Version 3

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A FOUR-YEAR REPORT ON THE FINDINGS FROM THE ANNUAL OUTCOME REPORTING PROCESS (2014-18)

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1. BACKGROUND

1.1. INTRODUCTION

This report provides the four-years findings for the First Nations and Inuit Component of the Federal Tobacco Control Strategy (FNIC-FTCS) projects for 2014-15, 2015-16, 2016-17 and 2017-18. The FTCS operates through First Nations Inuit Health Branch, Health Canada. This FTCS Annual Outcome Report has been completed by Williams Consulting through the National Aboriginal Diabetes Association.

1.2. FEDERAL TOBACCO CONTROL STRATEGY

The First Nations and Inuit Component of the Federal Tobacco Control Strategy (FTCS) aims to promote information and knowledge sharing. It supports the development and implementation of comprehensive tobacco control projects that are holistic in addition to being both socially and culturally appropriate. It also strives to reduce non-traditional tobacco use, while maintaining respect and recognition for traditional forms and uses of tobacco within communities.

The three main objectives are:

1. To prevent the use of tobacco among young people and adults.
2. To protect from exposure to environmental tobacco smoke (ETS).
3. To promote cessation among smokers.

The six essential elements of the Federal Tobacco Control Strategy are:

1. Protection
2. Reducing Access to Tobacco Products
3. Prevention
4. Education
5. Cessation
6. Data Collection and Monitoring

The goals of the FTCS are to support:

- A select number of First Nations and Inuit communities and organizations to establish comprehensive tobacco-control strategies and interventions aimed at reducing and preventing tobacco misuse, including reducing smoking rates; and,
- Dissemination of successes and knowledge acquired in the project communities and organizations to other First Nations and Inuit communities to encourage and inform their tobacco-misuse reduction strategies.

The First Nations and Inuit component of the FTCS has adopted four related ***key success indicators***:

1. An increase in the percentage of smoke-free spaces in projects' communities
2. An increase in the number and type of smoking-related resolutions and policies that are in place
3. A decrease in the percentage of daily smokers in comparison to initial baselines
4. Developing promising practices, both new and existing, that can be shared with other communities

1.3. FTCS PROJECTS

The FTCS projects serve First Nations and Inuit Peoples and communities across Canada. While each project is responsible for undertaking evaluations of its own services and programs, this report provides an aggregated overview of the outcomes during the four years of data collection across Canada. Table 1 identifies the First Nation and Inuit FTCS projects that informed this report by year:

Table 1: FTCS Projects by Year

2016-17 Projects (Funded recipients)	Year			
	2014-15	2015-16	2016-17	2017-18
Battle River Treaty 6 Health Centre	✔	✔	✔	✔
Beaver First Nation	✔	✔	✔	✔
British Columbia First Nations Health Authority Tobacco Strategy	✔	✔	✔	✔
Chemawawin Cree Nation/Chemawawin Health Authority	✔	✔	✔	✔
Cree Board of Health and Social Services of James Bay	✔	✔	✔	✔
Department of Health, Government of Nunavut, Tobacco Reduction	✔	✔	✔	✔
File Hills Qu'Appelle Tribal Council	✔	*	✔	✔
First Nations of Quebec and Labrador Health and Social Services Commission	*	✔	✔	✔
Fort Frances Tribal Area Health Services Inc	✔	✔		✔
Grand Council Treaty #3			✔	✔
Keewatin Tribal Council	✔	✔	✔	✔
Mawiw Council	✔	✔	✔	✔
Northern Inter-Tribal Health Authority	✔	✔	✔	✔
Nunavik Regional Board of Health and Social Services	✔	✔	✔	✔
Nunatsiavut Government Department of Health and Social Development	✔	✔	✔	✔
Nunee Health Board Society	✔	✔	✔	✔
Samson Community Wellness	✔	✔	✔	✔
Siksika Health Services	✔	✔	✔	✔
Southeast Resource Development Council	✔	✔	✔	✔

* *Note: This data was not provided by the previous evaluator during the file transfer.*

1.4. SUMMARY OF ANNUAL OUTCOME REPORTING FORM

The Annual Outcome Reporting Form was developed through a consultative process with the FTCS First Nation and Inuit Projects and has evolved over time. The following questions were included:

- Organization / Agency sponsoring the project
- Project name
- Contact person name and email
- Province or Territory served
- Number of communities served by each project
- The target populations served by each project as of March 31
- The community partners each project worked with as of March 31
- The number of Smoke-Free Spaces (indoor and outdoor) identified by each project as of March 31
- The number of smoking-related resolutions passed by governance bodies and the purpose of the resolutions
- The number of participants within identified target groups that:
    - Entered smoking-cessation programs or interventions
    - Completed the smoking cessation program or intervention
    - Reduced their daily smoking but did not quit (harm reduction)
    - Quit smoking during, or at the end of, the smoking-cessation program or intervention
    - When this data was collected
- Collection of information using a population or community-level survey, including:
    - A description of the population being surveyed
    - The status of each study
    - The actual or planned sample size
    - The response rate, if applicable
    - Whether there is a plan to replicate the baseline study and, if so, when this would be undertaken
- Types of activities or services delivered (*2015-16 and 2016-17 only*)
- A description of each project's ***promising practices*** as these related to:
    - Leadership (Protection, Reducing access to tobacco products)
    - Health Promotion (Related to prevention and education)
    - Smoking Cessation
- A description of each project's ***barriers or challenges*** as these related to:
    - Leadership (Protection, Reducing access to tobacco products)
    - Health Promotion (Related to prevention and education)
    - Smoking Cessation
- A detailed description of ***one successful process*** that each project completed

1.5.STATISTICAL ANALYSIS

The statistical analysis of this report included descriptive statistics and measures of association, including chi-squares for statistical significance. Descriptive statistics include frequency counts and percentage breakdown; mean; median; and standard deviation. Standard Deviation is the degree to which the range of scores clusters around the mean, or is more widely dispersed.

Measures of Association include statistical tests that show the direction and/or magnitude of a relationship between two or more variables. Depending upon the nature of the data, different statistical procedures are used to measure association. ***Chi-Square*** (χ^2) is a test of statistical significance based on a comparison of the observed cell frequencies of a cross-tabulation table. It compares to frequencies that would be expected under the null hypothesis (meaning the numbers presented happened due to random chance). When there is statistical significance, it means a relationship between the variables exists (i.e. not due to random chance). This test is used when comparing nominal variables (e.g. gender, marital status, and so on).

To test whether there is a significant statistical relationship between the variables under review, two additional factors must be examined. These include the degrees of freedom (df) associated with this table, and its level of probability (p). In this study, the degrees of freedom are usually 2 (when it compares four years of data) and indicates an increased potential for the data to be variable.

Probability asks the question: how likely is it that the relationship observed in the sample data could be obtained from a population in which there was no relationship between the two variables? If it can be shown that this probability is very high within the general population, then, even though a relationship exists in that larger sample, it is concluded that the two variables are not related (i.e. random chance). Only if the probability that the relationship being examined could have been created by sampling a population in which no relationship exists were small would it be concluded that a ***statistically significant*** relationship exists.

As a minimal standard, probability must be at least .05 or less (P <.05) in order for there to be a finding of significance. That is, in order for the data to be found significant, it would be expected that the results which were obtained would be found within the general population less than five times out of a hundred. In social research we can also determine when correlations have ***borderline significance***. These relate to values of P that range just above the .05.

2. QUANTITATIVE FINDINGS OF THE ANNUAL OUTCOME REPORTING FORM 2014-17

2.1. NUMBER OF COMMUNITIES EACH PROJECT SERVES

In 2017-18 the FTCS projects served 125 First Nation communities across Canada (Table 2). The FTCS project in British Columbia serves the entire province while the other projects are more regional in nature. According to the data received, there is no evidence that Ontario did not deliver the FN/I FCTS program.

Table 2: Number of Communities served by Province or Territory by Year

Year	Province or Territory									Total
	AB	BC	MB	NB	NL	NU	ON	PQ	SK	
2014-15	9	203	43	3	0	32	26	23	38	**377**
2015-16	9	201	48	3	7	25	26	42	27	**388**
2016-17	9	201	48	3	7	25	10	22	38	**363**
2017-18	8	201	36	3	7	25	-	42	39	**361**

2.2.TARGET POPULATIONS PROJECTS REACHED

Respondents were asked to identify the populations their projects reached for each fiscal year (Table 3). All projects targeted adults in the general population and students in grades one to twelve from 2016-2018.

