Federal Tobacco Control Strategy Annual Report

2014 – 2015

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PART 1

Federal Tobacco Control Strategy Work Plan Activities

Introduction

The Federal Tobacco Control Strategy (FTCS) Annual Report is presented in two (2) parts. The National Aboriginal Diabetes Association (NADA) submitted Part 1, called the FTCS Work Plan Activities, which describes the process, activities and outcomes of the FTCS work plan. Kaplan Research Associates, Inc., submitted Part 2, called the Annual Project Outcomes which describes the collection and examination of the project results submitted by the funded FTCS FNI projects for 2014 - 2015.

Acknowledgements

NADA hosted the FTCS Community of Practice Conference, held in Winnipeg in March 2015. Representatives from fifteen (15) FNI communities from across Canada attended this event. These participants were brilliant in their discussions, participation and especially focused on the Evaluation segments.

I wish to thank all participants and especially the members of the FTCS Evaluation Steering Committee who advised and developed the Annual Outcome Reporting Form for 2014 – 15. Their enthusiastic involvement and support is greatly appreciated.

FTCS - Community of Practice Backgrounder

This section will highlight the accomplishments of the Community of Practice methodology that supported a select number of First Nations and Inuit (FNI) communities /organizations in establishing partnership development and knowledge exchange opportunities as well as comprehensive strategies and interventions aimed at reducing and preventing commercial tobacco misuse.

NADA's primary goal was to assist the FTCS recipients and their respective communities to achieve project objectives focused on four (4) key indicators and enhance co-learning and knowledge exchange. The approach to comprehensive tobacco control is organized around four key intervention pillars of; leadership, health promotion, smoking cessation, and research and evaluation. Accordingly, the FTCS has adopted four related key success indicators, as follows:

1. An increase in the percentage of smoke-free spaces in their 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. The development of promising practices, both new and existing, that can be shared with other communities

The major objectives of the FTCS Community of Practice conference were to provide a host site that would augment learning and knowledge exchange opportunities. Plus, participants were encouraged to share relevant resources, promising practices/strategies around a continuum of tobacco control and prevention modules.

Participants had the opportunity to work with the experts in research and evaluation and tobacco reduction/cessation. These features enhanced the knowledge sharing on project performance measurement, data collection, tobacco cessation /reduction strategies, and community support. The following section features a step by step guide on the development of the Community of Practice.

Step One

NADA received funding for the FTCS Community of Practice in February 2015. With funding secured, NADA could honour contracts with the KRA and MB Lung Association as well as Victoria Inn Hotel and Conference Centre.

The Conference poster, agenda, and registration package were distributed to the 15 FNI FTCS funded recipients. Accommodations, travel arrangements, and meeting spaces were finalized. The delegate database was developed and revised as necessary. NADA, KRA and MB Lung Association developed six PowerPoint presentations in preparation of the FTCS conference.

The presentation topics included: Community of Practice, Shout Wiki website, Train the Trainer, Evaluation and small group work, Smoking Cessation and Prevention from Youth to Adults.

Pre-conference organizational meetings were held between NADA, KRA , and MB Lung Association as well as NADA, KRA and HC – FNIHB. The Annual Reporting Template framework was developed based on the four (4) key success indicators of:

KEY SUCCESS INDICATORS
1. **Increase in percentage of smoke-free public spaces**
2. **Increase in number and type of (formal and informal) smoking related resolutions and policies (by Band councils, Tribal councils, governance bodies, etc) in place**
3. **Number and type of promising practices identified (both new and existing) and shared with other communities**
4. **Decrease in percentage of daily smokers (in one or more sample population groups, such as adults, youth, pregnant women, etc.) in comparison to initial baseline**

Step Two

NADA contracted with Kaplan Research Associates (evaluation) and Manitoba Lung Association (tobacco cessation experts). These three (3) organizations co-facilitated the in-person meetings and provided ongoing support to NADA and project participants via membership in the community of practice meetings and uploads on the communityofpracticeshoutwiki.com website page.

Kaplan Research Associates (KRA) supported project performance measurement and data collection through the development of streamlined data collection tools to assist project leads with their reporting requirements, as indicated in their agreements with Health Canada (HC). This was a participative activity with the conference participants. Participants were so enthusiastic about this segment of the program that they volunteered to form the Evaluation Steering Committee (ESC). Three subsequent conference calls were held with the ESC from April to June 2015 resulting in the finalized version of the Annual Reporting Template 2014 – 2015.

Manitoba Lung Association experts provided information and resources related to cessation, protection, prevention and education activities for the program leads who attended the Community of Practice conference.

The tobacco-related topics spanned age ranges from youth to Elder and included presentation formats suitable for school environments. A nominal list of tobacco-related topics included:

- Smoking Prevention, Grade Five Pledge (children)
- Community-wide Protection activities (e.g. policies and/or bylaws prohibiting smoking in public places (e.g. eliminate harm related to second hand smoke), prohibiting sales to minors, and actions to influence social norms (e.g. Blue Light/Smoke Free Homes Campaign (families)
- Topics /strategies to reduce the presence of low cost tobacco within the community
- Smoking Cessation, Quit contests and cessation group support
- Education/Capacity Building
    - Lungs are 4 Life – Facilitation of the Grade Five Pledge program and present participants with resources in its application
    - Blue Light Project - Providing sessions, orientation, and support for smoke-free homes initiative
    - Not On Tobacco (NOT) and Lungs are for Life (LAFL) - Capacity building by introducing portable Train the Trainer skills/sessions for application within FN&I communities
    - Tobacco and Health Behaviour Change – Provision of resource kit and training tools for capacity building in Tobacco and Health Behaviour Change for project leads, staff, volunteers, partnerships

Step Three

Train the trainer sessions on the community of practice shoutwiki page were repeated throughout the FTCS conference. These sessions were held prior to meeting times, at breaks and at the end of the day. These sessions were one-to-one sessions and each participant was afforded as much time as he or she required. Registration, navigation, uploading information, chats were discussed at these training sessions.

