Around the Kitchen Table
Programming Connection
Case Study

**Organization:** Chee Mamuk Aboriginal Program, BC Centre for Disease Control  
**Region:** British Columbia  
**Prepared:** 2010

### Quick Facts

<table>
<thead>
<tr>
<th>Goal (immediate)</th>
<th>Engage women as natural teachers and leaders to deliver HIV, STI and hepatitis education as well as cultural activities in their communities.</th>
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<tbody>
<tr>
<td>Goal (ultimate)</td>
<td>Prevent the spread of HIV, STIs and hepatitis among Aboriginal people</td>
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<tr>
<td>Population</td>
<td>Aboriginal peoples, Women</td>
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<tr>
<td>Participants</td>
<td>Aboriginal women</td>
</tr>
<tr>
<td>Type of Program</td>
<td>Workshop</td>
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<tr>
<td>Setting</td>
<td>Community centres or other available meeting locations</td>
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**Required Resources**
- Venue for training
- 4 facilitators per community
- Local people strong in traditional teachings and activities
- Training binder and visual aids
- Venue in communities to host sessions
- Food and refreshments for training and workshops
- Promotional materials
- Supplies for any traditional activities that occur during workshops

**Scope and Duration**
- Recruitment and selection of communities
- Pre-training orientation and needs assessment
- 4-day training for community facilitators
- Suggested schedule includes six sessions to be held in each community but this varied by each community
- Follow-up support from Chee Mamuk for community facilitators to implement the training
What is the program?

Around The Kitchen Table (ATKT) trains Aboriginal women to be leaders and educators within their communities, reclaiming traditions and increasing awareness of HIV, STIs and hepatitis. ATKT follows a traditional Aboriginal approach to education, recognizing that traditional knowledge and skills are passed on through informal day-to-day activities. ATKT draws on a theory of community change called the “Community Readiness Model,” which integrates a community’s culture, resources and readiness for change to effectively address an issue, such as HIV prevention. See below for more information on this model.

ATKT identifies organizations within Aboriginal communities willing to participate and recruits local women to be facilitators, providing them with training and support. Peer-led ATKT workshops combine information about HIV, STIs and hepatitis prevention and treatment with traditional cultural activities, with each community tailoring its own approach.

ATKT is designed to create a ripple effect in each community whereby ideas and concepts are passed on beyond those immediately involved. By participating as facilitators, Aboriginal women leaders reclaim tradition, helping to keep their community and culture alive and healthy. After training, the women leaders are able to facilitate peer support in their own communities and become active in efforts to slow the spread of HIV. Participating communities are encouraged to network with each other to provide ongoing support.

What is the Community Readiness Model?

The Community Readiness Model is a model for community change. To effectively address an issue, such as HIV, this model integrates a community’s culture, resources and level of readiness to address that issue. ATKT utilizes assessment questions from this model to determine how ready a community is for HIV programming.

For more information on the process for using the Community Readiness Model, please see Other Useful Resources.

Why Was the Program Developed?

Aboriginal people, particularly women, are disproportionately affected by HIV/AIDS. According to the BC Centre for Disease Control, while Aboriginal people make up approximately 5% of the total BC population, Aboriginal women represented 24% of all new HIV infections in 2009.

Given the legacy of colonialism and the history of subjugation of Aboriginal communities, Aboriginal women face many challenges and barriers to health. Poverty, inadequate nutrition, low levels of education and a high level of sexual, emotional and physical abuse make Aboriginal women one of the most vulnerable populations. Aboriginal women also have the least access to support services, putting them at elevated levels of risk for contracting HIV.
In this context, Chee Mamuk engages local community organizations and educates Aboriginal women (often local health and social service staff) about HIV, STIs and hepatitis in a way that is not only culturally relevant but that actually strengthens the women’s sense of their cultural identities as well as their ability to serve within their traditional communities as educators and role models.

ATKT has been implemented in two rounds to date (2004-2007 and 2008-2010). In both rounds, ATKT staff conducted culturally appropriate training of local facilitators who then reached out to their communities across British Columbia, both in Vancouver and in remote communities. ATKT is currently being run a third time with five additional communities being trained and supported in 2010-2011.

Six communities were involved in the first round of the project. Four of those communities continue to facilitate activities. The second round of the project included five communities, three from the northwest area of BC, one from the interior and one in Vancouver’s Downtown Eastside. The third round of the project includes two communities from Vancouver Island, one from northern BC, one from southeast BC and one from the interior.