Table 3: Target Populations that have been reached by the Projects by Year

Target Population	2014-15	2015-16	2016-17	2017-18	Statistically Significant
	Percent (%)	Percent (%)	Percent (%)	Percent (%)	
Adults in the general population	17.6	94.1	100.0	**100.0**	Yes
Students in Grades One to Twelve	41.2	88.2	100	**100.0**	No
Healthcare managers and staff	23.5	88.2	100.0	**92.3**	Yes
Elders/Other seniors	23.5	76.5	94.1	**92.3**	Yes
School administrators and staff	52.9	94.1	82.4	**92.3**	No
Children/youth in non-school settings	35.3	94.1	88.2	**92.3**	Yes
Pregnant mothers	35.3	70.6	76.5	**84.6**	Yes
Chiefs and Band Councillors	41.2	82.4	88.2	**76.9**	Yes
Business owners/Retailers	35.3	64.7	58.8	**76.9**	Yes
Caregivers** with children at home	23.5	64.7	76.5	**76.9**	Yes
Recreation managers and staff	23.5	47.1	58.8	**76.9**	No
Preschool children	11.8	58.8	58.8	**69.2**	No
Other community leadership	11.8	76.5	64.7	**69.2**	Yes
Residents with chronic diseases	23.5	52.9	64.7	**69.2**	No
Mental health clients	41.2	58.8	58.8	**69.2**	Yes
Clients in addictions treatment/rehab.	58.8	41.2	52.9	**53.8**	Yes
Infants	17.6	35.3	41.2	**53.8**	Yes

*** 'Caregivers' can include, but are not limited to: parents, other family members, foster parents, other legal guardians.*

2.3. PROJECTS' COMMUNITY PARTNERS

There were a broad number of community partners that have been involved in the project's activities for the fiscal year (Table 4). In the 2017-18 year Schools and Community Elders/Elder Councils reached 92.3% involvement.

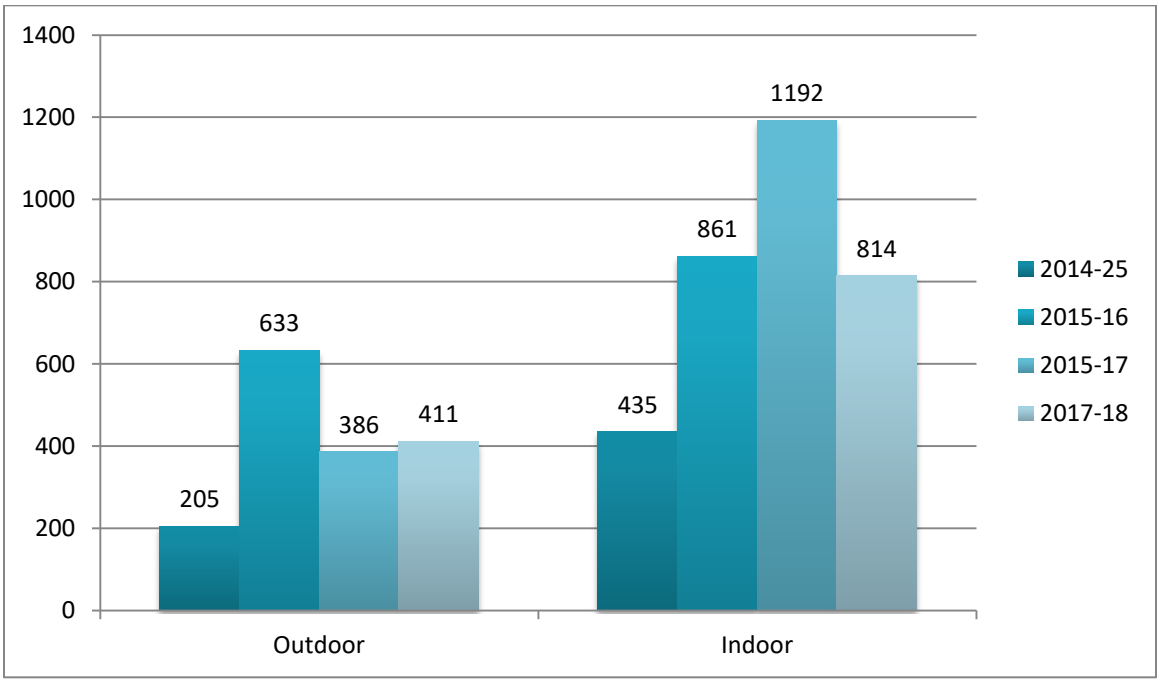
Table 4: Community Partners that have been reached by the Projects by Year

Community Partner	2014-15	2015-16	2016-17	2017-18	Statistically Significant
	Percent (%)	Percent (%)	Percent (%)	Percent (%)	
Schools	47.1	88.2	100	**92.3**	Yes
Community Elders / Elder Councils	47.1	82.4	100	**92.3**	Yes
Educators	17.6	82.4	82.4	**84.6**	Yes
Mental health service providers	29.4	58.8	76.5	**84.6**	Yes
Recreation Centres	23.5	58.8	58.8	**76.9**	Yes
Other healthcare service providers	23.5	76.5	47.1	**76.9**	Yes
Nurses	82.4	76.5	82.4	**76.9**	No
Chiefs and Band Councillors	52.9	70.6	82.4	**76.9**	No
Addictions service providers (e.g. NNADAP)	58.8	58.8	82.4	**76.9**	No
Youth role models	41.2	76.5	82.4	**76.9**	Yes
Child and Family Services	5.9	23.5	35.3	**69.2**	No
Daycares	5.9	35.3	23.5	**69.2**	No
Pharmacists	23.5	52.9	35.3	**69.2**	No
Aboriginal Head Start	11.8	58.8	47.1	**61.5**	Yes
Provincial/Territorial Government	17.6	41.2	47.1	**61.5**	No
Youth Councils	11.8	47.1	58.8	**53.8**	Yes
University/college instructors	23.5	29.4	23.5	**53.8**	No
Dental care specialists	11.8	35.3	35.3	**53.8**	No
Local Lung Association	23.5	41.2	47.1	**53.8**	No
Physicians	23.5	52.9	41.2	**53.8**	No
Bylaw Officers	0	23.5	11.8	**46.2**	No
Community media	29.4	64.7	64.7	**46.2**	Yes
Business owners/Retailers	11.8	52.9	64.7	**46.2**	Yes
Aboriginal Healers	17.6	52.9	58.8	**46.2**	Yes
Friendship Centres	5.9	17.6	23.5	**38.5**	No
Self-help organizations working with smokers	23.5	29.4	17.6	**38.5**	No
Federal/Provincial police (RCMP, OPP, SQ)	0.0	47.1	23.5	**30.8**	Yes
CancerCare / Cancer treatment centres	11.8	29.4	29.4	**30.8**	No
First Nations police	0	11.8	23.5	**23.1**	No

2.4. SMOKE-FREE SPACES IN THE COMMUNITIES

Promoting and developing smoke-free spaces is a key indicator of the Federal Tobacco Control Strategy that has been tracked by the projects. Respondents were asked to identify the number of indoor and outdoor smoke-free spaces that exist within their catchment area and are tracked annually. The number of indoor and outdoor smoke-free spaces combined has more than doubled since the 2014-15 fiscal year (Fig1).

Figure 1: Total Number of Smoke-Free Spaces by Year



A limitation of this data is that there is no capacity to interpret a proportional (%) response as to how many smoke-free spaces currently exist. Each project needs to identify the number of buildings they counted and/or the number of buildings that are not smoke-free to make this calculation. Some projects physically counted more buildings each year and are not using the same number as year 1.

2.4.1. INDOOR SMOKE-FREE SPACES BY THE TYPES OF RELATED BUILDINGS AND SPACES

The top three indoor smoke-free spaces reported by all projects for 2017-18 were Stores, Schools and Health Centres (Table 5).

Table 5: Number of Indoor Smoke-Free Spaces by Type of Building or Space

Type of Building or Space	2014-15	2015-16	2016-17	2017-18
	Count	Count	Count	Count
Stores	11	11	207	**95**
Schools	71	166	175	**94**
Health Centres	80	127	157	**91**
First Nations'/Band Offices	65	168	151	**90**
Community/Recreation Centres	31	84	118	**74**
Daycares	58	113	114	**67**
Aboriginal Head Start Sites	21	60	77	**58**
Restaurants	17	21	59	**43**
Outdoor sports facilities/arenas	10	0	51	**43**
Playgrounds	67	79	32	**7**
Bingo halls	3	17	30	**7**

* *Note: It is the opinion of the evaluator that taking the total number of buildings that are not smoke-free would greatly improve this data. At least some projects have collected counts on number of buildings.*

2.4.2. SMOKE-FREE OUTDOOR SPACES BY THE TYPES OF RELATED BUILDINGS AND SPACES, OVER TIME

Projects were asked to count the number of outdoor smoke-free spaces within their catchment area (Table 6). When reporting on this section, projects were asked to consider the smoking regulation legislation in their province or territory (e.g. no smoking 9 metres from the entrance to a building). The top outdoor smoke-free areas for 2017-18 were Schools, Daycares, and First Nations'/Band Offices (Table 6).