Additionally, a comprehensive PowerPoint presentation established the rationale, strengths, successes and workings of the community of practice and the community of practice shout wiki page. A practitioner's model of success reinforced the inner workings and benefits of belonging to a Community of Practice –" a sharing culture in which people are willing to help each other with no expected reward simply because they feel part of a family."

The following YouTube videos were presented:

- Community of Practice example: https://www.youtube.com/watch?v=lhMPRZnRFkk

- Community of Practice success model: https://www.youtube.com/watch?x-yt-ts=1422503916&v=mNCb7QsAb3I&list=PLfTOA9GXm5amtVCRb3_cbknQ1SV-8QdzJ&x-yt-cl=85027636&feature=player_detailpage

Step Four

The face to face meeting was held in Winnipeg on March 2015. Representatives from Quebec, Newfoundland/Labrador, New Brunswick, Nunatsiavut, HC – FNIHB, Manitoba, Saskatchewan, Alberta and British Columbia attended this 3-day event.

Several activities were carried out to support select FNI communities /organizations to establish comprehensive tobacco control strategies and interventions.

- Initially, FTCS regional and program contact lists were developed to facilitate networking opportunities and regular dialoguing channels
- Meeting materials were produced and bound in resource binders. A nominal listing of these resources include: PowerPoint presentations, tobacco resource tools for education, prevention, protection, and cessation of commercial tobacco use, Data collection tools, and communityofpracticeshoutwiki page, etc
- Networking activities were implemented throughout the conference as this setting was a perfect opportunity for FTCS participants from across Canada to become acquainted with their cohorts to learn about project nuances from coast to coast to coast

Four (4) projects, who demonstrated exemplary promise for addressing the four key indicators, were selected to provide a ten (10) minute presentation on one pre-selected indicator to report on and are as follows:

10 MINUTE PRESENTATIONS	
1. Increase in percentage of smoke-free public spaces	Olanoltinetj, Wollatomuhtine (Breath of Life) - NB
2. Increase in number and type of (formal and informal) smoking related resolutions and policies (by Band councils, Tribal councils, governance bodies, etc) in place	Nunatsiavut government (Inuit) Labrador
3. Number and type of promising practices identified (both new and existing) and shared with other communities	Northern Inter-Tribal Health Authority, SK
4. Decrease in percentage of daily smokers (in one or more sample population groups, such as adults, youth, pregnant women, etc.) in comparison to initial baseline	South East Resource Development Council (SERDC) MB

Step Five

Requests for **video conferencing** this 3-day event were addressed and supported. Audio Visual technicians worked diligently with NADA and HC-FNIHB in providing video feeds of this conference for HC regional representatives to participate via video link.

Step Six

The FTCS participants were enthusiastic to learn all they could about the Annual Reporting procedures. Robust discussions followed and ample time was provided to seek clarification on the Annual Report procedures for FTCS projects. Many questions and examples were provided by the participants in order to demystify this reporting function. As well, participants worked in small groups on the four key indicators as related to their projects, ie; how they were going about it. The project feedback was well received and greatly appreciated by the attendees.

Step Seven

KRA and the FTCS participants formed the FTCS Evaluation Steering Committee (FTCS-ESC) so that they may have more time dedicated for the development of an Annual Reporting template. This activity was deemed necessary so that the reporting format would address project nuances and individual FNI community needs. An unexpected outcome is that many FTCS projects volunteered to sit on this committee knowing that they would be adding tasks onto their already busy workloads. Additionally, the ESC participated fully and grew exponentially in their confidence.

Members of the FTCS -ESC

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The following section will highlight FTCS work plan activities supported by NADA, KRA and MB Lung Association.

Work Plan Activities - NADA

NADA was responsible for presenting a Community of Practice methodology that would support a select number of FNI communities/organizations in establishing comprehensive tobacco control strategies and interventions aimed at reducing and preventing tobacco misuse. NADA was also tasked with supporting these FTCS project leads in the area of knowledge exchange and co-learning activities, disseminating successes and best practices acquired in the FTCS projects to disseminate to other FNI communities in order to encourage and inform them of tobacco misuse and reduction strategies.

The primary goal of the FTCS Community of Practice was to support a select number of FNI communities/organizations to establish comprehensive tobacco control strategies and interventions aimed at reducing and preventing tobacco misuses, including reducing smoking rates. To facilitate this knowledge development and co-learning platform, NADA developed;

1. and shared the FTCS Database of key contacts
2. meeting materials focused on FTCS program pillars of Protection, Access, Prevention, Education, Cessation and Data collection
3. PowerPoint presentations on promising approaches, strategies and tools for Tobacco reduction, protection, cessation, Community of Practice, Shoutwiki, Train the Trainer, Evaluation and Program reporting
4. meeting schedules between NADA contractors for FTCS
5. Save the date posters and FTCS invitations and communications with national FTCS funded recipients

As a result of this preliminary work, the FTCS funded recipients attended a 3-day FTCS Community of Practice conference in Winnipeg in March 2015. Other notable outcomes include:

Outcomes

Activity A	FTCS Database of key contacts	Contact information uploaded onto communityofpractice.shoutwiki.com website for FNI project leads to access and stay connected (network) with other FTCS projects across Canada. This enabled FTCS project leads to continue sharing general program information, best practices, training tips and upcoming events.
Activity B	Meeting materials	Resource materials, Tobacco cessation/reduction strategies, program monitoring and evaluation procedures and community of practice modules completed and delivered at the 3-day conference. This comprehensive training package afforded key learning on tobacco strategies, evaluation methodology and enhanced connectivity through the community of practice website. Opportunities for networking, as in the FTCS Treasure Hunt, enhanced connectivity of FTCS funded projects across Canada
Activity C	PowerPoint presentations	Promising approaches and access to tobacco toolkits and other information was made available to all FTCS projects. This activity enhanced awareness and access to researched “tried and true” methods to decrease tobacco consumption, decrease second-hand smoke, increase smoke free spaces and increase smoking policies within FNI communities. National program monitoring and collection of program data as per the Four Key Success Indicators (mentioned on page 3 of this report) were made consistent and equitable for program leads to report upon.

