THE EVALUATION OF THE TRIPARTITE ABORIGINAL INFANT SAFE SLEEP TRAINING INITIATIVE

Evaluation Framework and Report on the Baseline Survey of Service Providers

Final Report
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EXECUTIVE SUMMARY

Background
A report prepared by the BC Coroners Service in 2005 indicated that Aboriginal children are dying at a much higher rate than the rest of the population of British Columbia; furthermore in 2007 the Provincial Health Officer and again in 2009 the BC Coroners Service, reported that Aboriginal infants are overrepresented four fold in cases of sudden infant death. In an attempt to address this disparity the Tripartite Aboriginal Safe Sleep Working Group was struck by the Tripartite First Nations and Aboriginal Maternal and Child Health Committee. The objective of the Working Group is to deliver and evaluate a safe sleep training initiative that can be incorporated into existing programs and services for Aboriginal peoples and service providers who work with Aboriginal families.

Honoring our Babies: Safe Sleep Cards and Guide
The goal of the Tripartite Aboriginal Infant Safe Sleep Initiative is to reduce the risk of sudden infant death syndrome (SIDS) among Aboriginal populations in British Columbia by strengthening safe sleep knowledge and skills through a culturally appropriate training initiative. A set of training tools, Honoring our Babies: Safe Sleep Cards and Guide was developed and launched on October 15, 2013. The toolkit included a deck of 21 discussion cards and 7 cards for use by service providers and/or community volunteers to prompt and guide discussions with families about safe infant sleep and a Facilitator’s Guide was developed to provide a greater degree of information on each card’s topic. The set of tools was developed to be interactive, evidence-informed, and culturally relevant to Aboriginal families.

Evaluation Framework
The Aboriginal Working Group recognizes that conducting an evaluation of the toolkit is an important mechanism through which to assess whether the Initiative’s training tools are being utilized and whether they are meeting the needs of service providers working with Aboriginal families, as well as whether they are working to increase service providers’ knowledge of key safe sleep practices.

An evaluation framework has been developed to address the following four key questions:

1. Is the toolkit being adopted/used in existing programs/services?
2. Is the toolkit meeting the needs of service providers working with Aboriginal families (e.g., ease of use, safe sleep content, cultural relevance)?
3. Has the toolkit contributed to increased service provider knowledge of key safe sleep practices?
4. How has the toolkit impacted service providers’ practice of discussing safe sleep with Aboriginal families?

In order to address these questions, the evaluation framework consists of two phases: Phase I: baseline data collection prior to the distribution of the toolkit; and Phase II: a follow-up survey and focus groups approximately two years after the toolkit has been disseminated.
Phase I: Baseline Data Collection

The baseline survey of service providers was administered online from April 10 – 30, 2013. During this time a total of 86 surveys were completed, yielding an estimated 30.0% response rate.

Data collected from the baseline survey of service providers offer a “snapshot” of the practices in providing information about safe sleep practices to Aboriginal families throughout the province of British Columbia prior to the implementation of the Aboriginal Infant Safe Sleep Training Initiative such as:

- More than seven out of ten service providers report sharing information related to sleep position and the importance of having a firm sleeping surface with tight fitting sheet and/or no bumper pads, pillows, heavy blankets or toys.
- Less than one in five service providers report having access to many resources to help discuss safe infant sleep practices with families.
- Only 14.1% of respondents believe that the safe sleep resources that they have access to are culturally relevant to Aboriginal families.
- Only one in ten service providers feel that the safe sleep resources that they have access to meet their needs completely.
- 12% of service providers report that they are unsure if there are actions that families can take to reduce the risk of SIDS.

Phase II: Follow-up Survey and Focus Groups

The evaluation methodology proposed includes a follow-up survey and focus groups with service providers approximately two years after the toolkits have been distributed, as well as a review of administrative data sources to identify what data, if any, is collected by providers to better understand the reach of the toolkit. As a tripartite partner, the Ministry of Health (Maternal, Child and Health Engagement Branch) has agreed to take the lead on conducting Phase II of the evaluation in partnership with the Aboriginal Safe Sleep Working Group and Tripartite Infant and Child Health Planning Committee.

The purpose of the survey will be to target those service providers who have had access to and/or have used the Honoring our Babies Toolkit. The survey will include questions to identify how service providers learned about the toolkit, their use of the toolkit, their perceptions about the extent to which the toolkit meet their needs and are culturally appropriate, and whether they completed the baseline survey. The survey will also ask questions about service provider infant safe sleep knowledge; increased knowledge about infant safe sleep practices among those who use the toolkit as compared to the baseline survey results would be an indicator that would support program success in increasing service provider knowledge about safe sleep practices.

Additionally, focus groups will be conducted to obtain qualitative perceptions of how service provider views have changed with the availability of the new resources. It is recommended that a minimum of one focus group be conducted within each of the five health authority regions, and that those invited to participate include a mix of different organizations, rural and urban communities and include service providers who work with families on- and off-reserve.
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SECTION 1: INTRODUCTION AND BACKGROUND

1.1 Project Background

The Transformative Change Accord is an agreement between the British Columbia provincial government, the federal government and the BC Assembly of First Nations, First Nations Summit and the Union of BC Indian Chiefs. This agreement was signed in November 2005 with the goal of improving the quality of life of the Aboriginal peoples of Canada. The Tripartite First Nations Health Plan was developed based on the accord identifying four priority areas and 29 actions to address the health status gap of First Nations in British Columbia. The Plan includes a recommendation that the Province of British Columbia (BC) and First Nations follow-up on the 2005 BC Coroners Service Child Death Review Unit report recommendation that “all levels of government, educators, parents, and Aboriginal leaders and their communities forge new relationships led by the Aboriginal people to address the results of this report that clearly illustrate that Aboriginal children are dying at disproportionately higher rates” (First Nations Leadership Council and the Province of British Columbia, 2006, p. 8).


In an attempt to address this disparity and in alignment with the recommendations of the TCA: FNHP, the Aboriginal Safe Sleep Working Group was struck by the Tripartite First Nations and Aboriginal Maternal and Child Health Committee, which includes membership from the First Nations Health Authority. The objective of the Working Group is to design, deliver and evaluate a safe sleep training initiative for Aboriginal peoples and service providers who work with Aboriginal peoples that can be incorporated into existing programs and services (Brown, 2012).

The Working Group is currently chaired by Perinatal Services BC, an agency of the Provincial Health Services Authority, and consists of eight members, including representatives from federal and provincial governments, a regional health authority, First Nations peoples, and content experts (Brown, 2012). Specifically, the membership of the Aboriginal Safe Sleep Working Group is comprised of representatives from:

- Perinatal Services BC;
- Health Canada, First Nations & Inuit Health Branch;
- Inter Tribal Health Authority;
- Ministry of Health, Maternal, Child and Health Engagement Branch;
- Island Health¹; and
- North Cariboo Family Program Society.

¹ Formerly referred to as the Vancouver Island Health Authority (VIHA)
1.2 The Tripartite Aboriginal Infant Safe Sleep Training Initiative

The goal of the Initiative is to reduce the risk of sudden infant death syndrome (SIDS) among Aboriginal populations in British Columbia by strengthening safe sleep knowledge and skills through a culturally appropriate training initiative (Brown, 2012). The Initiative is informed by safe sleep practices as recognized by the Province of BC (Perinatal Services BC, 2011; HealthLink BC, 2011), the federal government (Public Health Agency of Canada and Health Canada), and other federal organizations (Canadian Pediatric Society, Canadian Foundation for the Study of Infant Death and the Canadian Institute of Child Health).

Specifically, the Working Group used the following documents to inform the development of the toolkit with respect to infant safe sleep practices:

- **Safe Sleep Environment Guidelines for Infants 0-12 Months of Age** (Perinatal Service BC, 2011). This document was developed to provide health care providers with key recommendations to support infant safe sleep to promote prevention of sudden infant death syndrome (SIDS) and sudden unexpected death of an infant (SUDI). The guidelines are for infants one year of age or younger in either hospital or community settings.

- **Joint Statement on Safe Sleep: Preventing Sudden Infant Deaths in Canada** (Public Health Agency of Canada, 2012). This document was a collaborative effort prepared by representatives from the Canadian Paediatric Society, the Canadian Foundation for the Study of Infant Deaths, the Canadian Institute of Child Health, Health Canada, the Public Health Agency of Canada, experts in the field of sudden infant death, and with input from provincial/territorial, national, and regional public health stakeholders from across Canada. The statement was developed in order to provide evidence-based information to health practitioners in order to provide parents and caregivers with information and support to encourage safe sleeping practices and help prevent sudden infant death syndrome.

- **Recommendations for safe sleep environments for infants and children** (Children Paediatric Society, 2013). This position statement was first posted on November 1, 2004 and was reaffirmed on January 30, 2013. The document presents issues in choosing a sleep environment for infants and children, evidence-based data on bed sharing and a set of recommendations for a safe sleep environment.

Additionally, the following three documents helped inform the development of a set of tools that would be culturally relevant for Aboriginal families:

- **Cultural Competence and Cultural Safety in Nursing Education** (Aboriginal Nurses Association of Canada, 2009). This document presents a curriculum framework for recruiting and retaining an increased number of First Nation, Inuit and Métis people into nursing education and to enable curricula for both Aboriginal and non-Aboriginal nurses to realize and address social injustices and inequities faced by different populations. The framework is based on six core competencies: postcolonial understanding, communication, inclusivity, respect, indigenous knowledge, and mentoring and supporting students for success.

- **Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators** (National Aboriginal Health Organization, 2008). This document speaks to
the need for health care workers to provide culturally competent and safe care by respecting differences (i.e., culture, nationality, gender, religion, etc.) and communicating with patients in a way that speaks to that patient's political, social, spiritual or economic social reality. This work focuses on the education of health care providers as the means to achieving cultural competency/safety in health care and provides examples of how changes can be realized and examples of cultural safety in health care practice.

- **Using Traditional Practice to Support Change** (National Centre for Cultural Competence, 2007). This article presents an example of a project undertaken using American Indian traditions to connect with mothers to reduce the rate of SIDS among the American Indian population in and around Seattle, Washington. The National Centre for Cultural Competence identified this project as a promising practice as it demonstrates respect for cultural values, beliefs and practices; ensures meaningful involvement of community members and key stakeholders; uses cultural brokers and uses formats that the target audience is comfortable with.

Once drafted, the toolkit was further informed by two events that were held to gain insight from First Nations, Aboriginal Elders, and staff and service providers who work with Aboriginal families. The first event was a two day Culture Review Workshop. Participants included First Nations and Aboriginal Elders from various regions of the province. The purpose of the workshop was to review and revise the approach and language of the training tools to increase their cultural appropriateness and effectiveness. A half-day event was later held to review and revise the approach and language of the training tools to increase their usability, acceptability by staff and families, and in some cases, cultural relevance. The 20 participants who attended this event were made up of staff and service providers who work with Aboriginal families. Following these two events the tools developed were subjected to an additional plain language review.

The set of training tools were finalized in April 2013, and were launched on October 15, 2013. As part of the distribution plan, 1,500 hard copy sets were printed and distributed to the:

- Maternal Child Health Program (on-reserve);
- Fetal Alcohol Spectrum Disorder (FASD) Program;
- Pregnancy Outreach Program;
- Canadian Prenatal Nutrition Program;
- Aboriginal Friendship Centres;
- Aboriginal Infant Development Program; and
- Public Health Units in each Regional Health Authority.

The set of tools is also available for download from the First Nations Health Authority website at [www.fnha.ca](http://www.fnha.ca) under the Maternal and Child Health section.

The distribution of the toolkit was followed closely by an awareness campaign and training sessions. A number of training events were planned including a provincial train-the-trainer workshop with key representatives from each of the target populations; webinar sessions provided through the UBC Learning Circle; and additional training sessions/workshops at existing
meetings/in-service training events and conferences. A brief description of the toolkit is provided below.

**Honoring our Babies: Safe Sleep Cards & Guide**

A deck of 21 discussion cards and 7 illustrated cards assists service providers and/or community volunteers to prompt and guide discussions with families about safe infant sleep. The front side of each discussion card contains a question related to safe infant sleep, as well as to other holistic aspects of infant health and safety. The backside of each discussion card contains key messages to support service providers to discuss the topic and provide guidance to parents. The illustrated cards depict key safe sleep practices as well as less safe sleep practices, which can be used as visual aids to inspire dialogue and communicate key messages. A Facilitator’s Guide was also developed to provide a greater degree of information on each card’s topic, and includes an appendix with additional research, resources, and graphics. This set of tools was developed to be interactive, evidence-informed, and culturally relevant to Aboriginal families.

The logic model in Chart 1.1 was developed in consultation with the Aboriginal Safe Sleep Working Group to provide an overview of the desired theory of change guiding this initiative. The chart illustrates resources (inputs) and activities required to develop the *Honoring Our Babies Toolkit*, what would be produced (outputs) and the desired outcomes associated with availability of the toolkit. The logic model was developed to ensure a common understanding of the anticipated outputs and the desired outcomes that would be used to guide the evaluation.