Initially all finances for community implementation were handled centrally by Chee Mamuk. However, due to the difficulties associated with the remoteness of some of the participating communities, such as quickly receiving financial resources when needed, each community now receives a small budget ($2,500) under their local control. Communities then report back on how the funds were utilized. Chee Mamuk continues to promote the project, train and support the community facilitators and distributes the training and promotional materials.

How Does the Program Work?

Location

ATKT training and workshops can be conducted anywhere that is suitably private, comfortable, well lit and quiet enough to facilitate confidential participation in discussion and activities. ATKT events are most frequently held in meeting rooms at local community centres.

Recruitment and engagement

Templates for many of the documents referred to in this section are available in the Program Materials section.

ATKT Facilitators and Local Organizations

To implement ATKT in a community, one local health or social service organization and at least two of its staff members must sign on to the project. A local organization is needed to provide institutional support, a work space, access to a photocopier and fax machine, and two staff people who have some background in providing health services.

The ATKT Project Coordinator begins recruitment by sending a letter of invitation and information package to all of the First Nations communities in the province. Packages are sent out to key community workers, leaders and role models through several networks, including First Nations and Inuit Health, Community Health Associates, Friendship Centres and Aboriginal Organizations.

The letter of invitation introduces the recipients to the ATKT project and Chee Mamuk, explaining that this innovative yet traditional project can help service providers further their training, build skills and learn from other women. The letter also outlines the application process for participation, indicating that interested groups can contact the Project Coordinator for support.

In filling out the application, interested communities must provide a letter of support from a Health Director or Director of a community-based organization (CBO) who is dedicated to the project and able to allocate staff to support its implementation. In addition, each community must identify at least four women to be trained as facilitators—two women employed in health or social services (such as a community health representative or a drug and alcohol counselor) and two volunteer community representatives (such as an elder and a youth worker) who are willing to commit to participate in the four-day facilitator training. It is also preferable that communities provide additional funding to the project, as this helps with the sustainability of the project in the community over time.
The application also asks if sufficient resources (staff time, meeting space, community support, people to lead cultural activities, etc.) are available to facilitate the sessions that will take place in the community.

The application process itself is designed to indicate the community’s capacity to undertake the project. By completing the application within the deadline, a community demonstrates team work and local support for the project. Communities that demonstrate limited capacity may be supported by Chee Mamuk to implement the project. Communities that are not selected will be referred to other Aboriginal AIDS service organizations that can provide community education and help build readiness for a project like ATKT.

The Project Coordinator and the ATKT working group review the applications and send letters of acceptance to those selected, following up to arrange a time to speak with community representatives by telephone. During these conversations, each woman is asked to think about and discuss strengths and challenges in their communities, especially as they relate to readiness to discuss HIV, STIs and hepatitis. The ATKT working group is comprised of Chee Mamuk staff, the Evaluator, a representative from the funding organization from First Nations Inuit Health, and a street nurse from Chee Mamuk’s partner program. The working group helps guide major decisions of the project, such as selecting communities, reviewing evaluation results and making recommendations for future ATKT projects.

During a follow-up planning call any specific issues that the community representatives decide need to be addressed during the training are identified.

Training

The four-day facilitator training prepares community representatives to become leaders who will organize and implement the ATKT program within their communities. Participants from different communities are trained together in one central location, allowing the women to be away from their communities during training to more fully immerse themselves in the ATKT training. This also offers the opportunity to meet women from other communities with whom they can share ideas and begin networking.

Training is focused around modeling the ATKT program that the women will implement in their home communities. The future facilitators first act as participants in the same type of sessions they will lead in their own communities. The trainers then explain how to facilitate these sessions through traditional teaching techniques, providing tips for facilitating a successful workshop.

Topics covered include: the context for HIV and Aboriginal communities; healthy self-esteem; the basics of HIV, STIs and hepatitis; how people can stay safer with drug and alcohol use; and healthy sexuality.

Trainees are provided with project planning tools, session guides, instructional aids and a free-standing table chart. The table chart is used instead of a PowerPoint presentation to give a more intimate, informal feeling to the visual instruction component of each workshop they will be leading. For more information on these materials, please contact Chee Mamuk.