Activity D	Community of Practice	Capacity building, knowledge exchange and co-learning. After much research and development, the communityofpractice.shoutwiki.com website was launched for the FTCS projects. Train the trainer sessions were created and presented to FTCS project leads, KRA, MB Lung Association and other affiliates, such as Ontario and BC Lung Associations. A shoutwiki train the trainer tip sheet was developed and distributed. This format relays information to the Community of Practice key stakeholders in the areas of; • General information, Pictures, Videos, Resources • Evaluation News • Provincial/Territorial Tobacco Cessation and Reduction Resources • FTCS Program Best practices, Successes Project leads have embraced this feature and have uploaded information, resources, comments, requests, etc. Evidence of these uploads are presented in the final pages of the Part 1 report. The community of practice is a success as FNI project leads and staff has immediate access to resources, research, and best practices for FTCS activities. This supports staff and builds confidence in presenting information, trying new ideas and in the training of staff, program partners, volunteers and other health care professionals.
Activity E	Contracts	Legal contracts with conference contractors ensured contract terms were addressed and deliverables were attended to.
Activity F	Conference calls	Four quarterly conference calls are available for the FTCS program leads. With the 3 – day conference ending in March 2015, the first conference call was held in June 2015, just before the summer holidays. The next call is scheduled for early October 2015. Additional conference calls were added for the ESC to support their efforts on the Annual Reporting Template and Draft Annual Report. Meeting minutes were distributed to all ESC members. This practice encouraged knowledge sharing, transparency and on-going participation. This feature was not originally included in the FTCS Year 1 Work Plan but will be added to the Year 2 (2016) and Year 3 (2017) work plans. FTCS project leads receive ongoing support through a variety of means, such as; multi-media, phone, email, shoutwiki. This type of support helps bind the FTCS program into a comprehensive collective and provides equity of services across this nation.

Tobacco prevention and cessation experts shared information and resources related to tobacco cessation, protection and prevention and education activities for the FTCS program leads. The tobacco related topics spanned the ages from Youth to Elder and included presentation formats for school environments. A nominal list includes:

1. **Grade 5 Pledge**
2. **Blue Light/Smoke Free Homes Campaign**
3. **Quit contests**
4. **Education/capacity building**
    a. **Missing**
    b. **Policy and/or Bylaw**
    c. **Access (Minors)**
    d. **Second-hand smoke**
5. **Other community-wide prevention programs**

The FTCS program leads are at various stages of implementing the above-mentioned strategies. As such a few outcomes are reported below:

Outcomes

Activity A	Grade 5 Pledge	This activity focused on school environments and children, smoking prevention. This activity was introduced late in the year and many projects report that they will revisit the schools to introduce or follow up on this activity in the schools. This activity will empower school staff and other professionals and volunteers to provide information and resources to support healthier lifestyle practices and positively influence a reduction in children and youth smoking behaviours
Activity B	Blue Light/Smoke Free Homes Campaign	This activity targets the community, smoke –free homes, and secondhand smoke. This program aims to increase awareness about the dangers of secondhand smoke in the home. Homes display a Blue light (or other coloured light bulb – dependent on community) in the porch outlet and are designated as smoke-free indoors. This program is popular in the communities and it builds on a successful community trend towards smoking outside or in smoking designated areas. The Blue Light program offers social reinforcement of the value of smoke-free environments.
Activity C	Quit contests / Not on Tobacco (NOT)	Enhances capacity building by introducing portable Train the Trainer skills/sessions for application within FNI communities

Activity D	Policy and/or Bylaw Access (Minors) Second-hand smoke	Education and capacity building. Increasing the number of Smoking (ban) Policies and their enforcement at the community level strengthens regulatory enforcement, for example, prohibiting sales to minors. This activity is coupled with rigorous surveillance as well as increase public education, which in turn, will prevent sales to underage youth. Increasing awareness of the harms of secondhand smoke is an approach used to enable mothers of small children (and other family members) to protect their children from secondhand smoke in the home. This approach encourages cessation and quit attempts by providing a harm reduction approach without using threatening messaging.
Activity E	Other community-wide prevention programs	Youth and schools. Increased engagement and mentoring of Youth as leaders in tobacco reduction enhances the community role model concept as well as building capacity among future community leaders. This feature creates more 'buy-in' from the community and targets youth smoking behaviours. Multi-media approaches increase awareness and education of the abuse of non-traditional use of tobacco. Community-based health communication strategies are implemented by a variety of Health Care professionals (HCP) combined with effective media interventions are essential components of the tobacco control framework. Various communities have implemented the latter two strategies and others are contemplating this strategy. Tobacco and Health Behaviour Change is the provision of resource kits and training tools for capacity building in Tobacco and Health Behaviour change for project leads, staff, volunteers and partnerships.

Kaplan Research Associates, Inc.

NADA contracted with Evaluation and Research experts who shared information and resources related to program monitoring and evaluation and like supports for the FTCS program leads. A nominal list of activities and outcomes includes:

		Outcomes
Activity A	PowerPoint presentation	Capacity building as FTCS program leads displayed inconsistent knowledge and program readiness for implementing reporting and measurement practices. FTCS program leads shared their experiences with those present. Small group work highlighted program strengths, best practices and program monitoring implementation schedules.