**Chart 1.1 The Tripartite Aboriginal Safe Sleep Initiative’s Logic Model**

As illustrated in Chart 1.1, successful implementation of the *Honouring our Babies Toolkit* involves service providers who work with Aboriginal families receiving access to and training on the use of the toolkit, and is based on the assumption that service providers will then use the toolkit when working with Aboriginal families. The use of the toolkit is expected to increase awareness about options for safe sleep practices among Aboriginal families and ultimately make a contribution to reducing the incidence of SIDS/SUID among families in British Columbia.
1.3 Literature Scan

A literature scan was conducted to explore what research and evaluation work has been completed to date on safe sleep knowledge, attitudes and practices, among the general public and specifically among Aboriginal populations.

1.3.1 Research with Aboriginal Populations

To date it does not appear that similar baseline data exists for Aboriginal populations in Canada. Only two recent studies relative to SIDS and safe sleep in Aboriginal communities identified were found, both focusing on Inuit children.

The most relevant to this study is the *Early Inuit Child Health in Canada, Report 1 – Sleep Practices among Inuit Infants and the Prevention of SIDS* (Asuri, Ryan & Arbour, 2011) undertaken by members of the Department of Medical Genetics at the University of British Columbia and a representative from the Department of Health and Social Development at the Inuit Taparriit Kanatami (ITK). This study examines secondary data, responses to questions E3 (bed-sharing practices) and E4 (infant sleep position) collected in the 2006 Aboriginal Children’s Survey (ACS). However no questions were included in the survey about maternal smoking or substance use, both of which have been identified as risk factors in the resources that informed the development of the Honorings Our Babies Toolkit (Perinatal Service BC, 2011; HealthLink BC, 2011; Public Health Agency of Canada, 2011).

Asuri, Ryan and Arbour identify two factsheets on SIDS, “What is Sudden Infant Death Syndrome”, developed by Inuit Tutturvingat at the National Aboriginal Health Organization (NAHO, 2008) and “Look up to our ancestors” created by the National Indian & Inuit Community Health Representatives Organization (NIICHRO, 2004). They noted, however, that the efficacy of the two factsheets is unknown as they have not been evaluated (Asuri, Ryan & Arbour, 2011, p.9).

The second study examined the correlation between reduced ventilation in houses in Nunavut and the high rate of lower respiratory tract infections among Inuit infants (Kovesi, et al., 2012). This study is not of direct relevance to the work being undertaken by the Aboriginal Safe Sleep Working Group.

Although research has not been undertaken to understand the current safe sleep practice knowledge and awareness among Aboriginal communities, in their communications with the Aboriginal Safe Sleep Working Group, both representatives from the Public Health Agency of Canada and Alberta Health Services have indicated that they hope to undertake research in this area in the near future.

1.3.2 Research with the General Public

While research pertaining to infant safe sleep knowledge and awareness among Aboriginal populations appears to be sparse, projects have been undertaken to track infant safe sleep knowledge, awareness and practice before and after the implementation of Safe Sleep Initiatives. The works most relevant to that being undertaken by the Aboriginal Safe Sleep Working Group are described below.
Health Canada’s *Back to Sleep Campaign*

Most notably, Health Canada undertook a tracking survey on the awareness, knowledge and behaviors relating to Sudden Infant Death Syndrome (SIDS) of new parents, caregivers and those expecting to become parents to assess the effectiveness of Health Canada’s *Back to Sleep Campaign*. The initial survey was administered in 1999 prior to the launch of the campaign, the findings of which were compared to data collected when the survey was administered to a similar population in 2001, after the campaign had been underway for nearly two years.

Both the Final Report from the 1999 Benchmark Survey on Awareness, Knowledge and Behaviors Relating to Sudden Infant Death Syndrome (Environics Research Group & Health Canada, 1999) and the Final Report from the 2001 Tracking Survey on Awareness, Knowledge and Behaviors (Environics Research Group & Health Canada, 2001), including the survey instruments administered, were provided to the Aboriginal Safe Sleep Working Group.

**Alberta Health Services Safe Infant Sleep Study**

Alberta Health Services undertook a provincial project on Safe Sleep in 2009. One of the first activities of the project was to collect baseline data on professional and parent knowledge, practices and beliefs. A survey was administered to professionals (acute care, public health nurses, frontline staff, child care providers, physicians, etc.) in the fall/winter of 2010/11 and to parents in the summer of 2011.

The Safe Infant Sleep Professionals Survey Results Summary (Alberta Health Services, 2011) and all of the survey instruments (those administered to professionals and to parents) were provided to the Aboriginal Safe Sleep Working Group; a final report on the parent survey is not yet available for distribution.

**First Candle’s *Bedtime Basics for Babies!***

An evaluation is underway of First Candle’s *Bedtime Basics for Babies!, a national infant safe sleep campaign in the United States* (First Candle, 2009). The Working Group was informed, however, that the data for First Candle’s evaluation has not yet been analyzed and that they are unable to share information about the evaluation, including the instruments used, until their report has been published.

### 1.4 Report Overview

The remainder of the report is divided into two sections.

Section 2 provides an overview of the evaluation including the rationale for the evaluation, the evaluation objectives, the methodology used for Phase I of the evaluation and the methodology proposed for Phase II. Findings from the baseline survey are presented in Section 3.

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2 First Candle is a national non-profit health organization based in the United States that works to increase public participation and support to decrease SIDS and SUID.
SECTION 2: EVALUATION FRAMEWORK

As stated earlier, the mandate of the Working Group is “to design, deliver and evaluate safe sleep training tools for Aboriginal peoples and service providers working with Aboriginal peoples that can be incorporated into existing programs and services.” This evaluation project seeks to address the third component of the Working Group’s mandate, evaluating the safe sleep training toolkit.

A mixed methods formative evaluation is proposed. The evaluation will encompass components of an implementation evaluation (examining the extent to which the toolkit has been implemented as intended), a process evaluation (to explain and understand the relevance and use of the toolkit), and will explore preliminary outcomes associated with the toolkit. The data collected through a Survey of Service Providers in April/May 2013 will be used as the baseline to which data from a follow-up survey of service providers administered after the toolkit has been distributed and adopted will be compared. Additional information about the analysis proposed is contained in Section 2.4.1.1.

2.1 Rationale for Evaluation

The Working Group recognizes that conducting an evaluation of the toolkit is an important mechanism through which to assess whether the Initiative’s training tools are being utilized, whether they are meeting the needs of service providers working with Aboriginal families, as well as whether they are working to increase service providers’ knowledge of key safe sleep practices.

In addition to supporting accountability, conducting an evaluation will provide the opportunity to generate/document lessons learned that other groups could benefit from and to collect information that can be used to inform the adjustment of training tools to increase their effectiveness.

2.2 Evaluation Objectives

The objectives of the Evaluation of the Tripartite Aboriginal Infant Safe Sleep Training Initiative are to evaluate the implementation and immediate outcomes of the Working Group’s set of training tools, the Honoring Our Babies – Safe Sleep Cards (hereafter referred to as “the toolkit”).

There are four key questions that the evaluation will seek to answer. The first question focuses on the design and utilization of the toolkit while the last three focus on preliminary outcomes as identified in the Tripartite Aboriginal Safe Sleep Initiative Logic Model illustrated in Chart 1.1, in Section 1.2.

1. Is the toolkit being adopted/used in existing programs and services?
   • How frequently and in what circumstances do service providers use the toolkit?
   • What factors have supported the adoption/use of the toolkit among service providers?
   • Have service providers adapted the toolkit, and if so, in which ways?
   • What opportunities exist to increase the adoption/use of the toolkit among service providers?
2. Is the toolkit meeting the needs of service providers working with Aboriginal families (e.g. ease of use, safe sleep content, cultural relevance)?
   - What are the strengths and opportunities associated with the toolkit?
3. Has the toolkit contributed to increased service providers’ knowledge of key safe sleep practices?
4. How has the toolkit impacted service providers’ practice of discussing safe sleep with Aboriginal families?

In order to address these objectives, the evaluation framework consists of two phases:

- **Phase I:** Baseline data collection prior to the distribution of the toolkit; and
- **Phase II:** A follow-up survey, focus groups and a review of administrative data sources approximately two years after the toolkit has been disseminated.

### 2.3 Phase I: Baseline Data Collection

The baseline survey provided an important opportunity to gather data on service providers’ current practices of discussing safe sleep with Aboriginal families prior to the launch of the new tools. More specifically, the purpose of the initial survey was to collect baseline data from service providers on:

- Current practices of discussing safe sleep with Aboriginal families (frequency and content);
- Current access to tools and resources, if any, to discuss safe sleep with Aboriginal families;
  - Service provider perception of whether the current tools meet their needs;
  - Service provider perception of whether the current tools are culturally relevant for Aboriginal families; and
- Current levels of knowledge regarding key safe sleep practices among service providers.

The evaluation as a whole will employ a before and after design while data collection for the baseline survey uses a cross-sectional design. Data collected from the baseline survey of service providers provides a “snapshot” of the practices in providing knowledge about safe sleep practices to Aboriginal families prior to the implementation of the Aboriginal Infant Safe Sleep Training Initiative.

### 2.3.1 Design of the Survey Instrument and Related Documents

The baseline survey instrument was designed in close consultation with members of the Aboriginal Safe Sleep Working Group. Survey questions were formulated to address service providers’ current practice of discussing safe sleep with Aboriginal families; access to tools and resources; and current levels of knowledge regarding safe sleep practices. Additionally the survey was developed to allow for comparison over time (pre- and post- implementation). The survey took approximately 10 minutes for respondents to complete and consisted of a mix of fixed scale and open-ended questions. Refer to Appendix I for a copy of the service provider baseline survey instrument.

The survey was programmed into Fluid Survey, an online survey tool, which allows for a wide range of question formats and various complexities such as skip logics, looping, email triggering, on-page
addition (sums) and more. Perinatal Services BC has an account with the Canadian branch of FluidSurveys; as the data are held in Canadian servers they are not subject to American legislation.

On the last page of the survey, service providers were provided with a “Thank you Handout” (refer to Appendix II) that highlights safe sleep tips. This document could be printed off for the service providers’ reference.

### 2.3.2 Sampling Plan

The survey was not intended to be a census of all service providers throughout the province who provide information to Aboriginal families about safe infant sleep. In order to target those service providers to whom the toolkit would be provided, Aboriginal Safe Sleep Working Group members identified the specific service provider groups based on the implementation plan for the toolkit. Invitation emails were sent out to the service providers to whom hardcopies of the tool would be provided. The population identified was inclusive of service providers who work with Aboriginal populations both on-reserve and off-reserve, and those living in rural and urban settings. Those who completed the survey formed the convenience sample for the baseline survey of service providers. Section 3 of this report presents the proportion of responses received broken down by the various service provider groups.

### 2.3.3 Survey Administration

An invitation to participate was distributed to service providers by email from a representative within their respective organizations:

1. To Maternal-Child Health (MCH) program staff through the Maternal Child Health Program Manager for the First Nations and Inuit Health Branch, BC Region, Health Canada (approximate population size of 57);
2. To Fetal Alcohol Spectrum Disorder (FASD) Program Staff through a representative from the First Nations and Inuit Health Branch, BC Region, Health Canada (approximate population size of 25);
3. To Pregnancy Outreach Program (POP) and Canadian Prenatal Nutrition Program (CPNP) facilitators through the BC Association of Pregnancy Outreach Programs\(^3\) (approximate population size of 80);
4. To Friendship Centre staff working directly with families through a representative from the BC Association of Aboriginal Friendship Centers (approximate population size of 50); and
5. To Aboriginal Infant Child Development Program (AIDP) staff through the Office of the Provincial Advisor for AIDP (approximate population size of 75).

After providing an overview of the survey, the invitation introduced the service provider survey (including the purpose, how data collected from the survey will be used, contact information for the principal investigator and Chair of the Working Group etc.), and requested their participation by accessing the survey through a weblink provided in the email. An information letter was attached to the invitation to participate that provided respondents with additional information about the

\(^3\) All CPNP staff are attached through the BC Association of Pregnancy Outreach Programs (BCAPOP); therefore the email distributed through the BCAPOP included all CPNP workers.
study and emphasized the voluntary nature of the survey and also explained that as the survey was anonymous, consent would be implied if an individual chose to participate.

To increase the survey response rate, a reminder email was distributed to all potential survey participants through the same mechanisms as the invitation email one week prior to the deadline for survey completion.

2.3.3 Data Analysis & Reporting
Upon completion of survey administration the data were downloaded into SPSS for the preparation of statistical tables and cross-tabulations. The data were reviewed to ensure accuracy and consistency. Open-ended entries were checked to ensure that the data contained therein were truly ‘other’ responses; any open-ended comments that fit the hard codes provided were recoded. Inductive analysis was used to develop themes/categories for all open-ended responses to questions where hard codes had not been provided in advance. Descriptive statistics were used to analyze and summarize results of the survey. The findings of the Baseline Survey of Service Providers are provided in Section 3.

2.4 Phase II: Follow-up Data Collection
As a Tripartite partner, the Ministry of Health (Maternal, Child and Health Engagement Branch) has agreed to take the lead on conducting Phase II of the evaluation in partnership with the Aboriginal Safe Sleep Working Group and Tripartite Infant and Child Health Planning Committee. As decisions regarding the budget, and roles and responsibilities for the follow-up work have yet to be confirmed, activities outlined below provide a recommendation as to what data collection activities should be conducted as the follow-up and what analysis should be performed to compare data collected from the two surveys and from the focus groups.