Facilitators in training are also given six different lesson plans (see “Community Implementation,” below, for titles of sessions), which are helpful to the women when it comes to delivering ATKT sessions in their communities. Each lesson plan clearly outlines a session’s objectives, assessment of the group’s familiarity with the topic, activities, timeline and materials needed. The lesson plan also provides instructions to the facilitator about when to refer to the table chart to help illustrate a portion of the material being discussed.

Finally, the facilitators are given steps and guidance for creating, implementing and facilitating an ATKT program tailored to the needs of their own community. They are supported as they begin creating their community implementation plan, which includes dates for the sessions, location(s), which ATKT facilitator will be the lead on the team, and who will be responsible for various tasks (arranging food, communicating with the Project Coordinator). The training concludes with a traditional ceremony to celebrate the women’s completion of the training and honours their strength to bring these challenging teachings back to their home communities.

Community implementation

Though ATKT follows a specific organizational structure, sessions can easily be tailored to the needs of each specific community as determined by the participants and local facilitators.
Facilitators begin by deciding when it will be best to hold their sessions—in the afternoon or evening, on weekdays or weekends—to attract the most participants. Anywhere from 10 to 35 women may attend each session; the optimal number of participants has varied by community. Based on previous experiences with implementing ATKT in a community, Chee Mamuk recommends holding the ATKT sessions once every two weeks, as one session per month proved too infrequent to develop group cohesion and one per week may be challenging to prepare for.

**Recruitment of community participants**

Participants are recruited primarily by word of mouth, especially in smaller, more remote communities. Facilitators are encouraged to tell their family and friends, advertise in newsletters and newspapers, provide personal invitations and/or make announcements at community gatherings and meetings.

Recruitment is typically far more successful when communities promote ATKT as a “women’s wellness group” involving traditional culture and health topics such as healthy self-esteem, drugs and alcohol, healthy sexuality and HIV. One community initially promoted the program as an “HIV women’s group” and no one signed up. When this community advertised as a women’s wellness group with HIV as one of the many topics, they were able to recruit a good-sized group.

Groups have ranged in size from 11 to 35 participants. In communities that identified the need for more focused programming, recruitment was limited to a specific population, such as younger women or women who were at a particularly high risk for contracting HIV, STIs and/or hepatitis.

**Sessions**

The project is generally organized into six sessions of approximately three hours in length. A typical ATKT session consists of women gathering together to share a meal, followed by an hour of facilitated learning activities on the scheduled topic using the table chart and other visual aids. Then, the group participates in the cultural activity while continuing to casually discuss the topic of the evening. Each session covers a different topic:

**Session 1: Intro to ATKT and discussion of the strengths and challenges of Aboriginal peoples**

By the end of this session, participants will be able to:

- Identify Aboriginal peoples’ challenges and strengths
- Describe how challenges can lead a person to be at risk for HIV, hepatitis or STIs
- Explain how individuals and communities can use strengths to prevent infections and support people living with an infection

**Session 2: Healthy self-esteem**

By the end of this session, participants will be able to:

- Describe healthy self-esteem
- Identify sources of self-esteem
- Identify ways in which self-esteem impacts people’s lives
- Identify positive messages about self-esteem

**Session 3: Myths and truths about HIV and hepatitis**

By the end of this session, participants will be able to:

- Describe the ways people can and can’t get HIV and hepatitis
- Provide informal supports to people with HIV

**Session 4: Healthy sexuality**

By the end of this session, participants will be able to:

- Describe healthy sexuality
Describe testing, treatment and prevention of STIs
Identify positive messages about sexuality

Session 5: Drugs and alcohol

By the end of this session, participants will be able to:

- Describe drug and alcohol use in their community
- Discuss how alcohol and drug use increase the possibility for the transmission of HIV, hepatitis B and C and STIs
- Describe ways that people can reduce or stop using drugs or alcohol
- Identify support resources

Session 6: Closing ceremony

While communities are encouraged to facilitate each of these six topic areas, they can work with the Project Coordinator to choose alternative topics that are best suited to their community. For each topic covered, groups choose an accompanying traditional activity. Some groups may choose to do a different cultural activity at each session while others may choose to work on one activity involving several steps (e.g., drum making) throughout the entire six sessions.

Possible cultural activities include moccasin making, canning, weaving, fishing, drum making, basket weaving, paddle making, carving, and collecting traditional medicines.

The ATKT session guides, presented to facilitators during their training, outline which pieces of information to highlight at each session and provide tips for engaging participants in discussion.