		An Evaluation Steering Committee (ESC) was formed. An Annual Reporting Template was developed with input from ESC, Kaplan, NADA and HC. Such engagement and knowledge sharing elevated the confidence and knowledge base for all FTCS program leads
Activity B	CoP bi-monthly meeting/conference call schedule	Knowledge exchange, program engagement and networking activities were reported as a result of the FTCS program leads participation in scheduled conference calls. Ongoing support was provided for the project leaders via community of practice in a variety of ways, such as telephone, email, social media and communityofpractice.shoutwiki.com website. This support was especially offered to FTCS program leaders in their work on program monitoring and data collection via a continuous feedback loop via the communityofpractice.shoutwiki.com website and participation by Kaplan and NADA. Conference calls were held with FTCS program leads, ESC and Health Canada. The latter via the FNI conference calls. The Annual Report On-line Form was developed and distributed. The Annual Reporting Work Book was an additional form developed to further support the FTCS program leads.
Activity C	Annual Report	Kaplan analyzed results from data collection reports submitted by FTCS projects. A draft report was circulated to ESC for input before the revised report was sent to HC.
Activity D	Revisions	Conference call held on August 7, 2015 to review, clarify and discuss the Draft Annual Report. Revisions were made as directed by ESC and HC. Revisions made as appropriate. Annual Report submitted to HC and available for general dissemination. Knowledge exchange on FTCS on-going strategies can be replicated throughout Canada.
Activity E	Submit yearly final report	Base line data documented for year one and available for comparison for subsequent years. Program model can be replicated in more jurisdictions as opportunity presents itself. FTCS Annual Report disseminated to FNI communities across Canada. Other FNI communities may consider the lessons learned and best practices for input of Tobacco reduction strategies in their own communities.

Challenges

The project representatives who attended the FTCS conference reported a diverse spectrum of readiness from being either well on their way to just getting started. The latter situation impacted the conference the most as these projects didn't have their funding or staffing in place. The latter element might hamper reporting deadlines as the 'new hire' would have to be trained on all project and reporting guidelines.

The newer projects are still procuring staff for their Tobacco Coordinator positions while other projects have completed the Annual Reporting On-Line Survey and Workbook. These polar opposite examples represent the many differences experienced by each FNI community hosting a FTCS project. Some of the western provinces, such as Saskatchewan and British Columbia are experiencing wild fires and many communities are under evacuation notice. This may hamper or delay the delivery of the FTCS services and might possibly impact the annual reporting for the FTCS project leads.

The FTCS-ESC was an additional activity added to the NADA work plan for 2014 - 2015. This was an exceptionally good suggestion on behalf of KRA and FTCS projects. However, this new activity had financial implications as this activity was not written into the 2014 – 2015 work plan. Funds to support this activity were not available. This activity will be accommodated in the year 2 (2016) and year 3 (2017) FTCS work plan.

Funding for the FTCS community of practice was received in mid-February. This delay affected the organization, communication and flight arrangements for host organization and potential conference participants. It was a struggle but ultimately, the attendees were welcomed and the conference proceedings ran smoothly.

Video conferencing of the FTCS 3 – day conference was requested just prior to the event so that HC regional leads could "sign in" on an as available basis. Funding was approved for this activity. This option did provide value to the event however, often times the video feed would 'freeze' and cause delays to the proceedings.

National conference calls are extremely difficult to coordinate as there is a four (4-5) hour span from coast to coast. The ESC was notified in advance of four potential meeting dates and three possible meeting times per date to choose from. This process enabled all respondents to provide their strongest choices for meeting day and time. The ESC conference call was held on the date and time with most participation. Meeting minutes were sent to all ESC members following the meeting. This organizational strategy helped facilitate the participation in the conference calls and knowledge exchange for those projects unable to join the call.