Table 6: Number of Outdoor Smoke-Free Spaces by Type of Building or Space by Year

Type of Building or Space	2014-15	2015-16	2016-17	2017-18
	Count	Count	Count	Count
Schools	43	102	53	**69**
Daycares	40	75	48	**43**
First Nations'/Band Offices	14	74	59	**40**
Health Centres	48	79	51	**37**
Stores	1	95	29	**34**
Playgrounds	2	28	34	**33**
Community/Rec. Centres	5	36	36	**28**
Aboriginal Head Start Sites	15	30	23	**28**
Outdoor sports facilities/arenas	19	37	25	**15**
Restaurants	16	51	6	**15**
Bingo halls	2	6	4	**2**

2.5. COMMUNITIES PASSING SMOKING-RELATED RESOLUTIONS

The First Nation and Inuit FTCS projects have consistently reported on the number of smoking-related resolutions being passed by Band Councils, Tribal Councils and other Governance bodies. The first year the projects focused on other areas, whereas in 2015-16, 2016-17, and 2017-18 they had the full year of operation to address resolutions, which accounts for the increase in numbers after the first year.

Figure 2: Number of Smoking-Related Resolutions Passed by Governance Bodies

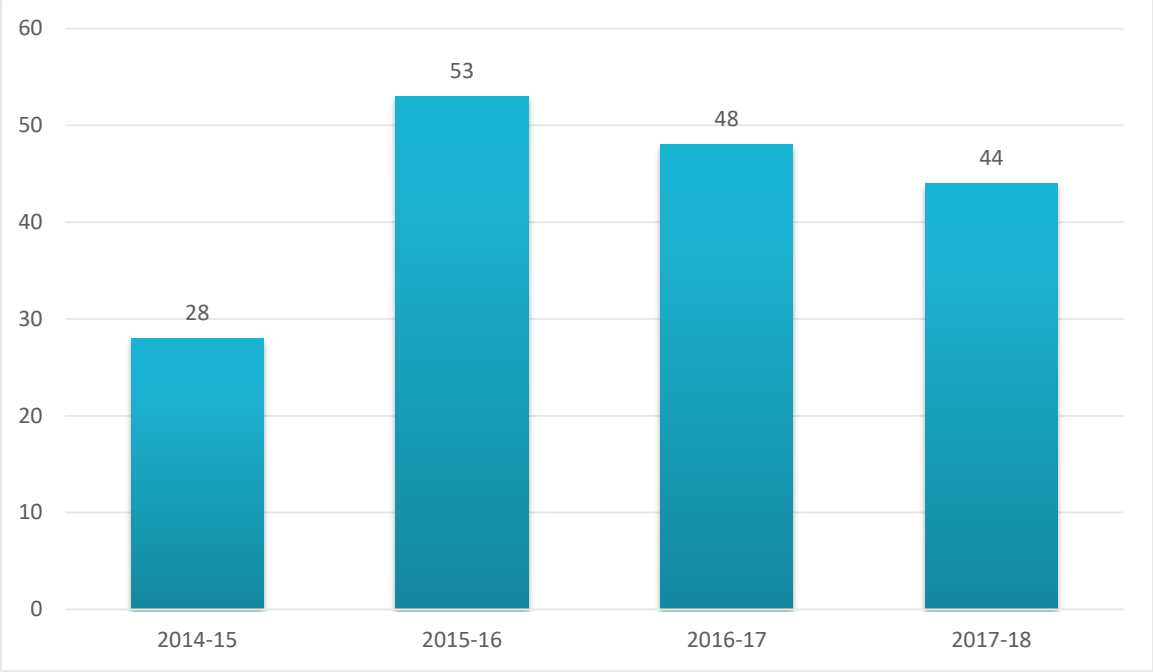


Table 7: Types of Smoking-Related Resolutions Passed by Year

Projects who Passed Bylaws									
Type of Smoking-Related Resolution	2014-15		2015-16		2016-17		2017-18		Statistically Significant
	Count	Percent (%)	Count	Percent (%)	Count	Percent (%)	Count	Percent (%)	
Designating smoke-free public spaces?	4	23.5	7	41.2	8	47.1	**5**	**38.5**	Yes
Enforcing smoke-free public spaces?	1	5.9	4	23.5	4	23.5	**5**	**38.5**	No
Promoting smoke-free homes?	1	5.9	7	41.2	4	23.5	**4**	**30.8**	No
Expanding smoke-free perimeters surrounding smoke-free buildings and spaces?	1	5.9	6	35.3	4	23.5	**4**	**30.8**	No
Promoting smoke-free vehicles (i.e. when young children are in the vehicle)?	0	0	2	11.8	4	23.5	**4**	**30.8**	No
Using tobacco-related revenues to fund health promotion activities?	2	11.8	4	23.5	3	17.6	**1**	**0.08**	No
Other	-	-	-	-	-	-	**21**	**100.0**	Yes

* *Note: Some projects in the 2017-18 annual reporting form did not categorize what types of smoking-related resolutions that were passed by Band Councils. As a result, they were placed in the 'Other' category.*

2.6. DECREASING THE NUMBER OF DAILY SMOKERS

The following are the aggregate responses from projects about smoking-related data they had obtained by intervention target group for the 2017-18 fiscal year, in comparison to the data collected in the 2016-17 year (Table 8).

Table 8: Smoking Cessation Data from Projects from April 1, 2016 to March 31, 2018

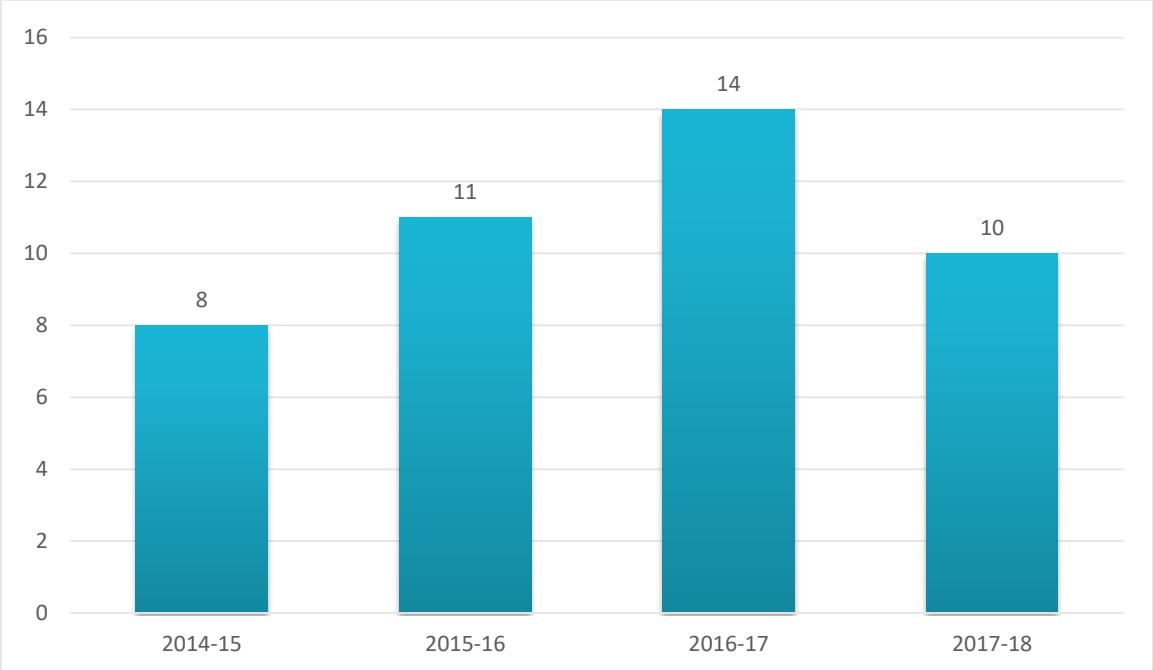
Intervention Target Groups	Count starting program / intervention		Count completing program / intervention		Count reducing smoking		Count quitting smoking	
	2016-17	***2017-18***	*2016-17*	***2017-18***	*2016-17*	***2017-18***	*2016-17*	***2017-18***
Pregnant women	34	**77**	22	**75**	21	**46**	4	**2**
Caregivers of infants / young children (less than 3 years of age)	21	**111**	13	**111**	12	**10**	2	**3**
Program participants in community-based smoking cessation programs	1,307	**1,800**	1,216	**1,581**	631	**1,042**	23	**42**
School-aged children and youth	1,272	**1,887**	530	**1,322**	10	**8**	3	**4**
Caregivers participating in community-based programs	8	**195**	6	**195**	5	**0**	7	**0**
Health care workers in specific settings (e.g. community health centres)	307	**65**	26	**36**	29	**4**	3	**1**
Elders/Other seniors	81	**158**	60	**81**	11	**12**	2	**6**
Clients in addictions treatment / rehab	22	**49**	20	**45**	22	**23**	3	**7**
Adults in the general population	1,101	**1,654**	64	**843**	79	**36**	28	**78**
Others	3,562	**562**	3	**562**	4	**0**	1	**2**
Totals	*7,715*	*6,558*	*1,960*	*4,851*	*824*	*1,181*	*76*	*145*
Two Year Totals	**14,274**		**6,811**		**2,005**		**221**	