The methodology proposed includes a follow-up survey and focus groups with service providers approximately two years after the toolkit has been distributed and a review of administrative data sources to identify what data, if any, is collected by providers to better understand the reach of the toolkit. Table 2.1 below presents the indicators identified for each evaluation question and the data collection method proposed to collect this data. The first evaluation questions seeks to understand the adoption and utilization of the toolkit while the remaining three evaluation questions explore the extent to which the immediate outcomes (identified in the Tripartite Aboriginal Safe Sleep Initiative Logic Model illustrated in Chart 1.1, in Section 1.2) have been achieved.

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Indicators</th>
<th>Data Collection Methods</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the toolkit being adopted/used in existing programs and services?</td>
<td>• Frequency toolkit is used</td>
<td>• Follow-up Survey</td>
<td>• Q6. Report on frequency of use</td>
</tr>
<tr>
<td></td>
<td>• Circumstances in which toolkit is used</td>
<td>• Focus Groups</td>
<td>• Activity #1: Service provider experiences</td>
</tr>
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Table 2.1: Evaluation Framework
<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Indicators</th>
<th>Data Collection Methods</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Factors that supported the adoption/use of toolkit among service providers</td>
<td>• Focus Groups</td>
<td>• Activity #1: Service provider experiences</td>
<td></td>
</tr>
<tr>
<td>• How, if at all, service providers have adapted the toolkit</td>
<td>• Focus Groups</td>
<td>• Activity #1: Service provider experiences</td>
<td></td>
</tr>
<tr>
<td>• Opportunities to increase the adoption/use of the toolkit among service providers</td>
<td>• Focus Groups, Follow-up Survey</td>
<td>• Activity #1: Service provider experiences and perceptions</td>
<td>Q5b. Report on reasons tools not used.</td>
</tr>
<tr>
<td>• Extent to which the toolkit meets needs</td>
<td>• Baseline vs. Follow-up Survey</td>
<td>• Q7 vs. Q8. Report on resources/toolkit meeting needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Baseline vs. Follow-up Survey, Focus Groups</td>
<td>• Activity #1: Service provider perceptions</td>
<td></td>
</tr>
<tr>
<td>2. Is the toolkit meeting the needs of service providers working with Aboriginal</td>
<td>• Cultural appropriateness of the toolkit</td>
<td>• Q6 vs. Q7. Report on cultural relevance of</td>
<td></td>
</tr>
<tr>
<td>families (e.g., ease of use, safe sleep content, cultural relevance)?</td>
<td>• Baseline vs. Follow-up Survey</td>
<td>resources/tools</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Baseline vs. Follow-up Survey, Focus Groups</td>
<td>• Service provider perceptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strengths</td>
<td>• Activity #1: Service provider perceptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Focus Groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Has the toolkit contributed to increased service provider knowledge of key safe</td>
<td>• Service providers knowledge of protective and risk factors</td>
<td>• Q8, Q9 &amp; Q10 Baseline knowledge about</td>
<td></td>
</tr>
<tr>
<td>sleep practices?</td>
<td>• Baseline vs. Follow-up Survey</td>
<td>protective and risk factors as compared to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Baseline vs. Follow-up Survey</td>
<td>follow-up survey Q10, Q11 &amp; Q12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Important points about infant safe sleep information shared with</td>
<td>• Q3 vs. Q3 Compare top important points</td>
<td></td>
</tr>
<tr>
<td></td>
<td>families</td>
<td>shared</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Baseline vs. Follow-up Survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How has the toolkit impacted service providers’ practice of discussing safe sleep</td>
<td>• Frequency service provider provide information or guidance related to</td>
<td>• Q1 vs. Q1. Frequency information is</td>
<td></td>
</tr>
<tr>
<td>with Aboriginal families?</td>
<td>safe infant sleep to Aboriginal families with or expecting a child</td>
<td>provided.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Baseline vs. Follow-up Survey</td>
<td>• Q5 vs. Q5 Use of resources/toolkit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Use of resources when discussing safe sleep with families</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Baseline vs. Follow-up Survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Service providers perceptions</td>
<td>• Activity #2: Service provider perceptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Focus Group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The remainder of this section outlines the important factors to be considered in Phase II of the evaluation and provides an outline for data collection and data analysis.

2.4.1 Follow-up Survey

It is expected that a similar methodology will be employed for the follow-up survey with service providers as was employed for the collection of baseline data, outlined in Section 2.3. The purpose of the survey will be to target those service providers who have had access to and/or have used the new toolkit developed by the Aboriginal Safe Sleep Working Group. It is therefore expected that a screening question will be included at the start of the survey to identify those respondents who have had exposure/used the toolkit and to identify those respondents who participated in the baseline survey; where possible the same or similar questions will be asked to facilitate comparisons from before and after implementation of the training toolkit. Additionally, a small bank of questions would be included to collect quantitative data about service providers’ perceptions of the toolkit.

2.4.1.1 Data Analysis

Data collected through the follow-up survey will provide insight into the extent to which Honoring Our Babies toolkit is being adopted and used in existing programs and services and the degree in which the toolkit is meeting the needs of service providers working with Aboriginal families. These two elements will be further explored through the focus group discussions (refer to Section 2.4.2). Data analysis will be performed using SPSS version 22.0 (SPSS, Inc. Apache Software Foundation, Chicago, IL, USA). Descriptive and inferential statistics will be used to analyze the data collected from the follow-up survey. Additional analysis will be performed to explore trends between the baseline survey and the follow-up survey.

Follow-up Survey Analysis

Descriptive analysis (frequencies and cross tabulations) will be prepared looking exclusively at the data from the follow-up survey to describe the uptake of and service provider perception of the Honouring Our Babies toolkit. Frequencies will be run to demonstrate:

- The proportion of service providers who have heard about the toolkit;
- The proportion of service providers who learned about the toolkit through different communication mechanisms;
- The proportion of service providers who have heard about the toolkit and have also used it;
- The frequency that service providers report using the toolkit when discussing infant safe sleep with Aboriginal families with or expecting a child;
- The proportion of service providers who feel that the toolkit is culturally relevant to Aboriginal families;
- The proportion of service providers that feel that the toolkit meets their needs; and
- The proportion of service providers that are satisfied with access to resources to help discuss safe infant sleep practices with families.

Cross tabulations will be run for each of the variables listed above to explore whether service provider experience with and perceptions of the toolkit varies by the type of populations served.
(e.g., on-reserve/off-reserve; urban, rural, remote/isolated; health authority region) and the type of position service providers hold and the length of time that they have been in their position.

Additionally, multivariate regressions will be performed to identify relationships related to the use and perceptions of the toolkit (O’Sullivan, Rassel & Berner, 2008, pp.430-443), specifically to explore the following questions:

- To what extent does the frequency the toolkit is used (independent variable) and the extent to which the toolkit is perceived as meeting service provider needs (independent variable) predict whether or not service providers view the toolkit as culturally relevant (dependent variable)?
- To what extent does satisfaction with access to resources (independent variable) and awareness that there are actions that families can take to reduce the risk of SIDS (independent variable) predict the frequency the toolkit is used (dependent variable)?

Trends indicative of success include: the majority of service providers have heard about and used the toolkit; service providers report frequent use of the toolkit; the majority of service providers report that they feel that the toolkit is culturally relevant and meets their needs; and the majority of service providers report being satisfied with access to resources to help discuss safe infant sleep practices with families.

**Qualitative responses:**

There are three questions in the follow-up survey that solicit open-ended responses:

- Q3. What are the most important points about safe sleep that you share with families? (list up to five)
- Q5b. If you have never used the Honoring our Babies toolkit please explain why.
- Q8. Please explain why the Honoring our Babies toolkit does or does not meet your needs.

A list of codes should be developed for each question, based on the responses provided. Once the coding structure has been developed and all of the open-ended responses coded, frequencies can be run to present the most frequently cited responses.

Coding of the open-ended data can be undertaken by developing an Access database or with qualitative analytical software such as NVIVO (QSR International Pty Ltd).

**Baseline-Follow-up Comparative Analysis**

As the baseline survey was anonymous and the follow-up survey will be anonymous there will be no way to link individual survey responses to track changes in individual service provider knowledge and use patterns as they relate to providing families with information about infant safe sleep. Analysis will, however, be performed to compare results between data collected in the baseline survey and from the follow-up survey. For questions that appear in both survey instruments the following comparative analysis will be undertaken:

- Responses provided in the baseline survey will be compared to a sub-sample of the responses provided in the follow-up survey, specifically those respondents who indicated that they also participated in the baseline survey.
- Responses provided in the baseline survey will be compared to the responses from all of the follow-up survey responses.
A comparison of responses provided in the follow-up survey will also be undertaken. Responses provided by service providers who indicated having also completed the baseline survey (“repeaters”) will be compared to those that did not complete the baseline survey (“non-repeaters”). If a difference is observed between the responses provided by the “repeaters” and “non-repeaters” then the analysis of responses provided in the baseline survey responses and to those of the “repeaters” should be used. If a difference is not observed between the “repeaters” and “non-repeaters” then the baseline survey responses can be compared to all of the responses provided in the follow-up survey.

The analysis of baseline and follow-up survey responses will be undertaken to explore whether there has been:

- An increase in the frequency that service providers share information or guidance related to safe infant sleep to Aboriginal families with or expecting a child;
- An increase in the frequency that resources are used when discussing infant safe sleep with Aboriginal families with or expecting a child;
- An increase in the proportion of service providers that believe the resources that they have access to are culturally relevant to Aboriginal families;
- An increase in the promotion of survey providers that feel that the resources that they have access to meet their needs;
- An increase in the proportion of service providers that are aware that there are actions that families can take to reduce the risk of SIDS; and
- An increase in the proportion of service providers that can identify protective and risk factors.

Where any difference are observed between the baseline survey and the follow-up survey for any of the variables listed above, responses will be analyzed using the Pearson Chi-Square test of significance to identify if there is a statistically significant difference between the baseline and follow-up survey responses that can be attributed to the Honouring our Babies toolkit (O’Sullivan, Rassel & Berner, 2008, pp.376-378).

Trends that would be supportive of program success would be a greater proportion of respondents who use the toolkit frequently reporting that they have access to culturally relevant tools and resources available to meet their needs, as compared to those who use the toolkit infrequently or not at all. Furthermore higher knowledge about infants safe sleep practices among those who use the toolkit would be another indicator that would support program success in increasing service provider knowledge about safe sleep practices.

2.4.1.2 Limitations
As there is no guarantee that baseline survey respondents will also complete the follow-up survey, the sample of follow-up survey respondents who report completing the baseline survey may be small. Nonetheless analysis should be undertaken to compare the responses of those who completed both surveys; however, due to the potentially small sample size, findings may need to be interpreted with caution. As there will be no way to link individual responses from the pre- and post-implementation surveys, data will not be directly comparable at the individual level (e.g., tracking changes in an individual from baseline to follow-up). Therefore, responses can only be compared in aggregate; as such it is strongly recommended that focus groups be used to learn
about service provider experiences with the toolkit and to provide qualitative perceptions of how service provider views have changed with the availability of the new resource.

2.4.2 Service Provider Focus Groups

Focus groups are a useful method for collecting detailed, introspective responses on individuals' thoughts, feelings, behaviors and motivations (Wholey, Hatry & Newcomer, 2010, p. 342). It is recommended that focus groups be conducted approximately two years after the toolkit has been distributed to obtain the qualitative perceptions of how service provider views have changed with the availability of the new resources.

2.4.2.1 Sampling

Purposeful sampling techniques are employed to provide in-depth understanding of the experiences (Patton, 2002, pp.46-47). It is recommended that purposeful sampling techniques be used to collect feedback from service providers about their experiences with the Honoring our Babies Toolkit. To ensure that focus group participants are able to speak to how their views have changed with the availability of the Honoring our Babies: Safe Sleep Cards & Guide the criterion for participation should be that service providers:

- have experience using the toolkit a minimum of three times during the last year; and
- have been in a position in which they are responsible for providing information to Aboriginal families about safe infant sleep for at least one year prior to the distribution of the toolkit (in April 2013).

In order to ensure representation from around the province and to capture different experiences that might exist based on geography or organizational affiliation, it is recommended that a minimum of one focus group be conducted within each of the five health authority regions, and that participants represent a mix of different organizations, rural and urban communities and include those who work with families on- and off-reserve. If resources are available it is recommended that, due to the large Aboriginal population residing in Northern Health, two focus groups be conducted in this region.

2.4.2.2 Recruiting Participants

Nonprobability samples cannot be generalized to a larger population with statistical validity; however, they can provide useful information to learn from the samples experiences (O’Sullivan, Rassel & Berner, 2008, pp.146-7). It is recommended that recruitment for the focus groups employ a nonprobability sampling design to collect feedback from service providers to better understand the use and the strengths and weaknesses of the toolkit. Both convenience sampling, which involves sampling available service providers, those who self-identify or volunteer in the survey (O’Sullivan, Rassel & Berner, 2008, p. 147); and snowball sampling, an approach used to identify participants who are in positions to provide infant safe sleep knowledge to Aboriginal families, through the use of well-situated contacts (Patton, 2002, p. 237) will be used.