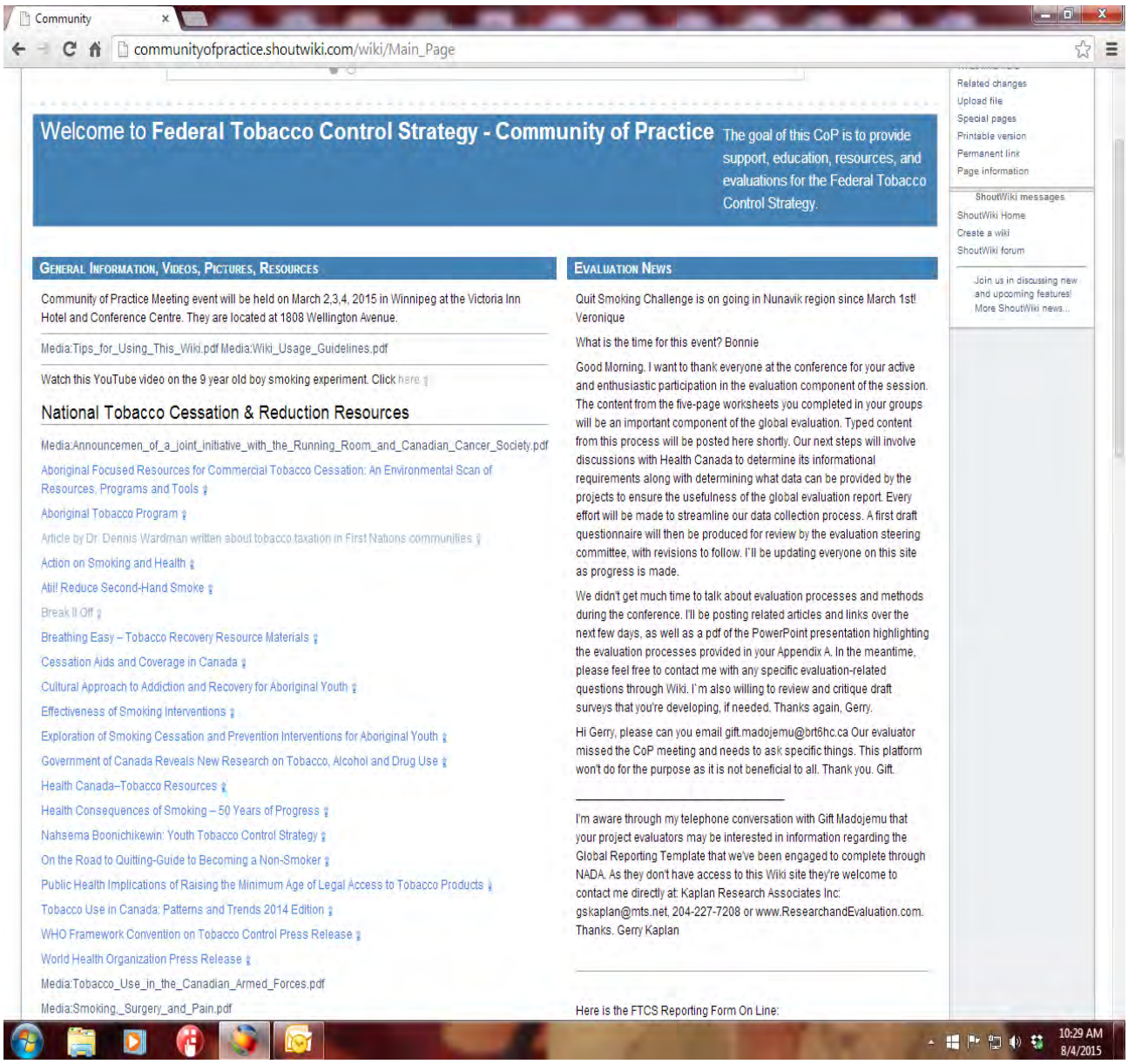
Recommendations

It is recommended that FTCS project leads continue to visit the communityofpracticeshoutwiki.com page with training updates, community survey tools, resources and best practices. Additionally, project materials, such as program models, toolkits, etc should be uploaded on the communityofpracticeshoutwiki.com page.

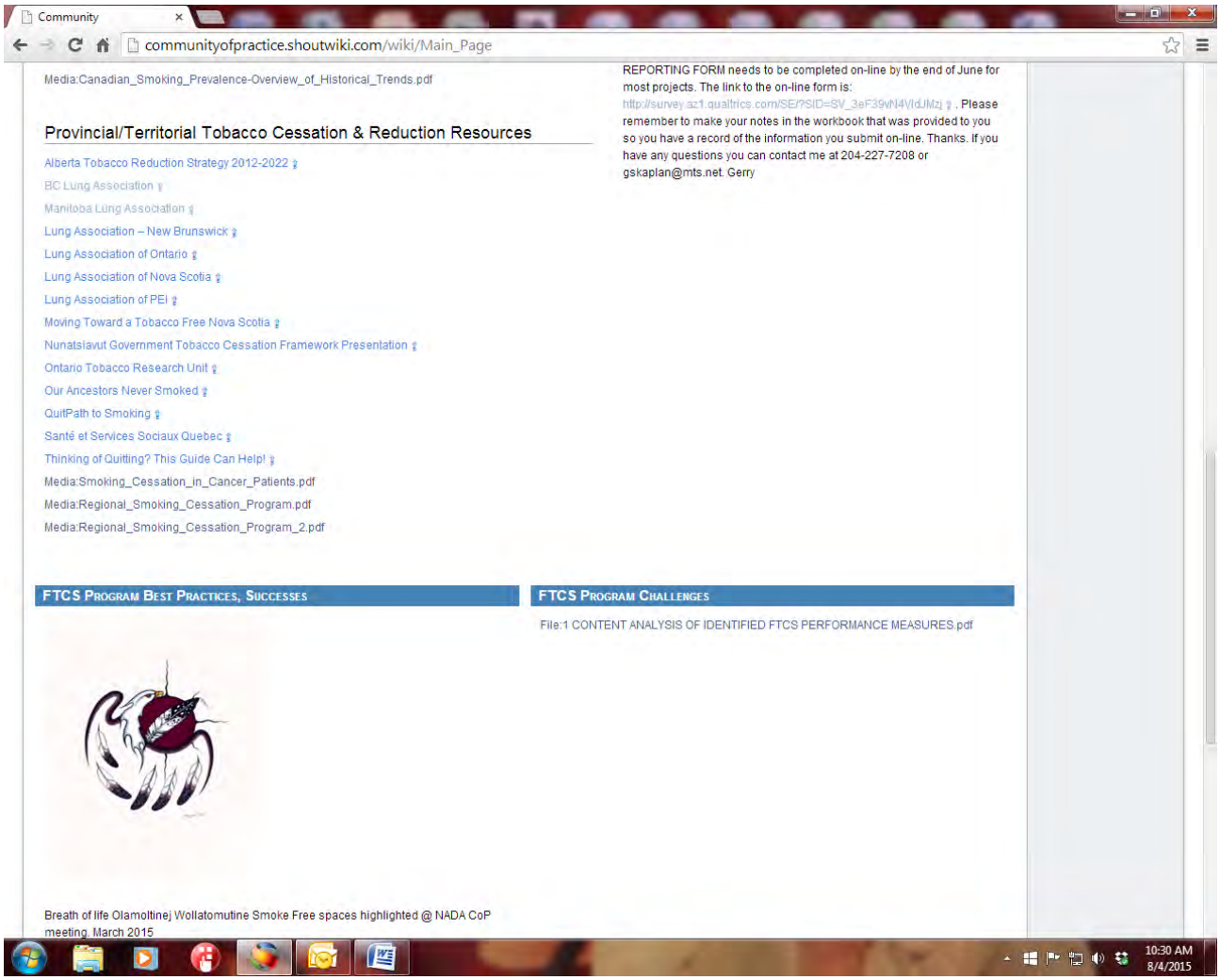
The ESC is an enthusiastic, confident group and should continue to exist for the 2015 – 2016 and 2016 – 2017 years.