The following Tobacco Cessation impacts have been documented through the First Nation and Inuit FTCS projects with data collected from 2016-17 and 2017-18:

- **14,274 people have started a cessation program / intervention**
- **6,811 people have completed a cessation program / intervention**
- **2,005 people have reduced smoking**
- **221 people have quit smoking**

Based on the above data, in 2017-18 more people have started and completed a cessation program than the previous 2016-17 year.

Figure 3: Number of Projects Collecting Smoking-Cessation Data using a Population / Community-level Survey by Year



The number of projects that are undertaking a population or community-level survey has been mostly increasing over the implementation of the First Nation and Inuit FTCS. For the 2017-18 year, three projects have completed their surveys while five projects are still in the process of undertaking their population or community-level surveys.

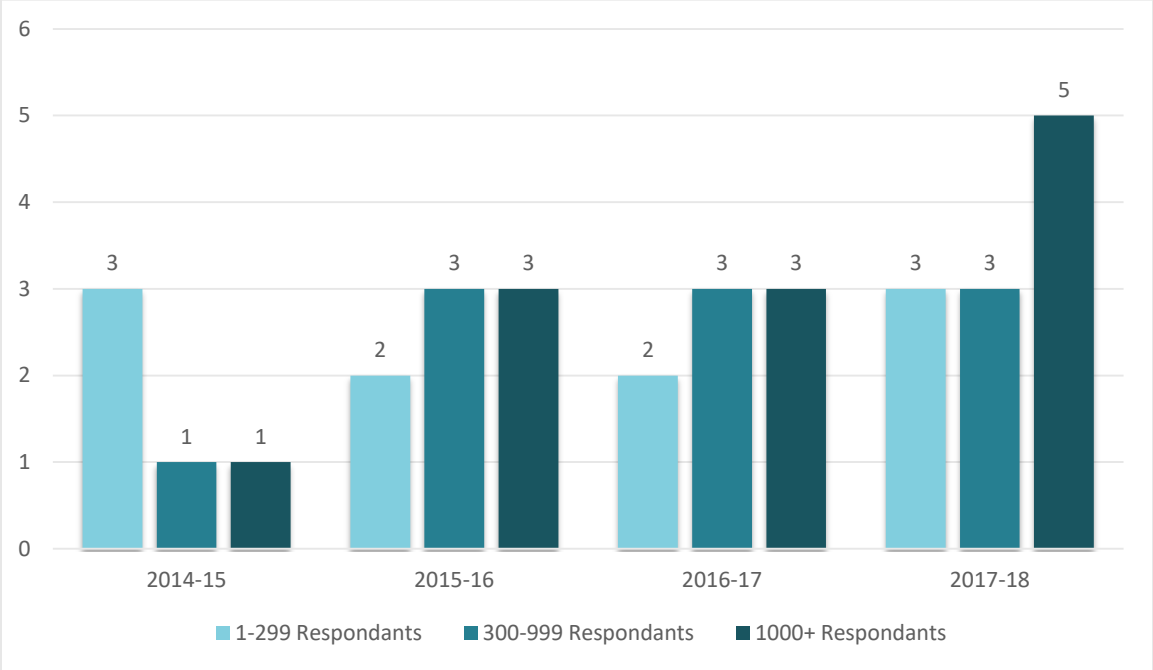
2.6.1. THE STUDIES PROJECTED OR ACTUAL SAMPLE SIZES

Projects that are able to collect larger sample sizes to their population or community-level surveys provide stronger smoking-cessation data. A number of projects that indicated they are collecting information using a population or community-level survey were able to provide the actual, or planned, sample size.

In the first year of FTCS implementation, five projects identified how many people would be taking the survey and the majority targeted 299 or fewer survey participants. However, in the following years, the projects were able to increase the amount of respondents they were targeting and the number of completed surveys. For example, in 2015-16 and 2016-17 there were 3 projects that identified a sample size of 300-999 respondents and another 3 projects seeking more than 1,000 respondents to their survey. One project started with a smaller

sample size in 2014-15 and increased to a larger sample in the following two years. In 2017-18 the total estimated sample size conducted by community projects was around 8,658. This increase in projects or actual sample size over time is demonstrated in Fig 4 below.

Figure 4: Projects that identify the Actual or Planned Sample Sizes by Year



2.6.2. THE STUDY POPULATIONS

The projects were asked to describe the study population being surveyed and data was only available for 2016-17 and 2017-18. The majority of projects focused their surveys on the Adults in the general population as well as School-aged children and youth (Table 9). The FTCS projects identified the following study populations being surveyed in 2016-17 and 2017-18:

Table 9: Study Populations in 2017-18

Populations being surveyed	Project Count	
	2016-17	2017-18
Adults in the general population	10	**9**
School-aged children and youth	9	**6**
Pre/Post-natal women	2	**3**
Health care workers in specific settings (e.g. community health centres)	2	**1**
Caregivers of infants/ young children (less than 3 years of age)	1	**1**
Program participants in community-based smoking cessation programs*	1	**1**
Elders/Other seniors	1	**3**
Clients in addictions treatment/rehab	1	**1**
Caregivers participating in community-based programs	1	**1**

In 2016-17, majority of projects identified they were planning to replicate their survey in the future. Two-thirds of the projects anticipated replicating their surveys in the fourth quarter of the 2017-2018 fiscal year. In 2017-18, 61.2% of projects stated that they were planning to replicate their studies in the future as well.

2.7. FTCS PROJECTS' SERVICES AND ACTIVITIES

The Annual Outcome Report asked projects in 2015-16, 2016-17, and 2017-18 to identify which activities or services were delivered (Table 10). It is notable that the education of junior high and high school students about the negative effects of smoking as well as sponsoring challenges/events were the top activities delivered by the projects. According to qualitative data, the projects have had success with these initiatives. Also aligned with qualitative data, is the outcome that working with bylaw officials, monitoring smoke free zones, and meeting with Chief and Council to discuss increasing tobacco prices, are the three lowest activities in this table.

Table 10: Activities or Services delivered by the Projects

Activities or Services delivered	2015-16 Percent (%)	2016-17 Percent (%)	2017-18 Percent (%)	Statistically Significant
Educating junior high school students about the negative effects of smoking	94.1	94.1	**92.3**	No
Sponsoring challenges/events/contests related smoking cessation/prevention	88.2	94.1	**92.3**	No
Educating high school students about the negative effects of smoking	94.1	100.0	**92.3**	No
Developing smoking cessation/prevention poster campaigns	82.4	100.0	**84.6**	Borderline
Educating parents/caregivers about the negative effects of smoking	76.5	94.1	**84.6**	No
Developing other partnerships to promote smoking cessation/prevention	70.6	76.5	**84.6**	No
Educating elementary school students about the negative effects of smoking	88.2	88.2	**76.9**	No
Developing other promotional materials (e.g. calendars, t-shirts, cookbooks, etc.)	76.5	82.4	**76.9**	No
Distributing 'no smoking' signs and/or posters	64.7	64.7	**76.9**	No
Educating others about the negative effects of smoking	76.5	100.0	**76.9**	Yes
Providing smoking cessation programs / services	64.7	82.4	**76.9**	No
Participating in health fairs sponsored by other groups	76.5	76.5	**76.9**	No
Educating Chiefs and councils about the negative effects of smoking	70.6	70.6	**76.9**	No
Creating 'no smoking' signs and/or posters	76.5	64.7	**76.9**	No
Developing partnerships with community leaders to promote smoking cessation / prevention	88.2	76.5	**76.9**	No
Promoting and/or facilitating Blue/Green Light Campaigns to encourage smoke-free houses	58.8	52.9	**76.9**	No
Educating school administrators and educators about the negative effects of smoking	76.5	64.7	**69.2**	No
Developing partnerships with health care providers to promote smoking cessation/prevention	82.4	88.2	**69.2**	No