It is recommended that the follow-up survey of service providers be administered prior to the focus groups in order to use the survey to recruit a convenience sample for the focus group. A question at the end of the survey can ask respondents to self-identify if they would be willing to be contacted...
to participate in a focus group in their area to discuss their perceptions of the *Honoring our Babies* toolkit. The feedback to this question will inform the identification of more specific locations (city/town) in which each focus group should be held. Once the locations have been confirmed, researchers will follow-up (email or telephone)\(^4\) with service providers who reside in the selected locations and indicated their interest.

It is recommended that snowball sampling be used should there be a need to identify additional focus group participants. An invitation will be distributed to service providers in the surrounding areas from their respective organizations (emails and posters to be displayed in staff areas of service provider locations).

If a focus group location does not become apparent for each health authority through recruitment from survey participants, potential focus group locations can be determined by exploring data presented in the Aboriginal Profiles of British Columbia based on the 2006 census, available on the BC Stats website (BC Stats, 2006). This data, specifically the data tables providing data about the Aboriginal population by health service delivery area will assist in identifying areas with large Aboriginal populations (with the assumption that this would provide a larger pool of service providers to recruit for the focus groups). Preference would be given to locations with high proportions of Aboriginal residents, and locations that would be accessible to service providers working with Aboriginal families residing in urban and rural settings, as well as on-reserve and off-reserve.

### 2.4.2.3 Approach

Appreciative Inquiry is grounded in participants’ actual experiences and focuses on the positive to help identify what is working well, why it is working well, and what can be done to increase or sustain positive outcomes. The intended result is an evaluation that takes a more holistic perspective (Cooperrider, et al., 2001; Coghlan, Preskill, Catsambas, 2003). It is recommended that an *Appreciative Inquiry* approach be used during the focus groups.

The discussions will be used to learn from service providers’ experiences with the toolkit, and inform the following questions:

- What about the toolkit is meeting the needs of service providers?
- What about the toolkit has been useful to initiate and guide discussion on safe sleep practices with Aboriginal families?
- Have the toolkit been changed or adapted to better meet service providers’ needs?
- What parts of the toolkit do parents/families seem to respond to positively?
- What are the strengths of the toolkit?
- What opportunities exist to increase the use of the toolkit?

A draft focus group guide is included in Appendix IV; however, the questions may be adapted to further explore trends identified in the follow-up survey.

\(^4\) Follow-up to occur using preferred communication as identified in the survey.
2.4.2.4 Data Analysis

It is recommended that data be collected and analyzed assuming an interpretivist theoretical perspective. This perspective is based on the premise that the usefulness of the toolkit is shaped by those using it rather than “neutral reports of their observations” (McDavid, Huse & Hawthorn, 2013, p.194). Therefore, the usefulness of the toolkit is based on the interpretation of service providers who have used the tool working with Aboriginal families.

The focus group discussions will all be transcribed and the data will be used to identify factors contributing to or limiting the use of the toolkit and to explore the impact of the toolkit. Inductive content analysis will be completed whereby responses will be reviewed by evaluation question to identify themes and areas of concurrence or divergence among service providers. This conventional content analysis approach uses inductive reasoning, by which themes and categories emerge directly from the raw responses through careful examination and constant comparison (Patton, 2002, p.41; McDavid, Huse & Hawthorn, 2013, p.200; Hsieh & Shannon, 2005). In reporting, these themes will be presented without identifying individual respondents. The focus group data will be first coded using a process known as open-ended coding. Open-ended coding is concerned with identifying, naming, categorizing and describing phenomena found in the text. This is usually done by “breaking down, examining, comparing, conceptualizing, and categorizing data” (Strauss & Corbin, 1990, p.61), either "line by line", by sentence or paragraph, or by a holistic analysis of the entire discussion.

2.4.2.5 Additional Considerations

Resources available for follow-up data collection and the synthesis of evaluation findings (e.g., travel expenses, contracting out of data collection and analysis, etc.), will impact decisions about who will be responsible for moderating the group discussions. The focus group moderator could be the same for all groups, thus ensuring a consistent approach and use of probes, or differ by group (e.g., someone local to each area identified).

Additional considerations related to resourcing the follow-up data collection include factors such as:

- Data collection and analysis: Ideally those undertaking these activities should have experience working with Aboriginal populations and conducting strength-based focus groups.
- Focus group logistics: Once the communities have been identified, the three main considerations for planning the focus groups will be: location to host the group, timing for the group and whether or not compensation will be required for participants. Additionally, it is recommended that beverages and a light snack be provided at each group. It is recommended that the groups take place in an inclusive environment such as a friendship center. Participating organizations should all come to an agreement as to whether or not their staff can participate if not the groups would need to be scheduled outside of working hours and it is recommended than an incentive/gratuity be provided.

2.4.3 Review of Administrative Data

It is recommended that a review of administrative data sources be undertaken to identify what data, if any, is regularly collected and reported on by service providers. If available this data would
be aggregated to describe the reach of the toolkit and would be reported on by service provider organization and by health authority region. Data collection may not be homogenous between organizations or across health authorities therefore aggregation may only be able to occur at the organization or health authority level rather than provincially. Possible data elements might include how many clients (Aboriginal families with or expecting a child) are served (e.g., by month, quarter or year); the frequency or proportion of clients who are provided with information about infant safe sleep (e.g., by month, quarter or year); and the frequency or proportion of clients with whom the Honouring our Babies toolkit is referenced or used.
### SECTION 3: BASELINE SURVEY FINDINGS

The survey of service providers was administered online from April 10 – 30, 2013. During this time a total of 86 survey completions were obtained.

#### 3.1 Response Rate

As described in Section 2.3.3, an invitation to participate in the survey was sent out through five organizations. Table 3.1 below provides the estimated population of service providers within each organization. As there was no mechanism employed to track the organization to which survey respondents belonged, it is not possible to calculate the exact response rate by organization. Respondents’ self-identified positions from the survey were used to estimate response rates by organization; however actual response rates are higher than estimated for some, if not all organizations as there were 9 positions whose organizational affiliations were unclear.

In order to provide a more accurate response rate by organization for the follow-up survey, a question has been added to the follow-up questionnaire asking respondents to identify the organization through whom they received the invitation to participate in the survey (Q19).

Based on an estimated total population of 287 and 86 survey completions, the overall survey response rate was 30.0%.

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Population*</th>
<th>Estimated Completions</th>
<th>Estimate Response Rate by Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Child Health Program Staff Coordinators (17), CHNs and Home-visitors (40)</td>
<td>57</td>
<td>26**</td>
<td>45.6%</td>
</tr>
<tr>
<td>Fetal Alcohol Spectrum Disorder (FASD) Program Staff Coordinators (8), Mentors (17)</td>
<td>25</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>Pregnancy Outreach Program (POP) and Canadian Prenatal Nutrition Program (CPNP) facilitators</td>
<td>80</td>
<td>18</td>
<td>22.5%</td>
</tr>
<tr>
<td>Aboriginal Friendship Centre Staff Working at the 25 member centers throughout the province</td>
<td>50</td>
<td>20</td>
<td>40.0%</td>
</tr>
<tr>
<td>Aboriginal Infant Child Development Program Staff Working at the 49 programs throughout the province</td>
<td>75</td>
<td>12</td>
<td>16.0%</td>
</tr>
<tr>
<td>Positions that could not be directly linked to any of the above listed organizations</td>
<td>-</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>287</strong></td>
<td><strong>86</strong></td>
<td><strong>30.0%</strong></td>
</tr>
</tbody>
</table>

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*The population figures represent an approximate number only provided by representatives of each organization

**Staff who reported being a Home-visitor or Outreach Worker, Maternal Child Health Worker, Community Health Nurse or Public Health Nurse were included under Maternal Child Health Program Staff
3.2 Respondent Profile

As presented in Table 3.2, the largest proportion of survey responses were from staff at an Aboriginal Friendship Center (23.3%) or from the Pregnancy Outreach Program or Canadian Prenatal Nutrition Program (20.9%).

<table>
<thead>
<tr>
<th>Position</th>
<th>Count</th>
<th>Percentage of Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff at an Aboriginal Friendship Center</td>
<td>20</td>
<td>23.3%</td>
</tr>
<tr>
<td>Pregnancy Outreach Program or Canadian Prenatal Nutrition Program Facilitator</td>
<td>18</td>
<td>20.9%</td>
</tr>
<tr>
<td>Home-visitor or Outreach Worker</td>
<td>16</td>
<td>18.6%</td>
</tr>
<tr>
<td>Aboriginal Infant Development Program (AIDP) Staff</td>
<td>12</td>
<td>14.0%</td>
</tr>
<tr>
<td>Other*</td>
<td>10</td>
<td>11.6%</td>
</tr>
<tr>
<td>Maternal Child Health Worker**</td>
<td>5</td>
<td>5.8%</td>
</tr>
<tr>
<td>Community Health Nurse (on-reserve)</td>
<td>3</td>
<td>3.5%</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>2</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>86</td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

* Other included positions such as FASD Worker; Program Coordinator; Nutritionist and Lactation Consultant; Child and Youth Mental Health Clinician; Community Health Representative; Early Childhood Educator; Comprehensive Community Planner; Childcare Manager.
**This was not one of the hard codes provided; this response was coded from open-ended descriptions provided.

According to Chart 3.1, slightly fewer than one in ten service providers surveyed (9.3%) have been working in their position for less than one year. Nearly one third of respondents (30.2%) have worked in their position for ten years or more and an additional 23.3% for five to ten years.

<table>
<thead>
<tr>
<th>Count</th>
<th>Percentage of Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.3%</td>
<td>Less than one year</td>
</tr>
<tr>
<td>12.8%</td>
<td>One to two years</td>
</tr>
<tr>
<td>24.4%</td>
<td>Two to five years</td>
</tr>
<tr>
<td>23.3%</td>
<td>Five to ten years</td>
</tr>
<tr>
<td>30.2%</td>
<td>Ten years or more</td>
</tr>
</tbody>
</table>

As presented in Table 3.3, the largest proportion of survey responses were from service providers working in the region of Island Health (39.5%) followed by Northern Health (26.7%).
Table 3.3: Responses by Health Authority Region

<table>
<thead>
<tr>
<th>Health Authority Region</th>
<th>Count</th>
<th>Percentage of Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Island Health</td>
<td>34</td>
<td>39.5%</td>
</tr>
<tr>
<td>Northern Health</td>
<td>23</td>
<td>26.7%</td>
</tr>
<tr>
<td>Interior Health</td>
<td>12</td>
<td>14.0%</td>
</tr>
<tr>
<td>Vancouver Coastal Health</td>
<td>10</td>
<td>11.6%</td>
</tr>
<tr>
<td>Fraser Health</td>
<td>6</td>
<td>7.0%</td>
</tr>
<tr>
<td>Northern &amp; Interior Health</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

When comparing the proportion of survey responses by health authority region to the proportion of the total provincial Aboriginal population by health authority (based on the 2006 Census), as illustrated in Chart 3.2, the main discrepancy is that Island Health had the largest proportion of survey completions, whereas the Aboriginal population of Island Health ranks third largest as a percent of the total provincial Aboriginal population (20.7%). One possible explanation for the higher proportion of responses is that Island Health was the only health authority with representation on the Aboriginal Safe Sleep Working Group. This could have resulted in additional promotion of the survey among staff in this region. The other notable variation is that of Fraser Health. Fraser Health contributed to the smallest proportion of survey completions, whereas its Aboriginal population is the fourth largest in the province, only slightly smaller than that of Interior Health. There are many variables that could have contributed to discrepancies between the proportions of survey completions and the size of the Aboriginal populations by health authority, these could include but may not be limited to staff engagement, the use of email among service providers, and survey fatigue (other surveys being administered to staff in certain regions).

Chart 3.2: Survey Completions and Aboriginal Population by Health Authority Region

More than seven out of ten service providers describe the population that they serve as either urban (37.2%) or a mix of urban and rural (36.0%). Slightly more survey respondents identify as serving remote/isolated populations (14.0%) than mainly rural populations (10.5%), although two respondents indicated that they serve both rural and remote/isolated populations (2.3%). Chart 3.3 illustrates the proportion of respondents working in the region of each health authority that serve each population type.

**Chart 3.3: Health Authority by Description of Population Served**

As is evidenced in Chart 3.3, the populations served by those who responded to the survey varied by health authority region:

- There was a roughly even distribution of service providers within the Northern Health region who work with remote/isolated, mainly urban and a mix of urban and rural populations. A slightly smaller proportion who work with mainly rural and less than 5% who work with rural and remote/isolated populations.
- Two-thirds of service providers that responded to the survey from Interior Health work with mainly urban populations. The remainder work with mainly rural or a mix of urban and rural.
- Half of the service providers in the Island Health region reported working with a mix of urban and rural populations with one third who work with mainly urban populations. Slightly more than 10% report working with mainly rural and approximately half as many report working with mainly rural populations.
- Half of service providers working in the Vancouver Coastal region reported working with mainly urban populations while 40% reported working with remote/isolated populations. The remaining 10% reported a mix of urban and rural.
- Two-thirds of service providers in the Fraser Health region reported working with a mix of urban and rural populations while the remainder reported either mainly urban or rural and remote/isolated.