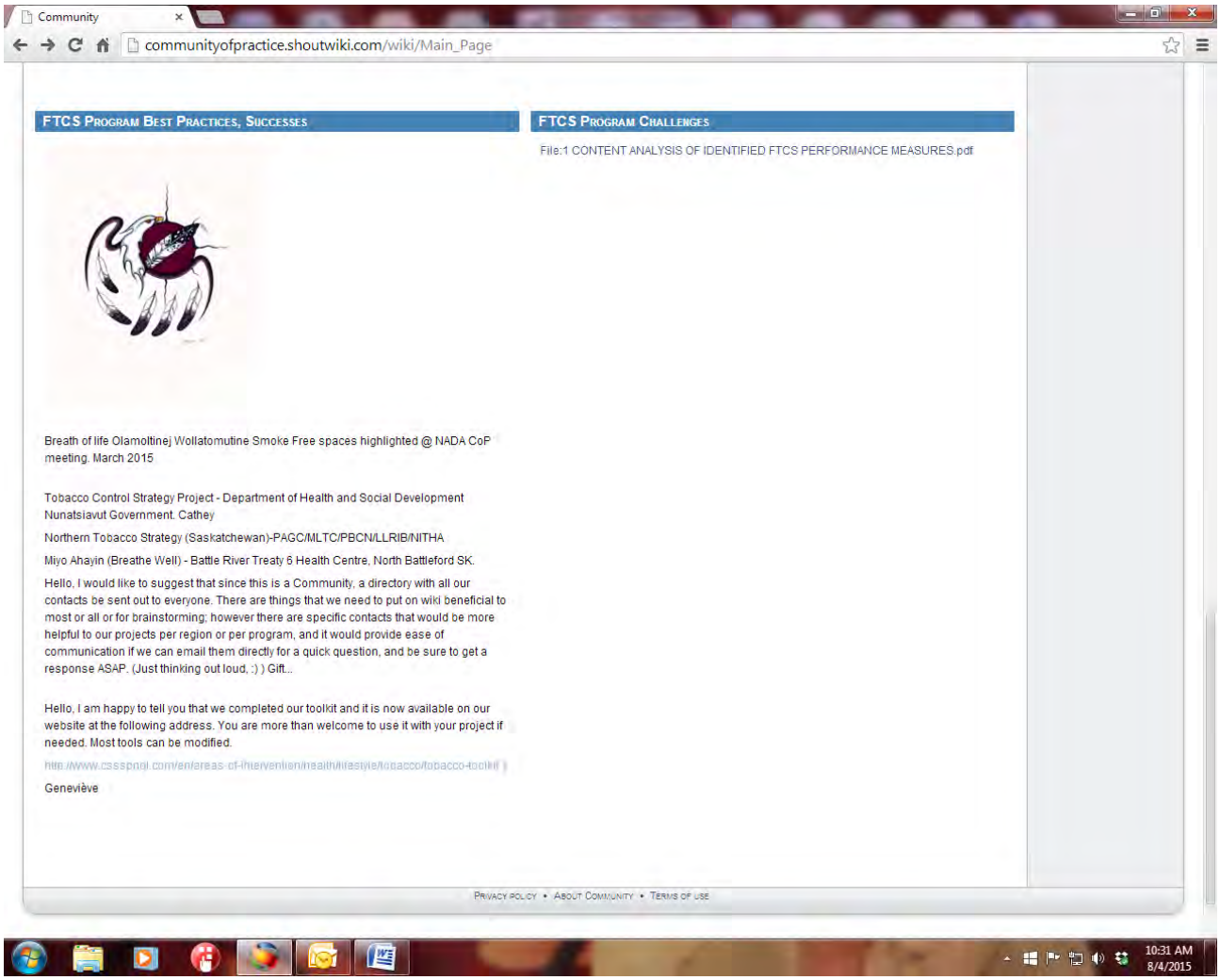
Additional funding for video conferencing should be considered for Year 2 and Year 3 conference events.

The following pages represent information uploaded onto the Communityofpractice.shoutwiki.com. Web site. See below for a nominal listing.



Provincial / Territorial tobacco Cessation & Reduction Resources




Community
communityofpractice.shoutwiki.com/wiki/Main_Page
FTCS Program Best Practices, Successes
FTCS Program Challenges
File:1 CONTENT ANALYSIS OF IDENTIFIED FTCS PERFORMANCE MEASURES.pdf
Breath of life Olamoltinej Wollatomutine Smoke Free spaces highlighted @ NADA CoP meeting. March 2015
Tobacco Control Strategy Project - Department of Health and Social Development Nunatsiavut Government. Cathey
Northern Tobacco Strategy (Saskatchewan)-PAGC/MLTC/PBCN/LLRIB/NITHA
Miyo Ahayin (Breathe Well) - Battle River Treaty 6 Health Centre, North Battleford SK.
Hello, I would like to suggest that since this is a Community, a directory with all our contacts be sent out to everyone. There are things that we need to put on wiki beneficial to most or all or for brainstorming; however there are specific contacts that would be more helpful to our projects per region or per program, and it would provide ease of communication if we can email them directly for a quick question, and be sure to get a response ASAP. (Just thinking out loud, :)) Gift...
Hello, I am happy to tell you that we completed our toolkit and it is now available on our website at the following address. You are more than welcome to use it with your project if needed. Most tools can be modified.
http://www.cssspnql.com/en/areas-of-intervention/health/lifestyle/tobacco/tobacco-toolkit/)
Geneviève
Privacy policy • About Community • Terms of use
10:31 AM
8/4/2015

