injury prevention workshop	(+1)	The injury prevention workshop was delivered as scheduled and involved all three communities. As an outcome of the workshop, participants indicated that this was the first real opportunity that they had to function as a team and requested future learning opportunities.
Development of a community action plan	(-2)	An expected outcome of the workshop was to develop community action plans. Although concerns were raised about specific injury issues and a desire to act on them, the community infrastructure was not present to support further action. The vacancy of key positions in the community shortly after the workshop was delivered resulted in an abrupt loss of continuity and project momentum.
Development of injury prevention skills	(0)	An expected level of injury prevention skills appears to have resulted from project activities. A higher level of success would likely have been achieved if more individuals had been trained.
Development of injury surveillance skills	(+2)	A significant number of computer and training related challenges occurred during the project period. Despite these challenges, skill sets have been developed to the point that staff members are demonstrating independent problem solving skills and the ability to train each other.

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Table 1: Short Term Outcomes		
Development of community mobilization skills	(-2)	The level of awareness and community readiness to mobilize on the problem of injuries was improperly assessed prior to the onset of the project. Community readiness was found to be much lower than was originally assessed. Efforts, therefore, were concentrated on increasing awareness and engaging community members to consider safety issues in the context of their families and communities. Community mobilization efforts were undertaken by incorporating or adding injury prevention activities to existing community efforts. This was seen as a necessary building block to focused programming efforts.

Table 2: Intermediate Outcomes		
Outcome	Rating	Progress
Greater awareness & understanding of injury prevention	(0)	The initial goal was to increase awareness and understanding at large within the community. It became clear early on that the mindset of health service providers as well as community members was predominantly treatment rather than prevention oriented. Given that this mindset impacted service providers, efforts were made to promote greater understanding about the preventability of injuries. Efforts were concentrated at this level so as to create a pool of advocates that could then work more effectively with community members.
Mobilization of targeted community-based injury prevention initiatives	(-1)	As previously noted community readiness to proceed with targeted and focused programming was premature.
Formation of community coalitions that include inter-agency partners	(0)	Given the low level of community readiness at the onset of the project it was determined that the formation of the coalitions would likely occur in the next phase of the project. Plans have emerged and are being developed to establish community-based injury teams involving inter-agency partners.
Increased ability to prioritize injury priorities	(0)	Evidence of this emerging ability was present at strategic planning sessions held at the end of the project period. Communities were reflecting on their community-specific injury data and engaging in discussions about injury priorities and action planning.
Ability to develop IP initiatives based on actual injury surveillance data	(+1)	During strategic planning sessions held at the end of the planning period, specific strategies were being articulated for actioning.
Ongoing long term commitment to vision of Safe Community	(+2)	Given the number of staffing changes which occurred during the project period and changes at Chief and Council level, the level of long term commitment was expected to change. Following strategic planning sessions and a community celebration, Chief and Council reaffirmed their commitment and interest in moving into the next phase of the project, committing to a Letter of Support.

Table 3: Long Term Outcomes		
Outcome	Rating	Progress
Membership to the WHO Safe Community Network	P	The LRRCN has moved forward in terms of meeting the criteria necessary to achieving membership status by establishing injury surveillance and demonstrating long term commitment.
Capacity of LRRCN to serve as a flagship for Safe Community status for northern & remote Aboriginal communities	P	Although it is too premature to assess this outcome, the Safe Community Demonstration Project has generated interest in First Nations communities in British Columbia. These communities are taking on injury surveillance activities as the direct result of the success demonstrated to date by LRRCN.
Development of a community model for sustained community action on injury	P	Lessons learned are emerging and have thus far provided ground elements for a community model for sustained community action.

7.0 A REFLECTION ON THEN AND NOW

Based on available health data, the KPMG produced in 1998, identified injuries as the number one cause of death for the communities of LRRCN. Focus group discussions held with community members on a range of health and social issues also rated injuries as being a high priority among community residents. A component of the focus groups was to identify potential strategies to address injuries as a priority area. The strategies generated were broad in scope and included a range of community action such as:

- holding workshops;
- establishing safety-related policies/bylaws such as speed limits, helmet use, stop signs;
- sponsoring alcohol free social events;
- holding more workshops on substance abuse for community members and school students;
- providing swimming pool lessons and water safety courses;
- providing lifeguards at pilgrimages; and
- conducting more research around participants and circumstances surrounding traffic related injuries.

Experience during the Safe Community project period demonstrated that community readiness and capacity to act on these strategies was low.

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Now as an outcome of the project community members are becoming engaged in examining their specific injury problems. Injury Prevention teams are under development in each of the communities and strategies needed to reduce specific injury problems are being examined.