*N=86, however one respondent reported working with populations in both Northern and Interior Health. This respondent was included in both the Northern Health and Interior Health data provided above.*
As illustrated in Chart 3.4, approximately six out of ten (59.3%) survey respondents work off-reserve while an additional 12.8% work both on- and off-reserve. Slightly more than one quarter of all respondents (26.7%) work on-reserve.

![Chart 3.4: Proportion of Respondents who Work On-/Off- Reserve](image)

Nearly half (47.8%) of service providers who indicated that they work with on-reserve populations were located within the Island Health region while nearly one third (30.4%) worked within Northern Health.

The proportion of service providers who work mostly with on- or off-reserve populations varied by health authority region:

- Interior (91.7%) and Northern Health (69.6%) regions respondents were more likely to work with off-reserve populations.

- Approximately half of respondents from Island Health (44.1%), Vancouver Coastal Health (50.0%) and Fraser Health (50.0%) regions serve off-reserve populations with the remainder serving either on-reserve or a mix of on- and off-reserve.

### 3.3 Current Practices of Discussing Safe Infant Sleep

According to Chart 3.5, slightly less than half (45.4%) of respondents reported providing information related to safe infant sleep to Aboriginal families with or expecting a child most (29.1%), or all of the time (16.3%). One third (33.7%) of respondents indicated that they sometimes or occasionally provide information, while approximately two out of ten (21.0%) reported doing so rarely (14.0%) or never (7.0%).

![Chart 3.5: Frequency of Which Service Providers Provide Information Related to Safe Infant Sleep to Aboriginal Families](image)
According to Chart 3.6, service providers in the Fraser Health Authority region were most likely (66.7%) to report providing safe infant sleep information to parents/families all or most of the time followed by those working the Vancouver Coastal Health region (60.0%). The Interior Health region had the highest proportion of service providers that indicated that they rarely or never provide safe infant sleep information to parents and families (33.3%) followed by Northern Health (27.7%).

Chart 3.6: Frequency of Which Service Providers Provide Information Related to Safe Infant Sleep to Aboriginal Families by Health Authority Region

As illustrated in Chart 3.7, service providers who work with on-reserve families (52.1%) were more likely than those working with off-reserve families (35.3%) to report providing information to families most or all of the time. However, those who indicated that they work with both on- and off-reserve families were most likely to report providing this information all or most of the time (81.8%). Service providers who reported working only with off-reserve families were most likely to report (25.4%) rarely or never sharing this information.

Chart 3.7: Frequency with Which Service Providers Provide Information Related to Safe Infant Sleep to Aboriginal Families by On/Off Reserve
As presented in Chart 3.8, service providers working with remote/isolated populations were more likely to report that they provide information related to safe infant sleep to Aboriginal families with or expecting a child all of the time (35.7%), whereas service providers who work with mainly urban families were the only group to identify as never providing this type of information (17.1%).

Chart 3.8: Frequency with Which Service Providers Provide Information Related to Safe Infant Sleep to Aboriginal Families by Population Served

As illustrated in Chart 3.9, Community Health Nurses working on-reserve were the occupational category who reported providing information related to safe infant sleep to Aboriginal families the most frequently. Other positions who reported providing this information all or most of the time included Aboriginal Infant Development Program (AIDP) Staff (75%), Pregnancy Outreach Program (POP) and Canadian Prenatal Nutrition Program (CPNP) Facilitators (72.2%) and Maternal Child Health Workers (60.0%). Public Health Nurses and Staff at Aboriginal Friendship Centres were least likely to report providing this information.

Chart 3.9: Frequency with Which Service Providers Provide Information Related to Safe Infant Sleep to Aboriginal Families by Position
The six service providers who reported never providing information related to safe infant sleep to Aboriginal families selected the following reasons as to why they did not provide this information:

- There are different opinions about safe sleep practices and I am unsure which information to give (n=4);
- I do not have resources, materials, or tools to support me (n=1); or
- There are other people whose job it is to talk to parents about these issues (n=1).

Service providers were asked to provide the most important points about safe infant sleep that they talk about with families. A total of 75 survey respondents listed important points that they share. More than one quarter (26.7%) of service providers listed eight important points about safe infant sleep that they share with families, an additional 22.6% provided six or seven points, 27.3% provided four or five important points and 13.3% shared one to three important points about safe sleep.

When all of the important safe sleep points listed by all providers are aggregated, the top two important points about safe sleep that service providers report sharing with families relate to:

- Having a firm surface with a tight-fitting sheet and/or no bumper pads, pillows, heavy blankets or toys (76.3%); and
- Sleep position (72.4%). The phrase "Back is Best" was used by many of those who cited sleep position as being important information that they share.

The next four most frequently cited pieces of information about safe sleep that service providers report sharing with families is with respect to:

- Having a smoke-free environment during and/or after pregnancy (32.9%);
- Baby sleeping in their own crib (32.9%);
- The risk of babies overheating (28.9%); and
- The risks of bed-sharing when impaired (27.6%).

### 3.4 Current Infant Safe Sleep Resources

#### 3.4.1 Access to Infant Safe Sleep Resources

As illustrated in Chart 3.10, of the service providers who reported that they discuss information related to safe infant sleep with Aboriginal families with or expecting a child, nearly half have access to some resources to help discuss safe infant sleep practices with families (46.9%), while an additional 18.5% say that they have access to many. However, nearly three out of ten service providers have access to very few (23.5%) or none (6.2%). The remaining 4.9% are unsure about their access to resources to help discuss safe infant sleep practices with families.
There were some variations noted by service providers in their access to resources depending on the populations with whom they work. Refer to Appendix V for an illustration of these findings.

- Service providers working in the Northern Health (39.1%) region were most likely to report having access to very few or no resources, followed by those in the Island Health region (31.3%) and those the Vancouver Coastal Health region (22.2%). However, Vancouver Coastal service providers (44.4%) were most likely to report having access to many. Interior Health (77.8%) and Fraser Health (66.7%) service providers were most likely to indicate having access to some resources.

- Service providers working off-reserve were 3.7% more likely than those off-reserve to say that they have access to many resources and 8.2% more likely to report having some. Service providers working with on-reserve populations were half as likely as those working with off-reserve populations to report having access to very few or no resources.

- Approximately two thirds of service providers working in a mix of urban and rural (67.7%), mainly rural (66.6%) and mainly urban (62.1%) areas reported having access to many or some resources. While service providers working in remote/isolate areas were approximately half as likely to report having access to some resources (21.4%), service providers in these areas had the largest proportion of respondents who indicated having access to many resources (35.7%).

- Staff at Aboriginal Friendship Centres were least likely to indicate having access to many or some resources (35.3%), compared to service providers in other positions.

### 3.4.2 Use of Infant Safe Sleep Resources

As illustrated in the Chart 3.11, approximately three quarters of service providers who discuss infant safe sleep information with families and have access to resources use them always (23.9%) or some of the time (47.9%). One quarter of service providers (25.4%) rarely use the resources that they have access to and a small proportion (2.8%) never use them.
As presented in the Chart 3.12, of the service providers who have many resources, two thirds (66.7%) reported always using them when discussing safe sleep with families while the remaining one third (33.3%) reported using them some of the time. As the reported access to resources decreases, so too does the frequency that service providers use resources when discussing safe sleep with families.

Chart 3.13 shows that the proportion of service providers who always use resources is highest among those who reported that the resources they have access to are culturally relevant to Aboriginal families. Conversely, those who do not believe that the resources they have access to are culturally relevant are more likely to report rarely using the resources when discussing infant safe sleep with families.
There were some variations noted by service providers in their use of resources depending on the populations with whom they work. Refer to Appendix V for an illustration of these findings.

- Service providers in Island Health were most likely to report always using the resources that they have access to (32.1%), however more than three quarters of those in Interior Health (77.8%) and Fraser Health (80.0%) report using the tools sometimes. Service providers in Northern Health were least likely to use the tools that they have access to (36.9% reported rarely or never).

- Service providers working with mainly rural populations had the highest proportion of respondents who indicated that they use the tools always or sometimes (88.9%), as compared to those working with remote/isolated (61.6%) or urban populations (78.3%); however those working with mainly rural populations also had the highest proportion of service providers who reported never using the resources (11.1%).

- The frequency of use did not appear to vary between those working with families on- or off-reserve.

- Public Health Nurses all reported always using the resources when discussing safe sleep with families (100.0%); conversely half of staff at Aboriginal Friendship Centres (50.0%) reported rarely using the tools. Home-visitor or outreach workers also had a high proportion of respondents who indicated that they rarely or never use the resources included home-visitor or outreach workers (42.8%).

### 3.4.3 Cultural Relevance of Current Resources

Nearly one third (32.4%) of service providers believed that the safe sleep resources that they had access to are not culturally relevant to Aboriginal families while only 14.1% felt that the resources were culturally relevant to Aboriginal families.
There were some variations noted by service providers in the perceived cultural relevance of the tools available depending on the populations with whom they work. Refer to Appendix V for an illustration of these findings.

- Perceived cultural relevance does not vary noticeably by health authority region; however, Northern Health and Fraser Health regions respondents were most likely to believe that the resources are culturally relevant (one fifth), whereas the Interior Health region was the only region in which no respondent reported that the tools that they have access to are culturally relevant and were most likely to say that they are not (44.4%); the remaining 55.6% reported that they were somewhat culturally relevant.

- Service providers working with remote/isolate communities were most likely to report that the tools that they have access to are culturally relevant (38.5%), whereas those working with mainly urban populations were least likely to feel this way (8.7%).

- Nearly twice as many service providers who work with off-reserve populations (41.5%) as on-reserve populations (22.2%) believe that the safe sleep resources that they have access to are not culturally relevant to Aboriginal families.

- Home-Visitors and Outreach Workers were most likely to report that the resources that they have access to are not culturally relevant (50.0%), followed by Aboriginal Infant Development Program Staff (40.0%).

Service providers are more likely to report always using safe sleep resources when discussing safe sleep with families if they believe that the resources are culturally relevant to Aboriginal families. As presented in the Chart 3.15, half (50%) of those who believe the resources they have access to are culturally relevant report always using them, while 31.3% of those who feel the tools are somewhat relevant and 8.7% who say they are not relevant report always using them.
3.4.4 Adequacy of Current Resources

As presented in Table 3.4, only one in ten (9.9%) service providers with access to resources felt that they met their needs, while six in ten (59.2%) felt that they somewhat met their needs. The remaining two out of ten service providers felt that the infant safe sleep resources they had access to did not meet their needs very well (18.3%) or at all (5.6%).

Table 3.4: Extent to Which Safe Sleep Resources Meet Service Provider Need

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely</td>
<td>7</td>
<td>9.9%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>42</td>
<td>59.2%</td>
</tr>
<tr>
<td>Not very well</td>
<td>13</td>
<td>18.3%</td>
</tr>
<tr>
<td>Not at all</td>
<td>4</td>
<td>5.6%</td>
</tr>
<tr>
<td>Unsure</td>
<td>5</td>
<td>7.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*N=71, excludes 6 respondents who indicated that they never provide information related to safe infant sleep to Aboriginal families with or expecting a child, 5 respondents who said they do not currently have access to resources to help them discuss infant sleep practices with family and 4 respondents who were unsure if they have access to resources.*

As illustrated in Chart 3.16, the extent to which safe sleep resources that service providers have access to meet their needs is highest among those service providers who reported that the resources that they have access to are culturally relevant for Aboriginal families. Resources are less likely to meet the needs of service providers who do not believe that the resources they have access to are culturally relevant.
As presented in Chart 3.17, those working in the Fraser Health region (40.0%) were most likely to indicate that the safe sleep resources that they have access to meet their needs, followed by those working in the Interior Health region (22.2%). Although only 5.3% of service providers from Northern Health completely agreed with this statement, more than two thirds (68.4%) somewhat agreed, as did two thirds of those working in Interior Health (66.7%). Service providers working in the Vancouver Coastal Health region were least satisfied with the extent to which the resources that they have access to meet their needs with one third (33.3%) saying that they did not meet their needs very well and an additional 11.1% reporting not at all. Similarly one quarter (25.0%) of those working in the Island Health region believed that the resources they have access to did not meet their needs very well with an additional 3.6% who believed they did not meet their needs at all.

**Chart 3.17: Extent to Which Resources Meet Needs by Health Authority**
As illustrated in the Chart 3.18, those working with off-reserve populations were more likely to report that the resources they had access to met their needs completely (12.2%) than those working with on-reserve populations (5.6%). Those off-reserve, however, were slightly more likely to report that the resources did not meet their needs at all (7.3%) as compared to those on-reserve (5.6%).

Service providers were asked to explain why the safe sleep resources did or did not meet their needs. A total of 32 out of the 71 respondents provided a comment explaining their response.

- Two of the seven respondents who reported that the safe sleep resources met their needs completely provided an explanation. These service providers reported that the resources they had were clear and concise; and that the information was useful for new mothers who might not know what to expect.