The Federal Tobacco Control Strategy
First Nations Inuit Health Branch, Health Canada

A REPORT ON THE BASELINE DATA FROM THE FIRST ANNUAL OUTCOME REPORTING PROCESS

2014-2015

PART II

SEPTEMBER 2015

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REPORT CONTENTS

ACKNOWLEDGEMENTS

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The participants in the ***Federal Tobacco Control Strategy Community of Practice Meeting***, held in Winnipeg on March 3 to 5, 2015, and hosted by the **National Aboriginal Diabetes Association**

These participants fully embraced the concept and importance of evaluating the processes and services of their FTCS projects. They also participated in two intensive half-day small group processes held during this meeting to provide feedback on key outcome questions.

The members of the FTCS Evaluation Steering Committee

The members of the FTCS Evaluation Steering Committee actively participated in the development of the study's areas of inquiry, and the development of the ***Annual Outcome Reporting Form*** for 2014-15. They also provided helpful suggestions to make the process of completing the form as simple as possible for the study respondents. Their enthusiastic involvement and support is greatly appreciated.

Project Representatives on the Steering Committee included:

Gift Madojemu	Health Promotion Specialist, Lung Health Coordinator, Battle River Treaty 6 Health Centre, Saskatchewan
Jaimee Marks	Consultant, File Hills Qu'appelle Tribal Council, Saskatchewan
Desmond Martin	Tobacco Control Strategy Prevention Coordinator, Chemawawin Health, Manitoba
Bonnie McCloud	Manager, Samson Community Wellness of Samson Cree Nation, Alberta
Justina Ndubuka	Tobacco Project Coordinator, Northern Inter-Tribal Health Authority, Saskatchewan
Laurie Nicholas	Health Coordinator, Mawiw Council Incorporated, New Brunswick
Kayla Serrato	Senior Policy Analyst, First Nations Health Authority, British Columbia
Genevieve Voyer	Agente de développement - projets en santé, Commission de la santé et des services sociaux des Premières Nations, Québec
Michele Wood	Researcher/Evaluator, Nunatsiavut Government, Department of Health and Social Development, Newfoundland and Labrador

We also acknowledge the support, advice and encouragement of the following individuals. They include representatives of Health Canada, which funds the FTCS, and the National Aboriginal Diabetes Association, which manages the FTCS Community of Practice, and the outcome reporting process, on behalf of Health Canada. These individuals were also active members of the Evaluation Steering Committee.

Anita Ducharme
Executive Director
National Aboriginal Diabetes Association

Mathieu Larose
Senior Advisor, Program Development - Community Health Promotion
First Nations and Inuit Health Branch, Health Canada

Anne Guy
Planning, Information, & Performance Measurement
First Nations and Inuit Health Branch, Health Canada

Finally the authors acknowledge, with gratitude, the project managers who completed their **Annual Outcome Reporting Forms**. Your commitment to the reporting process was essential to its success.

I) BACKGROUND AND METHDOLOGY:

1.1) The Federal Tobacco Control Strategy:[1]

This report provides the ***baseline findings*** for **Federal Tobacco Control Strategy** (FTCS) projects that were initiated in 2014-2015. FTCS operates through **First Nations Inuit Health Branch, Health Canada.** This ***FTCS Annual Outcome Report*** has been completed by **Kaplan Research Associates Inc**. under the auspices of the **National Aboriginal Diabetes Association** (NADA). This is a ***quantitative*** and ***qualitative*** evaluation process. It constitutes the first of three annual outcome reports that will be undertaken by the evaluators. The results of the second and third year reports will replicate the findings from the current report, and will be used as the basis by which to measure changes over time.

The ***First Nations and Inuit Component*** of the Federal Tobacco Control Strategy (FTCS) is a knowledge-development initiative focused on reducing the non-traditional use of tobacco, while recognizing and respecting traditional forms and uses of tobacco within First Nations communities. Recreational use of tobacco is a major contributing factor to a number of chronic diseases and is the leading cause of preventable illness and premature death in Canada. This includes smoking cigarettes, cigars, little cigars, blunt wraps, non-sacred pipes, chewing tobacco or snuff. Smoking rates for First Nations people living on-reserve and for Inuit are more than triple the Canadian average. Recent findings report that 57% of First Nations adults living on-reserve and in northern First Nations communities smoke daily or occasionally[2] and 54% of Inuit adults are daily smokers.[3]

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 approach to comprehensive tobacco control is organized around ***four key intervention pillars***:[4] [5]

1) Leadership
- Protection
- Reducing the access to tobacco products

2) Health Promotion
- Prevention
- Education

3) Smoking Cessation

4) Research and Evaluation
- Data collection and monitoring

The focus of the broader FTCS is to:

1) Prevent children and youth from starting to smoke [6]
2) Help people to quit smoking
3) Help Canadians protect themselves from second-hand smoke

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[1] Some of the information in this section was cited from the document: ***Guidelines to the First Nations and Inuit Component of the Federal Tobacco Control Strategy: 2014-2017***, First Nations Inuit Health Branch, Health Canada

[2] cf. First Nations Regional Health Survey, 2008/10

[3] cf. A fact sheet compiled by Inuit tapiriit kanatami (ITK), and referenced by FNIHB.

[4] Op. cit. ***Guidelines to the First Nations and Inuit Component of the Federal Tobacco Control Strategy: 2014-2017***, pages 5 to 7.

[5] More information about these four pillars can be found in **Appendix A** of this report.