To illustrate different topics and the connections between them, Chee Mamuk utilizes a number of “icebreaker” and “energizer” games to stimulate participation and discussion. One example is the “Sword and Shield” game, in which participants sit in a circle. Each participant selects two people from the circle: one is the sword, one is the shield. At the start, everyone moves around the room in an attempt to keep her shield between herself and her sword. Other games are included in the facilitator training manual and are meant to keep the energy levels up and to give participants the opportunity to interact with each other.

Facilitators may also invite guests, such as elders, nurses and cultural leaders, to guide participants through any of the topics. Sessions conclude with reminders of the next session, date, time and topic.

Providing ongoing community support

During the community implementation phases of ATKT, the Project Coordinator supports ongoing engagement via regular email and phone contact with each facilitator. While facilitators noted that they appreciated the ongoing support, Chee Mamuk will not provide teleconferences with all facilitators together in the future as facilitators greatly preferred the one-on-one support.

The Project Coordinator also visited each community in person to check in with facilitators, support planning and implementation of ATKT sessions, help solve problems and fill out ATKT paperwork if needed. The site visits proved to be an excellent opportunity to build an even better relationship between the facilitators and Chee Mamuk.

Required Resources

Human resources

The skills and experience of the Project Coordinator are critical to the success of this project. It is preferable that the Project Coordinator be Aboriginal, but if this is not possible, she does need to demonstrate:

- Ability to provide culturally competent services to Aboriginal people
- Experience working with Aboriginal women in rural, remote and urban areas

The Project Coordinator also must demonstrate:
Experience working in the HIV/AIDS field
Excellent organizational skills and ability to manage time effectively
Excellent analytical, critical thinking and communication skills
Initiative and willingness to work collaboratively with others

The instructors who facilitate the ATKT training must demonstrate:

- Extensive experience working with Aboriginal communities
- Credibility related to their work with Aboriginal communities
- Expertise in the area of HIV, hepatitis and STIs
- Sound instructional skills, utilizing a variety of instructional techniques that are both interactive and engaging
- One instructor with a nursing background is also beneficial

Professional and Volunteer Facilitators:

To run ATKT in a community it collectively takes approximately 150 hours.

The two community facilitators must be:

- Women from the local community
- Professionals in a related field (i.e., a community health representative, nurse, counselor or social worker)
- Comfortable speaking openly and in confidence about sexuality and HIV/AIDS with members of the community

The two volunteer community facilitators must be:

- Respected and influential women from the local community
- Comfortable speaking openly and in confidence about sexuality and HIV/AIDS with members of the community

The community elder(s) or cultural people must be:

- Respected and influential people from the local community
- Knowledgeable in various local traditional activities and able to teach facilitators and participants in these traditions

Material resources

- Training binders
- Table charts
- Promotional materials such as posters, stickers, postcards, magnets, t-shirts and shawls that have the project logo on them
- Visual aids for both training and workshops
- Materials for cultural activities engaged in during training and workshop
- Meals and refreshments for training and workshops

Financial resources

Rather than having to request funds from Chee Mamuk to pay for expenses, each community is offered $2,500 in “seed funds” to cover food, cultural activity materials and other expenses to get the project off the ground in their communities. Some sample costs of materials follow:

Funding the communities

Each community is allocated $2,500 in seed funds to implement ATKT. These funds cover the costs of food and any materials needed for session activities. While historically Chee Mamuk distributed half of the funds prior to training and half of the funds halfway through the implementation of ATKT, in future they will distribute funds after each community has developed a budget and community implementation plan, which occurs after training is completed.
Each community decides who will be responsible for the budget and reporting on the expenditures.

Other funding for Chee Mamuk is required to print the training binders, table charts and promotional materials (approximately $7,500), to hire a Project Coordinator and to fund the four-day training, including participants’ travel expenses (approximately $80,000).

**Barriers to Implementation**

- Delays are often encountered because of major events in the community, such as births, illness and death.
- Lack of ability for some facilitators to commit to the project given other responsibilities; it is important to recruit four facilitators to account for this.
- One facilitator in any one community may become overburdened with an uneven distribution of work among the team; this can be avoided by asking teams to identify individual strengths during training in order to lend clarity to roles and help distribute the work.
- The kinds of outcomes being sought involve change in some deeply rooted attitudes and behaviours, which takes time and are hard to measure. To reach more long-term outcomes with this initiative, a sustained program over time would be needed. This involves ongoing funding and refresher trainings for community facilitators to update their knowledge.