- Twenty-eight out of 42 service providers who indicated the resources somewhat met their needs provided further information. Many of these respondents indicated that the resources lacked cultural sensitivity for Aboriginal families (e.g., did not reflect housing challenges, cultural practices of swaddling or co-sleeping; did not include pictures of Aboriginal parents/children); and that resources should be developed to accommodate low literacy levels (should include pamphlets with pictures and simple key messages).

- Twelve of the 13 respondents who reported that the resources did not meet their needs very well and three out of the four who said they did not meet their needs at all provided an explanation. Several of these service providers felt that it should be recognized that some parents choose to co-sleep and that resources about safer co-sleeping are required; similarly others felt that safe sleep resources were too “black and white” simply telling parents what they should do and not recognizing the “grey areas”. Additionally it was felt that tools could be more relevant specifically for Aboriginal families. Others who rated the extent to which the resources they have access to meet their needs as not very well or not at all attributed this to a lack of resources.
3.5 SIDS AWARENESS

All service providers surveyed (100.0%) reported having heard of Sudden Infant Death Syndrome (SIDS); however, only 86% of respondents reported that there are actions that families can take to reduce the risk of SIDS. A very small proportion (2.3%) said that there are no actions that families can take to reduce the risk of SIDS, while the remaining 11.6% reported that they were unsure.

There were some variations observed by service providers regarding whether actions could be taken to prevent the risk of SIDS, depending on the populations with whom they worked. Refer to Appendix V for an illustration of these findings.

- Those working in the Northern Health region were most likely to be unsure (21.7%) if actions could be taken, followed by Interior Health (16.7%) and Island Health (8.8%). All of the service providers who responded to the survey working in the Vancouver Coastal Health and Fraser Health regions indicated that actions can be taken.
- Service providers working with remote/isolated populations had the largest proportion (21.4%) who were unsure if actions could be taken, and the smallest proportion (71.4%) who are aware that there are actions that families can take.
- Service providers working with on-reserve populations were twice as likely (21.7%) as those working with off-reserve families (9.8%) to be unsure if actions could be taken to prevent the risk of SIDS.
- Maternal Child Health Workers were most likely to be unsure (40.0%) as to whether or not families could take actions to reduce the risk of SIDS, followed by staff at Aboriginal Friendship Centers (20.0%). An additional 5.0% of staff at Aboriginal Friendship Centers reported that there are no actions that could be taken to reduce the risk of SIDS.

3.5.1 Protective Factors

Protective factors refer to those practices that have been identified to be protective against SIDS (Perinatal Services BC, 2011). When asked about risk and protective factors, all but one service provider surveyed (98.8%) believed that exposing a baby to second hand smoke increases their risk of SIDS; the remaining respondent was unsure about the associated risk.

Chart 3.19: Service Provider Knowledge and Perception of Protective Factors for SIDS

Of the protective factors listed, nearly nine out of ten (87.2%) service providers believed that placing a baby on their back to sleep decreases their risk; however, 8.1% reported that this would increase their risk. Breastfeeding babies is understood as decreasing risk by 69.8% of service providers although nearly one in five did not feel that it had any effect on risk.
3.5.2 Risk Factors

Risk factors refer to those practices that have been identified as putting a child at risk of SIDS (Perinatal Services BC, 2011).

More than nine out of ten service providers felt that the following situations would increase a baby's risk of SIDS:

- Smoking while pregnant (93.0%);
- Baby put to sleep on his/her tummy (91.9%); and
- Babies sleeping in areas where there are loose blankets, pillows, stuffed animals, toys, or bumper pads (90.7%).

Where and with whom a baby sleeps were factors perceived as having less of an effect on a baby's risk of SIDS:

- Although a protective factor, 32.6% of service providers believed that there is no effect on a baby's risk if they sleep in the same room as their parent(s);
- Furthermore, 20.0% of service providers felt that a baby sleeping in the same bed as others does not have an effect on their risk for SIDS.

This could be a result of the different opinions that exist with regards to co-sleeping and the risks/benefits to co-sleeping. Some comments in the survey spoke to the benefits of co-sleeping and frustration that co-sleeping is being portrayed in a negative light.

Of the risk factors presented, service providers were most unsure (22.1%) about the effect overheating while sleeping has on the risk of SIDS, followed by bed-sharing (11.6%), as presented in Chart 3.20.

**Chart 3.20: Service Provider Knowledge and Perception of Risk Factors for SIDS**
3.6 Recommendations for Follow-up Data Collection

The following four recommendation areas have been prepared based on experiences and knowledge gleaned through the implementation and analysis of the baseline survey.

#1 - Developing a List of Service Providers Trained on the Toolkit
It is recommended that when training is provided for the toolkit, organizations or the Aboriginal Infant Safe Sleep Working Group endeavor to collect a list of those service providers participating in the training and collect their consent to be contacted in the future for participation in a focus group and/or participation in a follow-up survey. This list could then be used to identify participants for Phase II of the evaluation.

#2 - Calculating the Response Rate by Service Provider Group
In the Baseline Service Provider Survey, question 14 asked respondents to select from a list, or provide their own response, to best describe their current position/job title. This information provided, however, only allows for the assumption of which positions are affiliated with each of the five target populations (i.e., Maternal Child Health Program Staff, Fetal Alcohol Spectrum Disorder Program Staff, Pregnancy Outreach Program and Canadian Prenatal Nutrition Program facilitators, Aboriginal Friendship Centre Staff, or Aboriginal Infant Child Development Program Staff). Therefore, it was not possible to calculate the response rate by service provider group (organization) for the baseline survey. It is recommended that this question be revisited for the follow-up survey. Adding a question asking respondents through which organization they received email invitation to participate would address this challenge; this question has been included in the draft follow-up survey (Appendix III, question 19).

#3 - Follow-up Survey Screening Questions
As described in Section 2 of this report, the second phase of the evaluation will involve the administration of a follow-up survey targeting those service providers who have access to and/or have used the new toolkit developed by the Aboriginal Safe Sleep Working Group. Therefore a screening question should be added to the beginning of the survey asking respondents to identify their exposure/use of the toolkit (included in the draft follow-up survey, Appendix III, questions 5a and 6) and to indicate whether or not they also participated in the baseline survey (included in the draft follow-up survey, Appendix III question 20).

#4 - Additional Focus Areas
Some of the open-ended responses provided in the survey reflected the different opinions that exist with regards to co-sleeping and the risks/benefits to co-sleeping; specifically stating that parents should not be dissuaded to co-sleep with their infant and/or should be encouraged to co-sleep with their child. It is recommended that this issue be further explored and additional messaging be provided on this issue.
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APPENDIX I: BASELINE SERVICE PROVIDER SURVEY

SAFE SLEEP FOR ABORIGINAL BABIES
SERVICE PROVIDER SURVEY

A Safe Sleep Initiative of the First Nations and Aboriginal Maternal and Child Health Strategy Area

Note: The survey will be programmed into Fluid Survey for online survey delivery.

The purpose of this survey is to better understand the current practices of discussing safe infant sleep with Aboriginal families, either on- or off-reserve. This survey is intended for people who in their current roles would have an opportunity to discuss safe infant sleep practices with Aboriginal families.

Your participation will help to inform a new, culturally relevant, safe sleep training tool that will be distributed to programs and services across the province.

CURRENT PRACTICES OF DISCUSSING SAFE INFANT SLEEP

1. In general, how often do you provide information or guidance related to safe infant sleep to Aboriginal families with or expecting a child?

   ☐ All the time (to 100% of families)    ☐ Occasionally (to 25-49% of families)
   ☐ Most of the time (to 75-99% of families)    ☐ Rarely (to 1-24% of families)
   ☐ Sometimes (to 50-74% of families)    ☐ Never (0% of families)

   [Programming Note: If Q1 = Never, Ask Q2 and then Skip to Q8]
   [Programming Note: If Q1 ≠ Never, Skip to Q3]

2. What is the reason(s) that you do not provide information or guidance to families about safe infant sleep practices? Please select all that apply.

   ☐ I do not have contact with parents/caregivers of babies.
   ☐ There are different opinions about safe sleep practices, I am not sure what information, guidance or recommendations to give.
   ☐ I do not have any resources, materials, or tools to support me.
   ☐ Not all families are at risk.
   ☐ Where babies sleep is not my concern; it is solely up to the parents to decide.
   ☐ I do not think that it is an important issue/big concern.
   ☐ I do not have time.
   ☐ There are other people whose job it is to talk to parents about these issues.
   ☐ Other, please describe: ________________________________
3. **What are the most important points about safe sleep that you share with families?**
   Please list as many as you want.
   1. ____________________________________________________________
   2. ____________________________________________________________
   3. ____________________________________________________________
   4. ____________________________________________________________
   5. ____________________________________________________________
   6. ____________________________________________________________
   7. ____________________________________________________________
   8. ____________________________________________________________
   □ I am not sure.

4. **Do you currently have access to resources (including materials or tools) to help you discuss safe infant sleep practices with families?**
   □ Yes, many □ Yes, some □ Very few □ None □ Unsure

   *Programming Note: If Q4 = None or Unsure Skip to Q8*

5. **How often do you use the resources when discussing safe sleep with families?**
   □ Always □ Sometimes □ Rarely □ Never

6. **Do you believe the safe sleep resources that you have access to, are culturally relevant to Aboriginal families?**
   □ Yes □ Somewhat □ No □ Unsure

7. **In your opinion, do the safe sleep resources you have access to meet your needs?**
   □ Completely □ Somewhat □ Not very well □ Not at all □ Unsure

   Why or why not? _____________________________________________________________
   _____________________________________________________________

**SUDDEN INFANT DEATH SYNDROME (SIDS)**

Sudden infant death syndrome (SIDS) is the death of a baby under one year of age which is sudden, unexpected and without a clear cause. SIDS usually happens during sleep or napping.

8. **Have you ever heard of Sudden Infant Death Syndrome (SIDS)?**
   □ Yes □ No □ I am not sure

9. **As far as you know, are there actions that families can take to reduce the risk of SIDS?**
   □ Yes □ No □ I am not sure
10. To the best of your knowledge, do the following situations raise or lower a baby’s risk of SIDS?

<table>
<thead>
<tr>
<th>Situation</th>
<th>Increases Risk</th>
<th>Decreases Risk</th>
<th>No Effect on Risk</th>
<th>I am not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby put to sleep on his/her back</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Baby put to sleep on his/her tummy</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Smoking while pregnant</td>
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<td>☐</td>
</tr>
<tr>
<td>Being around second hand smoke when pregnant</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A baby being around second hand smoke</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Babies sleeping in the same room as parents but on their own surface</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(crib, bassinette, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Babies sleeping in the same bed as others (parents or siblings)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Breastfeeding babies</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Babies overheating (becoming too warm) while sleeping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Putting babies to sleep on soft surfaces like adult mattresses, couches,</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>sheepskins, etc.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Babies sleeping in areas where there are loose blankets, pillows,</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>stuffed animals, toys, or bumper pads</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**BASIC INFORMATION ABOUT YOUR PROGRAM OR SERVICE**

To finish the survey, the last few questions are about your program or service. This information will help us better understand who is discussing safe infant sleep with Aboriginal families.

11. Do you work mostly: ☐ On-reserve ☐ Off-reserve
12. How would you describe the population that you serve?
*Please choose all that apply.*
- [ ] Mainly urban
- [ ] Mainly rural
- [ ] A mix of urban and rural
- [ ] Remote/Isolated
- [ ] Other, please describe: ______________________________

13. In which health authority region do you work?
- [ ] Northern Health
- [ ] Vancouver Coastal Health
- [ ] Interior Health
- [ ] Fraser Health
- [ ] Vancouver Island Health Authority
- [ ] Unsure

14. Which of the following best describes your position?
- [ ] Community Health Nurse (on-reserve)
- [ ] Home-visitor or Outreach Worker
- [ ] Public Health Nurse
- [ ] Staff at an Aboriginal Friendship Center
- [ ] Pregnancy Outreach Program or Canadian Prenatal Nutrition Program Facilitator
- [ ] Other, please describe: ______________________________

15. How long have you been working in your current position?
- [ ] Less than one year
- [ ] Five to ten years
- [ ] One to two years
- [ ] Ten years or more
- [ ] Two to five years
- [ ] I am not sure

16. Are you: [ ] Male  [ ] Female

### ADDITIONAL COMMENTS

If you have any comments or suggestions about this survey or about safe infant sleep, please use the space below.

**Thank you for completing the survey!**

Your participation will help to improve resources to promote safe sleep practices.
APPENDIX II: THANK YOU HANDOUT

This handout is made available to survey respondents once they have submitted their survey responses so as not to influence their responses to the survey.

SAFE SLEEP FOR ABORIGINAL BABIES

Thank you for completing the survey!

Every sleep counts!
Nap time, night time, home or away

Sudden Infant Death Syndrome (SIDS) is the death of an infant under one year of age which is sudden and unexpected and without a clear cause.