Developing Facebook campaigns to promote smoking cessation / prevention	76.5	76.5	**69.2**	No
Developing smoking-related toolkits	70.6	76.5	**69.2**	No
Training health care professionals in smoking prevention/cessation processes	82.4	82.4	**69.2**	No
Developing partnerships with educators to promote smoking cessation / prevention	82.4	76.5	**69.2**	No
Training others in smoking prevention/cessation processes	58.8	70.6	**69.2**	No
Training educators in smoking prevention/cessation processes	70.6	58.8	**69.2**	No
Encouraging smoke-free vehicles if children/youth are present	76.5	64.7	**69.2**	No
Developing smoking cessation programs	88.2	94.1	**61.5**	No
Teaching community residents about the traditional use of tobacco	64.7	76.5	**61.5**	No
Meeting with Chiefs and Councils to promote smoking-related resolutions	52.9	23.5	**53.8**	Borderline
Hosting health fairs	64.7	47.1	**53.8**	No
Promoting the use of Traditional tobacco	70.6	70.6	**53.8**	No
Meeting with Chiefs and Councils to promote smoking cessation/prevention initiatives in their communities	76.5	52.9	**53.8**	No
Working to expand outdoor smoke-free zones (e.g. increase distances from entrances)	58.8	47.1	**53.8**	No
Encouraging business owners/retailers to implement smoke-free zones	70.6	70.6	**46.2**	No
Monitoring smoke-free zones to ensure compliance	29.4	29.4	**38.5**	No
Working with bylaw officers and other officials to ensure compliance of smoke-free zones	29.4	23.5	**23.1**	No
Meeting with Chiefs and Councils to explore increasing commercial tobacco prices to promote smoking cessation	35.3	17.6	**15.4**	No

3. QUALITATIVE FINDINGS OF THE ANNUAL OUTCOME REPORTING FORM 2016-17 AND 2017-18

3.1. PROMISING PRACTICES

The First Nation and Inuit FTCS Projects were asked to describe any promising practices that had been developed or implemented during the 2016-17 fiscal year according to the following three pillars of the Federal Tobacco Control Strategy. These included lessons learned, innovative ideas, new concepts or successful activities. The three categories were:

1. Leadership (designated smoke-free spaces and/or smoking-related resolutions and policies)
2. Health Promotion (related to prevention and education)
3. Smoking Cessation

3.1.1. LEADERSHIP

Over the past four years, projects have had many promising practices related to leadership. One of the main themes for the projects throughout this time frame has been to work with leadership in designating smoke-free places, smoking resolutions and policies. One project from 2016-17 stated,

> *With the present Chief and Council there is a clear understanding of the importance of Tobacco Control in regards to ensuring "smoke-free" buildings and public spaces within the community. Two areas of concern included the skating rink and the playground. Both areas are "outdoor" facilities and with that came the assumption by the smoking population that smoking would be allowed as both areas were not enclosed. Chief and Council have agreed to deem both of these areas "smoke free" including the area surrounding the outdoor facilities. Chief and Council has agreed to ban e-cigarettes and vaping as part of the "smoke-free" building and areas within the community. New signs have been ordered to clearly identify the "smoke -free areas". As of July 2016, cultural camp and summer camp employees are no longer allowed to smoke near the camp kids. In fact, they cannot be seen by the children at all while smoking. The leadership agreed that they will adapt the Quebec Laws concerning smoking near main entrances of establishments that serve the community.*

Another project from 2017-18 shared,

Adoption of a resolution to add the community's park to the list of smoke free zones, putting up an increasing number of signs on building health centres and schools reminding people to respect bill 44 which prohibits smoking within a nine metre radius of said buildings, schools administration have been notified of the law and how to adapt to it. We created briefing and letters to encourage council to adopt a bylaw concerning no smoking in Nation vehicles. We also created briefing to recommend that the 9m rule be enforced outside of each public building. Chief and Council supports the importance of Tobacco Controls in regards to ensuring smoke free buildings and public spaces within the community including all public buildings and Public spaces such as the skating rink and the playground. Chief and Council have agreed to identify all of these areas smoke free, Chief and Council has agreed to ban e cigarettes and vaping as part of the smoke free areas within the community. Signs were purchased and hung within the community to identify these spaces.

One theme of promising practices discussed by the projects surrounded engagement with community leadership on education about the importance of tobacco cessation. Though it is recognized that community leadership sometimes possesses competing priorities, projects are making strides toward working with leadership on their goals. One project stated:

We continue to work with leadership and ask for support in having staff attend education sessions during work time and to be champions of the healthy lifestyle messaging. We have not had any new tobacco tax in the community…we are seeing that leadership is making more time to meet with health staff and this includes our program staff. Their focus on health broadly will help us link in the importance of tobacco cessation and prevention/education in the community.

It has been determined by many projects that relationships with community leadership is important to the overall success of the projects. Though some community leadership have competing priorities concerning tobacco, projects have found ways to connect with leadership around overall health goals for community wellness. This can involve less controversial goals, such as creating smoke-free homes in communities. One project shared in 2016-17 that,

…[r]ecognizing community leadership for a job well done in supporting any aspect of the tobacco project's initiative is a valuable lesson learned. With the completion of the Blue Light Campaign at the end of the 2015/16 fiscal year, in the 2016/17 fiscal year the project was able to present the community plaque and 4ft x 8ft sign to the Chief and Council of the winning community, in partnership with The Lung Association, SK (now Breathe the Lung Association). This has put one foot in the door with that community leadership, with hope to explore in the 2016/17 year. Relationship building is key is

proposing any sort of idea within leadership. This is time consuming but we find necessary for getting our project not pushed aside in the face of competing agenda items. With that is also sustaining the relationship built.

In 2017-18, this same project continued to note the importance of forming and sustaining these relationships with leadership. They reported,

Based on feedback from running the Blue Light Community Challenge in 2016/17, we hosted a series of Blue Winter Community events this 2017/18 year. We involved community leadership by working with the Health Portfolio Councillors in organizing and promoting these events. We realize that while some of our leadership aren't high on the readiness scale to have by-laws and policies around smoke-free public spaces we can get them on board in promoting smoke-free homes in the communities. In creating more community awareness and conversation around smoke-free homes we hope to build on this to garner community support in lobbying leadership to create by-laws and policies for community smoke-free spaces.

The support of leadership is necessary when seeking to improve or change tobacco-related policies in communities. One project supported retail pharmacists in promoting the new NIHB policy in which pharmacists can recommend NRT after patient assessment and bill NIHB for the drug cost. Another project developed new smoking policies for the employee handbook based on a staff survey. Yet another project stated that they,

…[n]eed support from the Chief and Council to update the current "No Smoking" policies to include 'All forms of Tobacco'. First Nations and Inuit community leaders have to support local tobacco control initiatives. We need to engage the community leadership and support them in learning about commercial tobacco, voicing their opinions and supporting tobacco control strategies. Increasing the capacity of community leaders to be strong advocates can empower the community and foster development. The support of NITHA leadership is needed in the area of enforcing smoke-free public policies/bylaws.

A promising practice that has been shared by the projects has involved modeling and a rewards system. This is leadership by example. Modeling no-smoking behaviour and encouraging key members of leadership to get on board with the projects has led to more efficient and effective roll-outs. This modeling behaviour has been successful, not just with the involvement of Chief and Council, but community leadership as well. This has included, youth leadership, Elders and respected knowledge holders. One project from 2016-17 shared,

Youth Engagement in the 11 Keewatin Tribal Council communities isolation in the 9 communities are long and difficult for young people. There are Jr. Chiefs and Council with

over 300 young people signed up from 3 different communities and the policy is no smoking for young leaders. We have created the KTC Youth Model Program and photo poster campaign, which includes all 11 reserves.

From 2017-18, another project reported continuing success with modeling. They stated,

The Tobacco Reduction Program (TRP) works to identify community/tobacco champions. These champions receive training and 'champion' tobacco prevention/cessation activities in the communities.

One project has developed a unique rewards-based system that is still in its draft form. This approach involves rewarding those that do not smoke with additional leave days from work, in lieu of smoke breaks taken by smokers every day. They stated,

A draft smoking policy has been submitted for review to the Policy Working Group and review by HR; once reviewed here it will proceed to Nunatsiavut Executive Council for approval. There has been some discussion in implementing a policy that would offer additional leave days to individuals who are smoke free to compensate for cigarette breaks. There has to be discussion and guidelines on how the policy would be implemented…this is still in initial planning stages.