**Evaluation**

To date, at least 361 people have taken part in the project, including both facilitators and participants. Since 2006, evaluation data has been compiled from multiple sources:

- Project documentation and reports prepared by various community facilitators (see *Reclaiming Our Traditions* in *Program Materials* for examples of reporting forms)
- Personal interviews (conducted in person, via telephone and by email) with project personnel, members of the ATKT working group, community facilitators and participants
- Participant observation at workshops by program staff
- Workshop evaluations

It was determined that the ATKT project had a positive overall impact on cultural sharing among participating communities and in building overall skill and confidence level of people in each community.

Collecting evaluation data has continued to be challenging for Chee Mamuk. Community facilitators have expressed distrust in evaluators and general apprehension about conducting evaluations. Chee Mamuk continues to problem solve this aspect of the project and offers incentives, such as additional dollars to run future ATKT sessions, for sending in forms.

While Chee Mamuk considers the implementation of ATKT in each community that completed the project to date a success and while some common positive outcomes were noted across the communities served, evaluators were unable to find one standard definition of “success.” Each community had different priorities and different resources to work with locally, so accomplishments varied. The majority of respondents, however, agreed that linking health education and the revival of cultural teachings was an effective model for reaching communities.

Evaluations of the training sessions by the facilitators were consistently positive. Short-term outcomes included small but promising increases in knowledge of HIV/AIDS and confidence in teaching others about cultural practices. Participants perceived growth in:

- cultural knowledge
- health knowledge
- cultural skills
- self-confidence
- pride and cultural identity

Local facilitators reported increased self-care behaviours among community members who attended their sessions as well as a “ripple effect” through which those who came to sessions passed on their new knowledge to others in the community. They also reported a decrease in HIV-related stigma in their communities.
Support for ATKT has been demonstrated through increasing interest in the project from BC communities. For round three, 19 communities applied to participate, not including 10 communities that did not meet the application deadline. Since the start of round three community implementation, 44 communities have requested the training. Given that Chee Mamuk currently can train five communities at one time, this is an overwhelming interest. In the future, Chee Mamuk hopes to run the project twice a year and also to hold a two-day follow-up training for any previous ATKT leaders who would like some additional training and support.

Limited funding did not allow for Chee Mamuk to conduct an evaluation to measure the medium- or long-term outcomes.

**Learned and Confirmed**

- Using the strengths of Aboriginal women as natural leaders and linking education to cultural teaching are effective ways to engage Aboriginal communities in HIV, STI and hepatitis information.
- Communities are at different levels of readiness to launch a peer-run project that deals with issues related to HIV, STIs and hepatitis.
- Taking care to determine the level of community readiness, tailor a program to the community’s specific realities and find committed staff for the project can increase the probability of success.
- Community facilitators need to fully understand the program model, develop a clear statement of objectives and activities, identify resources and plan for ongoing evaluation *before* implementation begins in each community. Ongoing support from program staff increases the probability of success.
- Networking new community facilitators with women who have already implemented ATKT eases the learning curve for new communities and helps sustain the model over time.

**Program Materials**

- [Reclaiming Tradition Around the Kitchen Table: A model for HIV, Hepatitis C and Sexual Health Education](http://www.catie.ca/sites/default/files/STI_Chee_Mamuk_ATKTguide_20100409.pdf)
- [Reclaiming Our Traditions Poster, Postcard and Sticker](http://www.catie.ca/sites/default/files/STI_Chee_Mamuk_reclaiming_poster_20100513.pdf)

**Other Useful Materials**

**Information found on the CATIE website**

- [Information on Aboriginal communities](http://www.catie.ca/en/prevention/populations#aboriginal)
- [Information on culture, race and ethnicity](http://www.catie.ca/en/prevention/social-and-legal-issues#social)
- [CATIE Ordering Centre: Resources for Aboriginal Communities and People who work with Aboriginal Communities](http://orders.catie.ca/index.php?cPath=14_52)

**Resources**

**Our search for safe spaces: A qualitative study of the role of sexual violence in the lives of Aboriginal women living with HIV/AIDS**

2009, Canadian Aboriginal AIDS Network (CAAN)

Report

English, French


**The Canadian Aboriginal AIDS Network**

2010, Canadian Aboriginal AIDS Network (CAAN)

Client resources

English, French
Contact Information

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