Now the communities have been able to identify their top 3 injury priorities. The data has illustrated that injury priorities by frequency of injury are identical, however, the causes and circumstances associated with these priorities varies significantly. In addition, community specific data was able to substantiate that alcohol is a frequent factor associated with injuries. Observations reported by LRRCN service providers gained through the subject review were confirmed. Injury data was also able to demonstrate that unlike several published studies associated with geographic risk factors, LRRCN residents were not at significantly higher risk for motor vehicle related injuries due to road conditions alone. The majority of motor related injuries occurred on or in close proximity to the communities and was associated with alcohol use, speed, non-seat belt use, and under age driving. A snapshot is provided to illustrate the respective injury profiles.

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Table 4: LRRCN Community Specific Injury Profile			
COMMUNITIES	Garden River	John D'Or	Fox Lake
Number of injury cases & data collection period	208 injury cases in total 8 cases/month Sept 2002-Oct 2004 (26 months data)	235 injury cases in total 8 cases /month Sept 2002-Dec 2004 (28 months data)	499cases in total 17 cases/month Sept 2002-Jan 2005 (29 months data)
Injury priorities	#1 (103/ 49.5%) Person/Object #2 (50/ 24.0%) Falls #3 (30/ 14.4%) Vehicle Related <i>Equals ~ 87.9% of all injuries</i>	#1 (99/ 42.1%) Person/Object #2 (66/ 28.1%) Falls #3 (28/ 11.9%) Vehicle Related <i>Equals ~ 82.1% of all injuries</i>	#1 (210/ 42.0%) Person/Object #2 (147/ 29.5%) Falls #3 (66/ 13.3%) Vehicle Related <i>Equals ~ 84.3% of all injuries</i>
Person or Object related injuries	Majority were unintentional Most impacted those 10 yrs of age or younger Involved unsupervised children rough housing or wrestling	Majority were unintentional Most impacted those 30 yrs or younger Involved sports, 6+ incidents involving BB guns, those involving assault usually involved alcohol & house parties	Intentional injuries in this category were 2.5 times greater than unintentional injuries. Most impacted those aged (20-30) and (30-40) The majority of intentional injuries involved alcohol, assaults, and spousal abuse
Fall related injuries	Majority were unintentional Most impacted those 10 yrs of age or younger Were associated with (natural terrain & icy wet surfaces) or falls occurring in the home.	Majority were unintentional Most impacted those aged: under 10 and 10-20 years of age Falls involving children under ten-(natural terrain & icy wet surfaces) or falls occurring in the home. Numerous injuries involved falling on STEPS or STAIRS Falls involving (10-20) year olds were sports & playground related.	Majority were unintentional Most impacted those aged 30 or younger affecting those 10 and under the most. (10-20) year olds-playground Those falls involving (20-30) year olds were most often associated with falling while intoxicated.
Motor vehicle related (MVR)	Majority were unintentional Most impacted were (10-20) & (20-30) year olds and involved trucks/vans Although the 3rd most freq cause, MVR injuries resulted in the most serious injuries! (head injuries, crushing injuries to the chest, DEATH) Underage children are driving vehicles. (alcohol, losing control, non-use of seat belts)	Majority were unintentional Most impacted those aged 30 years or younger and involved ATVs & snowmobiles. Most quad injuries involved alcohol and multiple people riding on the same machine. Only 2-3 incidents involved poor road conditions	Majority were unintentional Most impacted those aged 30 years or younger and involved ATVs & snowmobiles. A majority of cases involved alcohol, speed resulting in the loss of control, rollovers and collisions with other objects.

8.0 LESSONS LEARNED AND RECOMMENDATIONS

The project was a reminder that changes at the community level require concentrated effort over an extended period of time. Change must also be ACTIVELY supported through strategic activities. Specific lessons learned through the project include the following.

- **Capacity building:** is key to providing a foundation for sustained community action. Investments in developing skill sets may be time and resource intensive, however over time benefits will become visible.
- **Community mobilization:** requires a specific set of skills that are an important component of prevention planning. Efforts to build these skills within communities are required. This requires both training and mentoring not readily visible to outside agencies.
- **Dedicated staffing:** is an ongoing challenge faced by the project communities. As long as staff positions are structured to assume multiple responsibilities, placing a focus on any particular priority will remain a challenge.
- **A treatment & crisis management orientation:** is a barrier to undertaking prevention activities. Paradigm shifts are required to encourage the development of preventive mindsets. In addition prevention skills represent a new skill set for many health care providers.

Given these lessons learned the following recommendations are offered.



Investments in capacity building must be ongoing.



A higher level of awareness raising activities should be developed and actively supported.