3.1.2. HEALTH PROMOTION (RELATED TO PREVENTION AND EDUCATION)

In the past four years, the projects have approached health promotion in a variety of ways. One of the themes of promising practices for health promotion is innovation. People are very familiar with anti-smoking messaging and in order to make an impression, innovative health promotion has had some success throughout the projects. Two projects from 2016-17 state,

We have had great success with promotion activities related to art and creativity. The youth enjoy participating in activities to allow them to be creative…We have found that adding prevention/education message to fun activities for both youth and adults works best, i.e. the main focus can be a fun event like a fishing derby but we add educational messaging that cannot be missed by participants. Even one day events like the "walk for health" that we did with the school had a lasting impression as we provided t-shirts to all students so that they would have a memory of that day.

Our "Inside-Out" campaign, which aims to build awareness amongst families about second-hand smoke and how to work towards making the home a smoke free space, had a significant presence around British Columbia in 2016…It is designed to be set up as an information table for health fairs and community gatherings. A magnetic game board was

created as an interactive way for children to be drawn to the table, while the health promoters talk to the parents or care-givers about the harms of second hand smoke when children are present. The BC Lung Association Health Promoters, with the assistance of the First Nations Health Authority Community Engagement Coordinators, participated in 24 events across the Fraser Salish, Interior and Northern regions in 2016. In total over 1,000 people visited our booths and we collected 415 feedback forms.

Attending community events and setting up informational booths. Holding events such as an amazing race and connecting to the community over radio to answer questions and provide resources.

The sacredness of Tobacco to First Nations and Metis peoples cannot be overstated. As such, traditional teachings and ceremonies concerning tobacco are continually woven throughout most aspects of the projects for the past four years. Reminding community members, and the youth in particular, about Indigenous Knowledge surrounding tobacco is a way to reconnect to culture, as well as emphasizing overall health. Projects shared,

Engaged in numerous activities to educate on traditional tobacco usage. We are currently creating a film that is focused on Traditional tobacco specifically to our own Siksika/Blackfoot culture. This film is to be used for future presentations to all community members of Siksika and most especially to our youth.

To spread the awareness and prevention of tobacco use in all areas/departments within the NITHA communities planting Traditional tobacco in our community gardens to be use as gifts to elders. Community members especially the youth should be educated about the uses of traditional tobacco and its cultural and historical significance.

The ongoing promotion of tobacco cessation and the traditional use of tobacco. The promotion of planting and harvesting tobacco in a traditional manner. The youth have been thoroughly involved with the planting and harvesting tobacco, they understand the traditional uses and can explain the many traditional uses tobacco. One project focus is to 'Plant the Seed' of awareness of the health risks of commercial tobacco use and sacred tobacco use as a healthy practice (1) by engaging many partners (2) promotion in as many places and with as many people as possible.

One of the main targets of health promotion for the projects is the youth demographic, as evidenced throughout this report. As a result, the projects have developed a number of promising practices in order to reach and educate this audience. Some of these promising projects involve working closely with schools, pairing Elders and youth together, selecting role models, and designing fun activities with clear messaging. A project from 2016-2017 shared,

The project hosted its first Youth Gathering during the 2017 National Non Smoking Week. 8 schools participated sending a combined representation, over the two days, of approximately 150 youth and 15 chaperons. First Nations speakers, elder and youth role models shared their knowledge and experiences with the youth. We opted to showcase an adult and youth role model the youth would be able to relate to. Key messages shared were on traditional tobacco, commercial tobacco, healthy lifestyle, envisioning the future and aspiring for more. There was also a First Nations fashion designer who had her debut fashion show at the Gathering and a local youth band to promote youth talent and entrepreneurship. Infusing health promotion message with things that matter holistically to the population target is one way that effectively engages and connects with the group, while still getting the message across.

An example from 2017-18 project stated,

Our high school remains the ambassador of the DEFACTO program of which we are very proud. We are happy to recognize students for their sports efforts while remaining non-smokers by awarding students bursaries at the Meritas gala. We also helped 150 students receive Hero Training. This is an innovative and relevant project for our region, given the high number of smokers in the community and the risk of cardiac arrest. The training the health workers received helps better support people who would like to be accompanied through the process.

In order to reach as many people as possible, the projects have had continued success with utilizing social media and technology to amplify and spread their messages. This has been a great way to share and update community challenges, share upcoming event information, and pass along vital information on sacred tobacco use. It has also been a great way to engage youth. One project from 2016-17 discussed the impact of using youth the make two commercials:

In March of 2015 at the Gathering Our Voices youth conference, FNHA hosted a workshop called "Pitch us a commercial and we'll make it". Following the workshop, two of the ideas were chosen to be made into short public service announcements. We then worked with a consultant and film crew to develop two 30 second commercials. In 2016, we worked with a social marketing company to help leverage these videos into a broader campaign. This included producing trailer videos and outreach avenues with the purpose of directing youth towards our site. On this site, we host the two original commercials, important statistics and messaging that resonates with a youth audience, as well as instructions on how to enter our video contest. This whole project has maintained the theme of youth speaking with other youth in order to educate one another about the harmful impact of commercial tobacco.

Podcasts, a popular form of media, have also been successfully utilized by one project. In 2016-17, they stated,

> *To build on the success of our "Smokestack Sandra" podcast series from 2015/16, our team developed a second season of podcasts. "Tobacco Nation" is a four-part podcast series that highlights important areas of the relationship between tobacco and First Nations communities. Each of the four episodes centers around a different theme: Cancer Prevention and Care, Community and Collaboration, Respecting Traditional Tobacco, and Prevention and Youth. This series, recorded with professional audio technology and podcast developers, contains many stories and interviews with a wide range of community members and healthcare professionals. By touching on various aspects of tobacco use via personal stories, Tobacco Nation strives to begin the practice of sharing our personal experiences with tobacco in order to inform, educate and inspire one another.*

In 2017-2018, one project shared that social media was one of their best practices to engage a wider audience. This theme was shared throughout the four years for a variety of projects. This project stated,

> *As part of Northern Saskatchewan Breath Easy ongoing multi component awareness campaign about 75 anti-tobacco messages were posted on Northern Saskatchewan Breath Easy social media accounts…messages centered on health effects, consequences of tobacco, tobacco industry deceptive practices, second hand smoke and its potential harm. Northern Saskatchewan Breathe Easy Facebook Page has 1300 likes and 27000 people were reached and 600 plus were engaged…Social media marketing has been one of our best practices and innovation tools to engage and reach wider audiences. During the year under review, two contests were planned and implement in NSBE social media pages.*

The use of technology is not only limited to social media but can involve other items used by the projects to get their messages across. A few projects shared their continued success with the Smokerlyzer. One project shared from 2016-17,

> *Implementing of the Carbon Monoxide educational tool (Smokerlyzer) into the School of Tobacco Challenge has proven successful. Participants wanted to 'lower' their score' weekly and it had helped to reduce commercial tobacco use over the weeks. The use of the Smokerlyzer at community events (Treaty Day, Wellness Days) has also increased the discussion of cessation - following the Smokerlyzer reading, the community member will be given a handbook called Ready, Set, Quit from the Lung Association as well as a Cost of Smoking Handout. These interactions with community members are important in creating the discussion around tobacco cessation and reduction.*

Another project from 2017-18 stated,

We continue to use the CO monitor (Smokerlyzer) and Simulated Smokers' Lungs, with youth in particular, as health promotion tools in all communities Nunavut. Nunavummiut are interested in the display and will approach the health promoter to ask questions. The TRP team developed a children and youth tobacco prevention/cessation curriculum. The curriculum was rooted in best-practices in tobacco control and applied a youth engagement lens. TRP produced four teaching videos to support community health workers in utilizing and applying tobacco reduction resources.

One project utilized monitors in public spaces to consistently play health-related messages and smoking related messages. This project shared,

We have invested in monitors that are placed in key locations throughout the community such as our health building, the community store, the school, the band office, and the fitness center. These monitors have ongoing messaging about community activities as well as health related messages, particularly smoking related. By including scheduling and community update information that residents are looking for, we believe we increase both the frequency and amount of time spent viewing the health related messages.

3.1.3. SMOKING CESSATION

During the duration of FTCS, challenges, contests and games have been used by many projects to help make smoking cessation fun with short-term goals. It is a high bar to only measure success in these challenges by people quitting smoking forever. Instead, if it is possible during these challenges to demonstrate to people that they are able to quit for a period of time, then that can be viewed as a step toward cessation for those participants. Projects have found, however, that challenges must be accompanied by other supports, in order to encourage cessation. For instance, in 2016-17, some projects shared,

Northern Saskatchewan Breathe Easy developed an information and fitness Smoking Cessation Mobile App. The Smoking Cessation Mobile App was launched on October 21, 2016 at Prince Albert. A total of 70 youth and elders from Northern Inter-Tribal Health Authority communities were in attendance.