SAFE SLEEP TIPS

Baby is safest when:

- Placed on his/her back for every sleep.
- The sleep surface is firm, flat, and separate from other sleepers.
- The baby's environment is smoke-free during pregnancy and after birth.
- A crib, cradle, or bassinet is used that has a firm mattress, a tight-fitting sheet and no bumper pads, pillows, heavy blankets or toys.
- The crib is placed beside the parents' bed for the first six months (called 'room-sharing').
- The baby does not share the same bed as others for sleeping, as 'bed-sharing' has been linked to SIDS.
- The baby is breastfed. Breastfeeding your baby can help protect him/her against SIDS.
- The baby does not over-heat.
- The baby does not sleep on a sheepskin, pillow-top mattress, waterbed, couch, sofa, armchair, recliner, or any adult bed.

If you do not have access to a crib, cradle or bassinet, other safe sleep surfaces could include:

- Traditional cradleboard placed flat on the floor (only use a light blanket and do not swaddle the baby),
- Sturdy, laundry-type basket with a smooth, firm bottom,
- Heavy, reinforced cardboard box or carton with an open top (no lid),
- Dresser, kitchen or desk drawer placed flat on the floor, or
- Metal or plastic basin with a flat bottom, such as a washtub.

For more information about infant safe sleep practices talk to your doctor, midwife, or a community health nurse.

You can also access information online at:

The Best Chance Website
http://www.bestchance.gov.bc.ca/you-and-your-baby-0-6/caring-for-your-baby

Prepared on Behalf of the Aboriginal Safe Sleep Working Group
APPENDIX III: DRAFT FOLLOW-UP SERVICE PROVIDER SURVEY

SAFE SLEEP FOR ABORIGINAL BABIES
FOLLOW-UP SERVICE PROVIDER SURVEY

A Safe Sleep Initiative of the First Nations and Aboriginal Maternal and Child Health Strategy Area

The purpose of this survey is to better understand how service provider access to tools and infant safe sleep knowledge may have changed as a result of the Honoring our Babies toolkit that was launched in the fall of 2013. This survey is intended for people who in their current roles have an opportunity to discuss safe infant sleep practices with Aboriginal families on- or off-reserve.

Your participation will help to evaluate the Honoring our Babies toolkit, specifically this survey will help provide and understanding about whether or not service providers know about the toolkit, if the toolkit is being used, how useful the toolkit is, and to collect information about the current levels of knowledge regarding key infant safe sleep practices among service providers.

CURRENT PRACTICES OF DISCUSSING SAFE INFANT SLEEP

1. In general, how often do you provide information or guidance related to safe infant sleep to Aboriginal families with or expecting a child?

- All the time (to 100% of families)
- Occasionally (to 25-49% of families)
- Most of the time (to 75-99% of families)
- Rarely (to 1-24% of families)
- Sometimes (to 50-74% of families)
- Never (0% of families)

[Programming Note: If Q1 = Never, Ask Q2 and then terminate]
[Programming Note: If Q1 ≠ Never, Skip to Q3]

2. What is the reason(s) that you do not provide information or guidance to families about safe infant sleep practices? Please select all that apply.

- I do not have contact with parents/caregivers of babies.
- There are different opinions about safe sleep practices, I am not sure what information, guidance or recommendations to give.
- I do not have any resources, materials, or tools to support me.
- Not all families are at risk.
- Where babies sleep is not my concern; it is solely up to the parents to decide.
- I do not think that it is an important issue/big concern.
- I do not have time.
- There are other people whose job it is to talk to parents about these issues.
- Other, please describe: ________________________________
3. What are the most important points about safe sleep that you share with families?
   Please list up to five.
   1. ____________________________________________
   2. ____________________________________________
   3. ____________________________________________
   4. ____________________________________________
   5. ____________________________________________
   ☐ I am not sure.

Use of the Honoring our Babies Toolkit

On October 15, 2013 a set of training tools became available called “Honoring our Babies: Safe Sleep Cards and Guide”. The Honoring our Babies toolkit included a deck of 21 discussion cards and 7 illustrated cards for use by service providers and/or community volunteers to prompt and guide discussions with families about safe infant sleep, as well as a Facilitator’s Guide to provide a greater degree of information on each card’s topic.

4. a) Have you ever heard about the Honoring our Babies toolkit?
   ☐ Yes ☐ No ☐ I am not sure

[Programming Note: If Q4a = No or Unsure, then Skip to Q9]

   b) How have you heard about the Honoring our Babies toolkit? Please select all that apply.
   ☐ Received a hard copy set of the toolkit
   ☐ Word of mouth (colleague)
   ☐ Communication from the UBC Learning Circle (email)
   ☐ Communication from the First Nations Health Authority (email, Internet site)
   ☐ Other, please describe: ________________________________

5. a) Have you ever used the Honoring our Babies toolkit?
   ☐ Yes ☐ No ☐ I am not sure

[Programming Note: If Q5a = Yes, then Skip to Q6]

[Programming Note: If Q5a = No or I am not sure ask Q5b and then Skip to Q9]

   b) Please explain why you have never used the toolkit.
   ___________________________________________________________________
   ___________________________________________________________________

6. How often do you use or refer to the Honoring our Babies toolkit when discussing infant safe sleep with Aboriginal families with or expecting a child?
   ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

7. Do you believe that the Honoring our Babies toolkit is culturally relevant to Aboriginal families?
   ☐ Yes ☐ Somewhat ☐ No ☐ Unsure
8. In your opinion, to what extent does the Honoring our Babies toolkit meet your needs?

- [ ] Completely
- [ ] Somewhat
- [ ] Not very well
- [ ] Not at all
- [ ] Unsure

Why or why not? 
________________________________________________________________________________
________________________________________________________________________________

9. Overall, how satisfied are you with your access to resources (including materials or tools) to help you discuss safe infant sleep practices with families?

- [ ] Very Satisfied – I have access to enough resources
- [ ] Satisfied – I have access to some resources
- [ ] Dissatisfied – I have access to very few resources
- [ ] Very Dissatisfied – I do not have access to adequate resources

SUDDEN INFANT DEATH SYNDROME (SIDS)

Sudden infant death syndrome (SIDS) is the death of a baby under one year of age which is sudden, unexpected and without a clear cause. SIDS usually happens during sleep or napping.

10. Have you ever heard of Sudden Infant Death Syndrome (SIDS)?

- [ ] Yes
- [ ] No
- [ ] I am not sure

11. As far as you know, are there actions that families can take to reduce the risk of SIDS?

- [ ] Yes
- [ ] No
- [ ] I am not sure

12. To the best of your knowledge, do the following situations raise or lower a baby’s risk of SIDS?

<table>
<thead>
<tr>
<th>Situation</th>
<th>Increases Risk</th>
<th>Decreases Risk</th>
<th>No Effect on Risk</th>
<th>I am not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby put to sleep on his/her back</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Baby put to sleep on his/her tummy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Smoking while pregnant</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Being around second hand smoke when pregnant</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A baby being around second hand smoke</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Babies sleeping in the same room as parents but on their own surface (crib, bassinette, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### Evaluation Framework and Report on the Baseline Survey of Service Providers

<table>
<thead>
<tr>
<th>Increases Risk</th>
<th>Decreases Risk</th>
<th>No Effect on Risk</th>
<th>I am not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies sleeping in the same bed as others (parents or siblings)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Breastfeeding babies</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Babies overheating (becoming too warm) while sleeping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Putting babies to sleep on soft surfaces like adult mattresses, couches, sheepskins, etc.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Babies sleeping in areas where there are loose blankets, pillows, stuffed animals, toys, or bumper pads</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### BASIC INFORMATION ABOUT YOUR PROGRAM OR SERVICE

To finish the survey, the last few questions are about your program or service. This information will help us better understand who is discussing safe infant sleep with Aboriginal families.

13. **Do you work mostly:**
   - ☐ On-reserve
   - ☐ Off-reserve

14. **How would you describe the population that you serve?**
   *Please choose all that apply.*
   - ☐ Mainly urban
   - ☐ Mainly rural
   - ☐ A mix of urban and rural
   - ☐ Remote/Isolated
   - ☐ Other, please describe: ________________________________

15. **In which health authority region do you work?**
   - ☐ Northern Health
   - ☐ Interior Health
   - ☐ Island Health
   - ☐ Vancouver Coastal Health
   - ☐ Fraser Health
   - ☐ Unsure

16. **Which of the following best describes your position?**
   - ☐ Community Health Nurse (on-reserve)
   - ☐ Public Health Nurse
   - ☐ Pregnancy Outreach Program or Canadian Prenatal Nutrition Program Facilitator
   - ☐ Home-visitor or Outreach Worker
   - ☐ Staff at an Aboriginal Friendship Center
   - ☐ Other, please describe: ________________________________
17. **How long have you been working in your current position?**

- [ ] Less than one year
- [ ] One to two years
- [ ] Two to five years
- [ ] Five to ten years
- [ ] Ten years or more
- [ ] I am not sure

18. **Are you:**

- [ ] Male
- [ ] Female
- [ ] No Response

19. **Through which organization did you receive the invitation to participate in this survey?**

- [ ] Maternal Child Health Program
- [ ] Fetal Alcohol Spectrum Disorder Program
- [ ] Aboriginal Friendship Center
- [ ] Fetal Alcohol Spectrum Disorder Program
- [ ] Other, please describe: ________________
- [ ] Pregnancy Outreach Program or Canadian Prenatal Nutrition Program

20. **A similar Survey of Service Providers was circulated in April/May 2013, to better understand practices of discussing safe sleep with Aboriginal families prior to the launch of the Honoring our Babies toolkit. To the best of your recollection did you complete this survey in April/May 2013?**

- [ ] Yes
- [ ] No
- [ ] I am not sure

---

**ADDITIONAL COMMENTS**

If you have any comments or suggestions about this survey or about safe infant sleep, please use the space below.

---

**Thank you for completing the survey!**

Your participation will help to improve resources to promote safe sleep practices.

---

**GROUP DISCUSSION**

A group discussion may be held in your area with service provider in positions to provide infant safe sleep information to families or parents with or expecting a child. Would you be willing to be contacted to see if you would be able to attend a group discussion if one was held in your area?

- [ ] Yes
- [ ] No

*Programming Note: If Yes – Submit survey responses and open up a separate window.*
Please note that any information shared on this page cannot and will not be linked to your survey responses.

Please provide the following information so that we can contact you if there is a group discussion being held in your area.

Name ________________________________________________________________
Telephone ____________________________________________________________
Email _________________________________________________________________
City/Town of Residence ________________________________________________

Thank you for your interest! If a group is held in your area, you will be invited to participate.
APPENDIX IV: DRAFT FOCUS GROUP MODERATOR GUIDE

Welcome [5 minutes]

Thank you very much for coming today. [Moderator to provide brief self-introduction]

You have been asked to come here today to talk about your experiences with the Honoring Our Babies: Safe Sleep Toolkit. The purpose of this group discussion is to hear about what parts of the toolkit have been working well and what might be some areas for improvement. Some of you may have completed a survey about your practices of discussing infant safe sleep with Aboriginal families. The results of the survey and the group discussions we are having will be combined and the results will be provided to [to be identified] to evaluate the Honoring Our Babies: Safe Sleep Toolkit. As someone in a position that provides information or guidance about to safe infant sleep to Aboriginal families with or expecting a child, your feedback is extremely valuable in helping to identify areas that are working well and areas where changes may need to be made.

Before we begin, I would like to remind you that your participation in this group is voluntary. Your decision to participate or not participate in this discussion will in no way affect your job. We will be recording this discussion to make sure that we hear everything you say, but we will only use the recording to assist in writing the final report. When we are finished writing the report, the recordings will be destroyed. Nothing you say will be connected to you personally – that is, your name will not be linked with anything you say. If you do not wish to participate, this will not affect you in any way. Does everyone want to continue?

Today’s discussion should take about one hour.

Remember, there are no wrong answers. I would like everyone to have a chance to talk. I would just like to ask that you talk one at a time so that I do not miss any of what you say and so that what you say is easily understood on the recording. Remember that we are not looking for everyone to agree on any of the topics. If your experience is different than someone else’s, please tell me.

My job is to make sure the talk stays on track and that everyone has a fair chance to tell us their ideas.

Before we begin, are there any questions?

Activity #1: Use of Toolkit [Approximately 35 minutes]

Room setup: There are three poster boards placed around the room. At the top of each poster board is written one of the following: “Most of the Time”, “Some of the Time” or “Not Very Often”.

Moderator to Provide Instruction: I would like you to think about your current practices of discussing infant safe sleep with families. When discussing safe sleep with families, would you say that you use the Honoring Our Babies: Safe Sleep Toolkit most of the time, some of the time or not
very of often? Please take a minute to think about this, when you are ready please get up and go put your sticker on the piece of paper that indicates how often you usually use the toolkit.

**Participants to place stickers on appropriate posters.**

**Moderator to summarize activity results & lead discussion:**

_Focusing on the posters that say “Most of the Time” or “Some of the Time”_

I would like to hear about the circumstances in which you use the *Honoring our Babies Safe Sleep Toolkit*. Please tell me about situations when you decided to use the safe sleep toolkit to provide information or guidance related to infant safe sleep to Aboriginal families with or expecting a child.

**Probes:**

- What was it about the toolkit that made you decide to use it in these situations?
- What did you find worked well when you used the toolkit?
- What parts of the toolkit do families/parents seem to connect with?
- Did you change or adapt the tools at all when you were using them to better meet your needs?