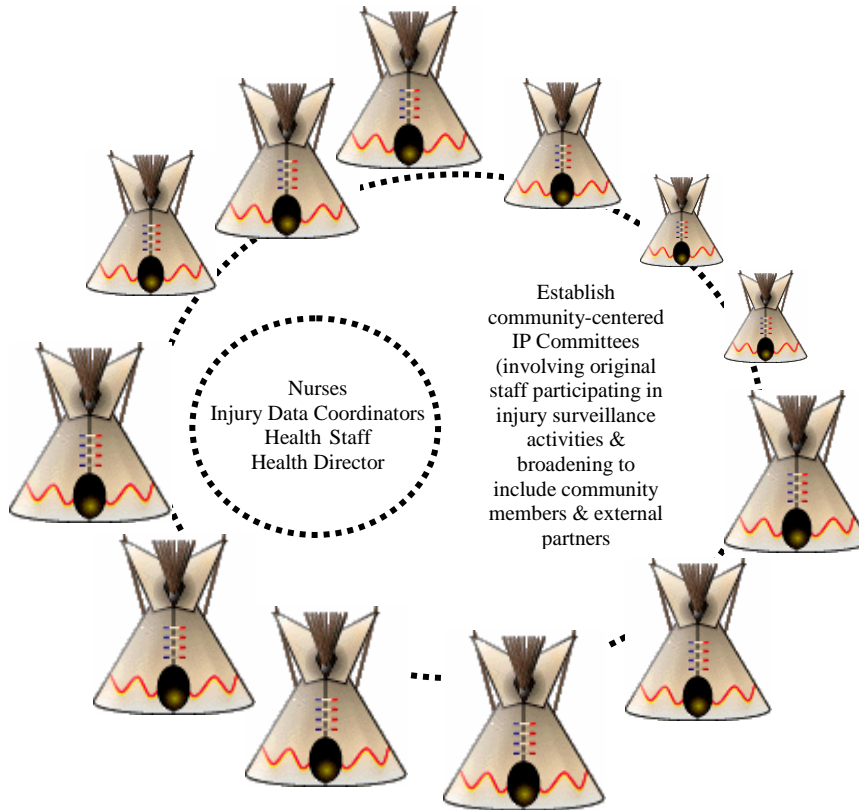


Injury Prevention Coordinator positions at the community level should be encouraged and supported. They play a critical role in awareness raising, knowledge development and community mobilization efforts.

9.0 FUTURE PLANS

Injury prevention program planning has been initiated. Planning is being directed by emerging

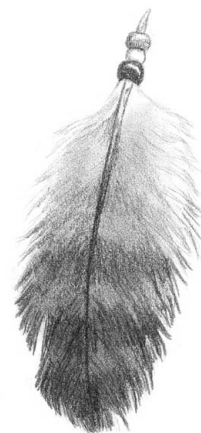
Figure 2:
Expanding the Injury Prevention Circle



priorities as identified by community specific injury data. Specific attention is being placed on expanding the Circle of project personnel, as illustrated in **Figure 2**, by establishing Community-centered IP committees whose work it will be to raise community awareness and involvement in injury prevention.

***'Injury prevention is not for a day
or a week but for a lifetime.'***

*Elder: Celestan Nanooch
John D'Or*



LEGEND FOR APPENDICES

● = discrete events
 ▲ = significant event
 C = cancelled/rescheduled site visit
 ●—● = planned time period
 P = planned time of project activity
 ☺ = project celebration
 ●- - -● = actual time period
 A = actual time project activity carried out

Project Years	1999												2001												2002											
Pre-project Timelines	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		
1999 Explorative dialogue / Consultations	●		●				●					●	●																							
2000 Literature Review & Needs Assessment																																				
Memorandum of Understanding (MOU) To conduct literature Review & assessment (i.e. subject review)														▲ MOU																						
Subject Review Conducted															●—●																					
Informal & formal Presentations discussions Re (subject review) Results																●—●																				
2001 Safe Communities Demonstration Project Proposal																																				
Planning discussions & Proposal development																										●—●										
Funding submission to approval																																	●—●			
Phases	Exploratory Dialogue & Consultations 13 months												MOU-Literature Review & Needs Assessment (Subject Review) 12 months												Project Proposal (Preparation-Submission-Funding) 9 months											

<i>Project Years</i>	2002												2003												2004												2005		
<i>Key activities by project year</i>	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2002 SITE VISITS			A			P			P	▲		P																											
Deliver injury prevention (IP) workshop	P	A																																					
Create community action plan		●																																					
Identify & initiate 1 st IP initiative		● objective modified																																					
Train staff in each community to implement injury surveillance system (ISS)	P	—						● A	—	—		●																											
Set up & initiate (ISS) in each community																																							
2003 SITE VISITS													●	●	●	●	●	●	●	●	●	●	●	●															
Maintain & support (ISS) activities																																							
Generate 1 st injury data report	P												A																										
Identify & initiate 2 nd IP initiative													● objective modified																										
2004 SITE VISITS																																							
Maintain & support (ISS) activities																																							
Generate 2 nd injury data report	P																																						
Identify & initiate 3 rd IP initiative																																							
Extend community driven IP initiatives																																							
2004 SITE VISITS																																					P	P	☺
Facilitate strategic planning sessions																																					P	A	