We initiated a Let's Kick Butt Challenge for Youth in school and Be a Winner, Be a Quitter Challenge for Adults - June - Sept 2016. June-July for cessation groups. July-Sept for follow-up to see who is able to stay quit and provide support with challenges. 71 adults registered during the Treaty Day events and via Facebook; and 26 youth in school registered. This indicated that there was interest in quitting or the thought of quitting had crossed these individuals' minds. However 9 adults and 18 youth followed through

the registration to actually starting a cessation group session. At the end of the 5 week session for adults and 3 sessions for youth, 5 adults completed and 9 youth did.

During the second season of Let's Kick Butt for Youth, in 2017-18,

There were 29 registered and 6 that completed the whole challenge. There were two 7-Day Challenges - with a total of 48 people registering and 24 completing 4 hour Challenge for World No Tobacco Day - 37 registered and 4 completed.

Other challenge examples from 2016-2017, include:

Tobacco Timeout, our monthly provincial quit contest on the first Tuesday of each month, is an opportunity for contestants to sign up, quit commercial tobacco for 24 hours, and be entered into a draw to win a cash prize. For this program, we partner with QuitNow, which looks after BC's smoking cessation resources and is funded by the provincial government. Between April 2016 and March 2017, we had had 577 people sign up. Toward the end of that 12-month period, we modified our promotion strategy which resulted in us seeing higher participation numbers during the most recent contests.

School of Tobacco Challenge focuses on reduction throughout the challenge by providing participants with the tools for cessation. The Challenge included the following tools:

1. *Traditional Education and Growing Natural Ceremonial Tobacco. (Elder)*
2. *Journaling as own tracking tool*
3. *Catching Your Second Wind, Tobacco Addiction Recovery, Partnership to Assist with the Cessation of Tobacco and group discussions*
4. *Elder Video*
5. *Nutrition Education*
6. *Reduction and misuse of Commercialized Tobacco*
7. *Community vs Community Challenge*
8. *Manuals, Journals, registration release forms*
9. *Tobacco Planting (single modular greenhouses)*
10. *Implementation of the Smokerlyzer*

The School of Tobacco seen reduction of up to 50% in participants over the 8 week challenge in Little Black Bear. This was a very successful challenge and Little Black Bear won the challenge. The Challenge added in incentives for every time a participant attended a meeting their name was entered into the final draw for a FitBit as well as

weekly nutrition door prizes for attending meetings and this was strongly linked to the increase in participation over the Challenge weeks.

Not all challenges have met with success. For some projects, these smoking cessation initiatives have been difficult to even get off the ground. They are taking the time to re-evaluate these activities to find ones which will work for their communities. One project from 2017-18 recognized that perhaps more support was necessary, however remained difficult to convince people to show up. This project shared,

We tried 3 new things this year: 1) we offered an interactive workshop for youth smoker-entrants one day before the Challenge started. While the participants enjoyed it, unfortunately all of them relapsed during the Challenge. 2) We offered individual and group counselling with a professional smoking counsellor on our team. Only one person accepted the offer. Her nurse came with her to learn about smoking counselling so that the 2 of them could continue the counselling relationship after the NBTI support team had left the community. 3) The doctor in Waswanipi offered to run a special NRT clinic the day before the Challenge started. Our team called every smoker-entrant who said they smoked 8 or more cigarettes per day to invite them to the clinic. Many agreed to come, but only 2 showed up.

3.2. BARRIERS OR CHALLENGES EXPERIENCED

3.2.1. LEADERSHIP

Though the projects have experienced success in working with leadership in communities, there remains some substantial challenges. One of the main challenges with leadership continues to be the fact that tobacco sales are an economic driver for many communities. This results in competing priorities not just for the leadership as a whole but even personally for individuals in leadership positions. This can result in a resistance by leadership to pass or enforce bylaws concerning smoking. In addition to this, retailers in communities may not be co-operative in receiving any of this information provided by the projects. In other cases, project goals may not be a priority for the leadership and it might take a long time to have any initiatives approved by council. Projects shared,

> *Chief and Council meetings are few and far between. It takes time for us to gain access to propose and present our program ideas. At this point our propositions have required additional research in order for our Chief and Council to fully understand the benefits of our proposals for our community. (2016-17)*

> *Distinction between traditional and ceremonial tobacco use implementing retailers training with manager to band owned stores have been challenging. For example, trying to schedule training for their staff have been difficult, there appears to be a resistance to any training even when it is offered for free. It is also a huge revenue source and this may negatively impact any efforts to enforce smoking regulations and sales to minor.*

> *Also, we have experienced Implementing Smoking Shelters is under discussion, however has been slow to acquire all necessary approvals, meaning it must wait until next boat-shipping season. For smoking related policies it has been a slow moving process in terms of having the Policy Working Group dedicate time to discussing the draft policies.*

Enforcement has continued to be an issue throughout the four years of FCTS. Though leadership may be supportive of the overall health goals championed by the projects, the passage of smoking-related bylaws and policies cannot be effective without their enforcement. In those instances, community members will see the posted signs and smoke anyway. Projects must continue to work with leadership on these issues. Projects stated,

> *We had challenges with the previous Bylaw officer - not reporting complaints and infractions as we had requested. However, there is now a new Bylaw officer and we will continue to*

work with her to encourage ongoing monitoring and reporting of tobacco related Bylaw issues. (2016-17)

With staff becoming knowledgeable in the BCR making process, one challenge became evident. Enforcement of these policies are not within the work plan, or in the job description of program staff. It was clear that although enforcement of the smoke-free by-laws could not be achieved by program staff, it was still important to begin structuring a strategy for the eventual drafting of smoke-free by-laws. This is because, these smoke-free by-laws would not otherwise begin being drafted if it were not for the work of this program. (2016-2017)

What we have learnt is this process is that if we want it to work 100% with regards to having a smoke free public places, then communities should have bylaw officers to enforce these policies. Our finding is that people in the communities know the building are smoke free and will smoke outside, but some smoke right outside the door. In reality it should be 9 meters from the doorway, most people do not comply with that. The support of NITHA community leadership is needed in the area of enforcing smoke free public policies bylaws. (2017-18)

There are no enforcement policies in the provisions of the policy. Employees do not take heed of the signs since there are no enforcements in place. There have been no complaints to HR regarding noncompliance of the no smoking policies. The biggest barrier is lack of compliance with following directions well. Most people still smoke outside the door which leaves the building smelling like smoke inside. (2017-18)

These challenges with leadership remain a reality with which many projects must contend, however, with the imminent legalization of marijuana some leaders have reached out to the projects to have conversations. This could work to the benefit of some projects. For instance, one project said,

A challenge remains getting leadership to create by-laws/policies and for those who have them to enforce the smoke free spaces policies. Some chief and council are more challenging to work with however we leverage the goodwill we have and try to work around more challenging leadership in getting program and project buy in. With the legalization of marijuana pending some leadership are reaching out to have conversations around that. It is hoped that sitting on that table to have the discussion on legalization we can create the space for tobacco as it deserves a place. (2017-18)

3.2.2. HEALTH PROMOTION (RELATED TO PREVENTION AND EDUCATION)

The regular turnover of staff in some projects has had a challenging impact on the completion of goals and objectives. Knowledgeable staff and confidence in funding is necessary to keep momentum in the projects on pace. When workers leave, the same training must be delivered once again to the new hire, which causes a slowdown in activities. Throughout the four years of FCTS, many projects have had to contend with staff shortages and fiscal restraints (including uncertain funding), which impacted their timeline. Projects said,

> *The program officer that was responsible for the tobacco file passed away suddenly in the spring of 2017. Since then, there have been six unsuccessful job postings to fill the tobacco position. The Public Health Department will redistribute its files amongst the program officers in place for 2018-2019, in order to deliver the programs as planned. (2017-18)*

> *We have not had success with the nursing station in linking to our program. We have had no referrals that we know of to our programs and have not been provided information about what the nursing station might offer to program clients that we see. We have inconsistency in the nurse staffing- nurses come in periodically from other communities and even other provinces, so there is no on-going link to our program and the transiency of staff makes it difficult for us to get our program on the radar. We have provided the station with promotional items such as baby bibs but we have not had success in reporting back about how many bibs were given out and if materials related to our program were also given to patients*.