*If cultural appropriateness of the toolkit is mentioned, probe:* What aspects of the toolkit seemed to be most appropriate, or did parents/families seem able to understand or relate to?

_Focusing on the posters that say “Some of the Time” or “Not Very Often”_

Now thinking about circumstances when you do not use the toolkit, what suggestions do you have that would help make the toolkit more useful in these situations?

**Probe:**

- What opportunities exist to make the toolkit something you would use more often?
- What would make you more likely to use the Toolkit with Aboriginal families with or expecting a child in the future?

*If cultural appropriateness of the toolkit is mentioned, probe:* What are the opportunities to make the toolkit more culturally appropriate or to encourage parents/families to relate to the toolkit?

**Activity #2: Impact on Service Provider Practice** [Approximately 20 minutes]

To finish our discussion today I would like to hear about how you feel the *Honoring Our Babies: Safe Sleep Toolkit* has helped, or changed the way in which you discuss safe sleep with Aboriginal families with or expecting a child.

**Probe:**

- What are the biggest changes in how you share information or guidance related to safe infant sleep?
- What changes, if any exist to what safe infant sleep information you share with?

*Note: Specific questions may be added to further explore trends identified in the follow-up survey.*
APPENDIX V: BASELINE SURVEY CROSS TABULATIONS

Q4. Access to Resources by Health Authority Region

<table>
<thead>
<tr>
<th>Health Authority Region</th>
<th>Yes, Many</th>
<th>Yes, Some</th>
<th>Very Few</th>
<th>None</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraser Health</td>
<td>16.7%</td>
<td>16.7%</td>
<td>66.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vancouver Coastal Health</td>
<td>22.2%</td>
<td>33.3%</td>
<td>44.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Island Health</td>
<td>6.3%</td>
<td>6.3%</td>
<td>25.0%</td>
<td>37.5%</td>
<td></td>
</tr>
<tr>
<td>Interior Health</td>
<td>11.1%</td>
<td></td>
<td>16.7%</td>
<td>77.8%</td>
<td></td>
</tr>
<tr>
<td>Northern Health</td>
<td>4.3%</td>
<td>8.7%</td>
<td>30.4%</td>
<td>47.8%</td>
<td></td>
</tr>
</tbody>
</table>

Q4. Access to Resources by Population Type

<table>
<thead>
<tr>
<th>Population Type</th>
<th>Yes, Many</th>
<th>Yes, Some</th>
<th>Very Few</th>
<th>None</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote/Isolated</td>
<td>7.1%</td>
<td>21.4%</td>
<td>35.7%</td>
<td>35.7%</td>
<td></td>
</tr>
<tr>
<td>Mix of Urban and Rural</td>
<td>6.5%</td>
<td>12.9%</td>
<td>25.8%</td>
<td>54.8%</td>
<td></td>
</tr>
<tr>
<td>Mainly Rural</td>
<td>8.3%</td>
<td>8.3%</td>
<td>16.7%</td>
<td>58.3%</td>
<td></td>
</tr>
<tr>
<td>Mainly Urban</td>
<td>17.2%</td>
<td>10.3%</td>
<td>41.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q4. Access to Resources by On-/Off-Reserve

![Bar chart showing access to resources by On-/Off-Reserve with percentages for Yes, Many, Yes, Some, Very Few, None, and Unsure categories.]

Q4. Access to Resources by Position

![Bar chart showing access to resources by position with percentages for AIDP Staff, Staff at Aboriginal Friendship Centre, Home-Visitor or Outreach Worker, POP or CPNP Facilitator, Public Health Nurse, Community Health Nurse (on-reserve), Maternal Child Health Worker, and Other positions with the same categories as above.]

Evaluation Framework and Report on the Baseline Survey of Service Providers
Q4. Access to Resources by Years in Position

<table>
<thead>
<tr>
<th>Years in Position</th>
<th>None</th>
<th>Very Few</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Many</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
<td>14.3%</td>
<td>14.3%</td>
<td>22.2%</td>
<td>25.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>11.1%</td>
<td>4.0%</td>
<td>14.3%</td>
<td>35.0%</td>
<td>44.4%</td>
</tr>
<tr>
<td>2-5 years</td>
<td>15.0%</td>
<td>5.0%</td>
<td>20.0%</td>
<td>28.0%</td>
<td>35.0%</td>
</tr>
<tr>
<td>5-10 years</td>
<td>26.3%</td>
<td>5.3%</td>
<td>20.0%</td>
<td>32.0%</td>
<td>68.4%</td>
</tr>
<tr>
<td>10+ years</td>
<td>52.0%</td>
<td>4.0%</td>
<td>20.0%</td>
<td>25.0%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Q5. Frequency Resources are Used by Health Authority Region

<table>
<thead>
<tr>
<th>Health Authority Region</th>
<th>Always</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraser Health</td>
<td>20.0%</td>
<td>31.6%</td>
<td>22.2%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Vancouver Coastal Health</td>
<td>22.2%</td>
<td>42.1%</td>
<td>22.2%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Island Health</td>
<td>32.1%</td>
<td>28.6%</td>
<td>11.1%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Interior Health</td>
<td>11.1%</td>
<td>32.1%</td>
<td>11.1%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Northern Health</td>
<td>21.1%</td>
<td>42.1%</td>
<td>5.3%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Q5. Frequency Resources are Used by Population Type

<table>
<thead>
<tr>
<th>Population Type</th>
<th>Always</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote/Isolated</td>
<td>38.5%</td>
<td>38.5%</td>
<td>17.2%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Mix of Urban and Rural</td>
<td>48.4%</td>
<td>48.4%</td>
<td>23.1%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Mainly Rural</td>
<td>66.7%</td>
<td>66.7%</td>
<td>22.2%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Mainly Urban</td>
<td>43.5%</td>
<td>43.5%</td>
<td>34.8%</td>
<td>21.7%</td>
</tr>
</tbody>
</table>
Q5. Frequency Resources are Used by On-/Off-Reserve

Q5. Frequency Resources are Used by Position
Q5. Frequency Resources are Used by Years in Position

- **10+ Years**: Always - 17.4%, Sometimes - 30.4%, Rarely - 21.1%, Never - 52.2%
- **5-10 Years**: Always - 5.3%, Sometimes - 15.8%, Rarely - 25.0%, Never - 57.9%
- **2-5 Years**: Always - 14.3%, Sometimes - 25.0%, Rarely - 25.0%, Never - 50.0%
- **1-2 Years**: Always - 28.6%, Sometimes - 42.9%, Rarely - 33.3%, Never - 33.3%
- **<1 year**: Always - 33.3%, Sometimes - 33.3%, Rarely - 33.3%, Never - 33.3%

Q6. Resources Perceived Cultural Relevance by Health Authority Region

- **Fraser Health**: Always - 20.0%, Sometimes - 40.0%, No - 20.0%, Unsure - 20.0%
- **Vancouver Coastal Health**: Always - 11.1%, Sometimes - 44.4%, No - 33.3%, Unsure - 11.1%
- **Island Health**: Always - 14.3%, Sometimes - 39.3%, No - 32.1%, Unsure - 14.3%
- **Interior Health**: Always - 55.6%, Sometimes - 44.4%, No - 26.3%, Unsure - 5.3%
- **Northern Health**: Always - 21.1%, Sometimes - 47.4%, No - 26.3%, Unsure - 5.3%

Q6. Resources Perceived Cultural Relevance by Population Type

- **Remote/ Isolated**: Always - 38.5%, Sometimes - 23.1%, No - 30.8%, Unsure - 7.7%
- **Mix of Urban and Rural**: Always - 13.8%, Sometimes - 48.3%, No - 27.6%, Unsure - 10.3%
- **Mainly Rural**: Always - 11.1%, Sometimes - 55.6%, No - 22.2%, Unsure - 11.1%
- **Mainly Urban**: Always - 8.7%, Sometimes - 39.1%, No - 43.5%, Unsure - 8.7%
Q6. Resources Perceived Cultural Relevance by On-/Off-Reserve

- **On- and Off- Reserve**
  - Yes: 27.3%
  - Somewhat: 36.4%
  - No: 18.2%
  - Unsure: 18.2%

- **Off-Reserve**
  - Yes: 12.2%
  - Somewhat: 41.5%
  - No: 41.5%
  - Unsure: 22.2%

- **On-Reserve**
  - Yes: 55.6%
  - Somewhat: 22.2%
  - No: 27.3%
  - Unsure: 22.2%

Q6. Resources Perceived Cultural Relevance by Position

- **AIDP Staff**
  - Yes: 20.0%
  - Somewhat: 30.0%
  - No: 40.0%
  - Unsure: 10.0%

- **Staff at Aboriginal Friendship Centre**
  - Yes: 8.3%
  - Somewhat: 41.7%
  - No: 33.3%
  - Unsure: 16.7%

- **Home-Visitor or Outreach Worker**
  - Yes: 7.1%
  - Somewhat: 35.7%
  - No: 50.0%
  - Unsure: 7.1%

- **POP or CPNP Facilitator**
  - Yes: 33.3%
  - Somewhat: 55.6%
  - No: 27.8%
  - Unsure: 16.7%

- **Public Health Nurse**
  - Yes: 16.7%
  - Somewhat: 50.0%
  - No: 33.3%

- **Community Health Nurse (on-reserve)**
  - Yes: 16.7%
  - Somewhat: 33.3%
  - No: 66.7%

- **Maternal Child Health Worker**
  - Yes: 28.6%
  - Somewhat: 42.9%
  - No: 28.6%

- **Other**
  - Yes: 28.6%
  - Somewhat: 33.3%
  - No: 33.3%
  - Unsure: 16.7%

Q6. Resources Perceived Cultural Relevance by Years in Position

- **10+ Years**
  - Yes: 13.0%
  - Somewhat: 43.5%
  - No: 34.8%
  - Unsure: 8.7%

- **5-10 Years**
  - Yes: 18.3%
  - Somewhat: 52.6%
  - No: 36.8%
  - Unsure: 10.5%

- **2-5 Years**
  - Yes: 25.0%
  - Somewhat: 37.5%
  - No: 31.3%
  - Unsure: 6.3%

- **1-2 Years**
  - Yes: 28.6%
  - Somewhat: 42.9%
  - No: 14.3%
  - Unsure: 14.3%

- **<1 Year**
  - Yes: 16.7%
  - Somewhat: 33.3%
  - No: 33.3%
  - Unsure: 16.7%
Q9. Belief that Actions Can be Taken to Reduce the Risk of SIDS by Health Authority

<table>
<thead>
<tr>
<th>Health Authority</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraser Health</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vancouver Coastal Health</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Island Health</td>
<td>91.2%</td>
<td>8.8%</td>
<td></td>
</tr>
<tr>
<td>Interior Health</td>
<td>75.0%</td>
<td>16.7%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Northern Health</td>
<td>73.9%</td>
<td>21.7%</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

Q9. Belief that Actions Can be Taken to Reduce the Risk of SIDS by Population Type

<table>
<thead>
<tr>
<th>Population Type</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote/ Isolated</td>
<td>71.4%</td>
<td>7.1%</td>
<td>21.4%</td>
</tr>
<tr>
<td>Mix of Urban and Rural</td>
<td>96.8%</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>Mainly Rural</td>
<td>83.3%</td>
<td>8.3%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Mainly Urban</td>
<td>80.0%</td>
<td>2.9%</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

Q9. Belief that Actions Can be Taken to Reduce the Risk of SIDS by On-/Off-Reserve

<table>
<thead>
<tr>
<th>On-/Off-Reserve Type</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>On- and Off- Reserve</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Off-Reserve</td>
<td>86.3%</td>
<td>3.9%</td>
<td>9.8%</td>
</tr>
<tr>
<td>On-Reserve</td>
<td>78.3%</td>
<td></td>
<td>21.7%</td>
</tr>
</tbody>
</table>
Q9. Belief that Actions Can be Taken to Reduce the Risk of SIDS by Position

<table>
<thead>
<tr>
<th>Position</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDP Staff</td>
<td>91.7%</td>
<td>8.3%</td>
<td></td>
</tr>
<tr>
<td>Staff at Aboriginal Friendship Centre</td>
<td>75.0%</td>
<td>5.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Home-Visitor or Outreach Worker</td>
<td>87.5%</td>
<td>12.5%</td>
<td></td>
</tr>
<tr>
<td>POP or CPNP Facilitator</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Nurse (on-reserve)</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Child Health Worker</td>
<td>60.0%</td>
<td>40.0%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>80.0%</td>
<td>10.0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

Q9. Belief that Actions Can be Taken to Reduce the Risk of SIDS by Years in Position

<table>
<thead>
<tr>
<th>Years in Position</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
<td>87.5%</td>
<td></td>
<td>12.5%</td>
</tr>
<tr>
<td>1-2 Years</td>
<td>45.5%</td>
<td>9.1%</td>
<td>45.5%</td>
</tr>
<tr>
<td>2-5 Years</td>
<td>85.7%</td>
<td></td>
<td>14.3%</td>
</tr>
<tr>
<td>5-10 Years</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10+ Years</td>
<td>92.3%</td>
<td>3.8%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>