The logistics of working across a variety of communities, with different available resources, taking into account weather and infrastructure, is challenging. Consistent access to internet can be an issue in many communities, so the idea of creating one presentation and assuming it can be delivered online is not possible. The weather can impact intended activities, such as on the land activities, as well as travel for project workers to different communities. All of this can lead to cancelled activities and/or poor turn out. Projects stated,

> *Lack of storage space or space to conduct health related activities such as having no gym space available regularly and storage for supplies.(2016-17).*

> *We had planned to have a "blue light" campaign within the community however we could not find blue lights in reasonable priced bulk amount. Scheduling of health promotion delivery is always a challenge in some schools because of curriculum limitations and scheduling. For some communities, it is difficult to promote health due to*

the distance of members and the lack of resources to go directly to the schools and other environments. (2016-17)

Weather and travel to the communities continues to be a challenge with implementing and supporting communities. Missing or malfunctioning resources in the communities meant that not all communities have access to a consistent level of service. Poor internet connectivity and bandwidth, even in Iqaluit, means that we can't take for granted that once we create a resource that it can be delivered electronically.(2017-18)

Given that the community member are spread out over the territory, following up is difficult. Since the internet bandwidth is limited in certain regions, uses of social media to promote health is limited…Difficult to get people to attend to our event…For hosting on the Land Activities with Youth and Elders specifically and the general population the weather has been poor to host events this fiscal, also we have dealt with issues of staff shortage for planning and implementing programming therefore some programming has been cancelled. Some community events have been advertised and we haven't had enough interest to hold the event. (2017-18)

In some cases, it has been difficult mobilizing workers due to their heavy loads. One project mentioned that there was some resistance to it, as it might not have seemed a priority. In most communities, when an emergency occurs, all health workers turn their attention to that for as long as needed. One project stated,

Brief intervention on tobacco cessation has been challenging for alternative health care giver. Most times they are either too busy with their own duties or it is a scheduling issue. More, so there seem to be a reluctance and resistance to having a discussion on tobacco cessation and its harmful effects even when their job mandates it. Limited Difficulty mobilizing the health workers from other sectors around the issue of tobacco use. In one community, prevention and promotion activities had to be set aside for a time since the team had urgent situations to handle (suicide and disappearance). (2017-18)

A major challenge is scheduling appointments with councilors and the transition time it takes to get new leadership wanting to engage with the project when it seems like they have more pressing community issues. While there is the recognition that the misuse of tobacco is concerning it seems to not be a pressing issue on some of the leadership's agenda in the face of issue like overdosing on drugs and suicide. Understandably so, but it makes putting tobacco policy on the agenda a non-issue. (2016-17)

3.2.3. SMOKING CESSATION

Many challenges surrounding smoking cessation have revolved around participation. Though the projects have approached smoking cessation with creativity, having participants come out or follow through with programs/challenges can be difficult. Projects shared:

> *Commitment of registered participants to attend sessions still is a challenge. Looking at ways to modify current cessation manual so it is not as lengthy but still providing enough information for participants to make their quit plan and stick with it. Cessation ultimately isn't a one size fit all, finding ways to be creative in support, using text messages, FB chats, one-on-one are some ways we try to be supportive. Accepting that despite cessation challenges with prizes, various ways to support, it doesn't always result in a quit can be a challenge in itself to continue thinking of innovative ways for cessation. Yet knowing people are more conscious of their smoking habits, thinking of quitting and some actually reducing their use of cigarettes is a milestone not to be ignored.*

Competing priorities can be an issue not only with community members, but health workers as well. Many of them also smoke but face urgent situations at their jobs every day. Building these relationships have been identified as important to projects as well. Projects said,

> *The support from staff to implement tobacco cessation programs is a challenge because the support staff use tobacco as well. The First Nation and Inuit people of Canada have a long history with traditional use of tobacco, therefore there is need to denormalize commercial tobacco use while being respectful of the traditional tobacco. This is built on the notion that traditional and commercial uses of tobacco are two opposing ideologies and practices. Lack of capacity to expand smoking cessation training for frontline health staff. (2016-17)*

> *Many of the health care providers and the community health representatives use tobacco. It takes time to build trust and partnerships with the health care providers before we can start working with the community population. Tobacco prevalence is so high that tobacco use is the normative culture, even when pregnant. (2017-18)*

All Indigenous communities face a variety of health challenges related to social determinants of health, such as environmental issues, poverty, colonization, housing problems, etc. As a result of these factors, quitting smoking may not be the first priority for people in the communities. Project stated,

> *There is still a lot of people who smoke…they smoke because they are addicted to the nicotine however they also have underlying issues they are dealing with…sometimes kicking the habit is the last thing on their minds and smoking cessation is put on the back*

burner to assist the participants deal with other issues such as depression stress etc. (2017-2018)

An ongoing challenge is follow up with clients who wish to quit but either due to conflicting schedules, other priorities or commitment level are unable to continue with cessation support or programming. Seeking help and getting to that place of readiness to quit can be a daunting process for many, so we extend patience, empathy, support and creativity in seeing how best to make the process less scary thus increasing an uptake and commitment to quit smoking. (2017-2018)

The issue with smoking cessation remains the same, the majority of community members who smoke have smoked for multiple years, even decades. We often find that the only incentive for these members to attempt to stop smoking is if they are experiencing health issues. We need to focus our prevention strategies with this target group to identify how quitting can impact their health before complications arise i.e.) how smoking plays a part in their diabetes care, heart health etc. The local cigarette stores promote smoking because the success of their business relies on smokers. One challenge that our Smoking Cessation Support Nurses experience is that when people are referred by doctors and other health care professionals, they are not necessarily motivated to quit at that time. (2016-2017)

APPENDIX A: ESSENTIAL ELEMENTS

Essential Element #1: Protection

Actions on tobacco protection measures

- Community leadership implementing youth-focused tobacco protection measures within communities (e.g. prohibiting sales to minors).
- Policies to protect community members from second hand smoke (e.g. no smoking bylaws in public places, smoke-free workplaces, reducing exposure

Essential Element #2: Reducing Access to Tobacco Products

Actions to reduce access to and availability of tobacco products within communities

- First Nations and Inuit leadership to take action to reduce demand and accessibility of tobacco products within their communities by leveraging various strategies impacting access to and availability of tobacco products, including access to low cost cigarettes.
- In communities where measures to reduce access to tobacco products are already implemented or are in place by default (e.g. Inuit communities in remote locations), activities may focus on developing strategies to ensure access to tobacco products remains limited.

Essential Element #3: Prevention

Innovative approaches to prevent tobacco misuse at the group or population level that engage and target community members in relevant settings and environments

- Integration of healthy behaviours and smoking prevention messages and activities in different settings (e.g. family/home environment, school-based programs, community programs, media, and health, cultural and, sport, recreation and treatment centres), targeting specific age-groups.
- Strong focus on children, youth and families, including youth engagement/youth-led activities.
- Elder engagement/elder-led activities.

Essential Element #4: Education

Education and skill development activities directed to community members; and, training for community workers on health promotion and tobacco-related topics

- Age and gender-specific education on the dangers of tobacco misuse (e.g. activities that focus on the family environment, peer pressure, pregnancy, second-hand smoke exposure, etc.).
- Training of health workers on effective approaches to supporting smoking prevention.

Essential Element #5: Cessation

Tools, programs, training and activities to support community members to quit smoking or quit other forms of tobacco misuse

- Services and supports to help people quit smoking, such as nicotine replacement therapy, brief-interventions, etc.
- Linking to existing federal/provincial programming and supports, such as quit-lines.
- Providing role models, mentors and support groups to help people quit smoking.
- Training for health care workers in smoking cessation

Essential Element #6: Data Collection and Monitoring

Use of tools and strategies to collect, analyze and report on data; and, share best/promising practices

- Collection of baseline data on smoking statistics within the region/communities (e.g. rates of smoking, views of community members toward tobacco use, community needs assessments, etc.), in order to inform the planning and design of the project, including performance reporting
- Integration of data collection strategies with provincial partners to prevent duplication of interventions
- Monitoring and reporting on the project, including data collection, reporting and analysis mechanisms that align with First Nations and Inuit principles for information and research governance, such as OCAP™ and others.
- Plans to report on trends and share best/promising practices and knowledge gained from the project with partners and other communities.
- Analysis of Four Key Success Indicators:
    - An increase in the % of smoke free public spaces
    - An increase in the # and type of smoking related resolutions and policies (by Band councils, Tribal councils, governance bodies, etc.) are in place
    - The # and type of promising practices that are identified (both new and existing) and shared with other communities
    - A decrease in the # of daily smokers (in one or more sample population groups, such as adults, youth, pregnant women, etc.) in comparison to initial baseline