[6] Cited from http://www.hc-sc.gc.ca/hc-ps/pubs/tobac-tabac/fs-sf/index-eng.php

4) Regulate the manufacture, sale, labeling and promotion of tobacco products by administering the *Tobacco Act*

Accordingly, 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) The development of promising practices, both new and existing, that can be shared with other communities

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 surrounding the four key indicators during the first year of data collection for sixteen FTCS projects. They include data provided by:

- Battle River Treaty 6 Health Centre
- Beaver First Nation
- British Columbia First Nations Health Authority Tobacco Strategy
- Chemawawin Cree Nation
- Cree Board of Health and Social Services of James Bay
- Department of Health and Social Development, Nunatsiavut Government
- Files Hills Qu'Appelle tribal council
- Grand Council Treaty #3
- Health Canada, First Nations and Inuit Health
- Keewatin Tribal Council
- Mawiw Council
- Northern Inter Tribal Health Authority
- Nunavik Regional Board of Health and Social Services
- Nunee Health Board Society
- Samson Community Wellness
- Siksika Health Services
- Southeast Resource Development Council

Some projects are implemented in a single community, while others serve multiple communities, or in three cases, entire provinces or territories.

Because of unique approaches in implementation, three additional FTCS projects were not included in this first year of data collection and analysis. These included the project with the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC), and two projects with the Governments of Nunavut and the Northwest Territories. Their data were therefore not available for this report. However, their baseline data will be added to the current database as they complete reporting for years two and three.

1.2) The Study Methodology:

In March, 2015, NADA sponsored a three-day conference, held in Winnipeg, Manitoba. Representatives of the participating projects, Health Canada, NADA and Kaplan Research Associates were in attendance. In terms of FTCS Annual Outcome Report, this venue was used to outline the role and process of this report, in contrast to the individual evaluations being undertaken by each of the projects. Participants voiced their support for collaborative development process. On the afternoon of the second day of the conference, and the morning of the third, participants were broken into four groups to assist the evaluators with the development of a global evaluation framework. Each group was asked to address six questions, each of which were associated with the four key success indicators.[7] The questions included:

[7] The results of these group processes can be found in **Appendix B** of this report.

1) What related baseline data are available regarding your community, as of March 31, 2015. What baseline data currently exist and how would they be accessed?
2) What are your related project objectives? What are the measurable outcomes that your projects are designed to achieve?
3) What target populations are your projects designed to impact? (For example, prenatal parents, infants, school-age children, seniors, organizations, departments, etc.).
4) Who are the community partners or champions that you plan to involve in your projects?
5) What related activities, services or materials does your project plan to design and/or deliver?
6) What are the anticipated challenges or barriers that your projects may experience?

One of the last evaluation-related activities at this conference was a call for volunteers to participate on an Evaluation Steering Committee. Their role would be to work on the questions for analysis, to participate in the development of the questionnaire (the ***Annual Outcome Reporting Form***), and to review and comment on the draft report. The final report would be amended based on any questions or comments that ensued through this consultative process. Eight project representatives volunteered to participate on this committee.

It was confirmed at the first meeting of the steering committee that the data collected in year one (2014-2015) would constitute ***baseline data***. This is important because some of the projects were just getting underway in March 2015. In fact, for one manager at the conference, that was her first week on the job. As such, it would be unrealistic and unfair to expect that the projects will have measurable outcomes at this juncture.

1.2.1) The Areas Of Inquiry:

The development of the ***Outcome Annual Reporting Form*** was a consultative process that required approximately seven drafts. The content of the form is based, in part, on the results of the small group processes at the conference, along with the projects' key success indicators. The following questions were included in this form:

- Project name
- Number of communities served by each project
- The target populations served by each project as of March 31, 2015 [8]
- The partners or 'champions' with which each project worked, as of March 31, 2015
- The number of inside and outside smoke-free spaces identified within the catchment area of each project, as of March 31, 2015
- The number of smoking-related resolutions passed by governance bodies of their communities by this juncture
  - The specific smoking-related resolutions that had been passed at this time
- The number of representatives of identified target groups regarding the following factors:
  - The number of participants who entered their smoking cessation programs or interventions
  - The number of participants who completed them
  - The number of participants who reduced their daily smoking but did not quit (harm reduction)
  - The number of participants who quit smoking during, or at the end of, the smoking cessation program or intervention
  - When these data were collected
- Whether each project collected information (data) using a population or community-level survey. If 'yes,' then:

[8] The end of the initial fiscal year, to serve as the study baseline.

- A description of the population being surveyed
- The status of each study (i.e., completed, in process, not yet started, unknown)
- The actual or planned sample size
- The response rate, if applicable
- The baseline prevalence of daily smokers, if this is known
- Whether there is a plan to replicate the baseline study and, if so, when this would be undertaken

- 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 detailed description of ***one successful process*** that each project completed in 2014-2015

The Annual Outcome Reporting Form was developed as an online survey. In addition, each project representative was provided with a pdf of the form to use as a ***worksheet***. They were asked to retain this worksheet as a hardcopy version of their responses. In the end 16 out of the 16 projects completed the form.

All **quantitative** data were analyzed using the ***Statistical Package for the Social Sciences*** (SPSS). All open-ended (**qualitative**) data were subjected to a ***content analysis***. In terms of the latter, respondents' verbatim responses are included in the body of this report. All of the data collected is presented in the ***aggregate*** in this report. No regional variations are tracked through this analysis.

1.2.2) Technical Notes:

This section describes the statistical measures incorporated into this report. Given that this report provides the baseline information, and given that no analyses will be undertaken by region or other independent variables, analysis is solely based on the use of **Descriptive Statistics.**

Descriptive statistics include frequency counts and percentage breakdown; mean; median; and standard deviation (sd).

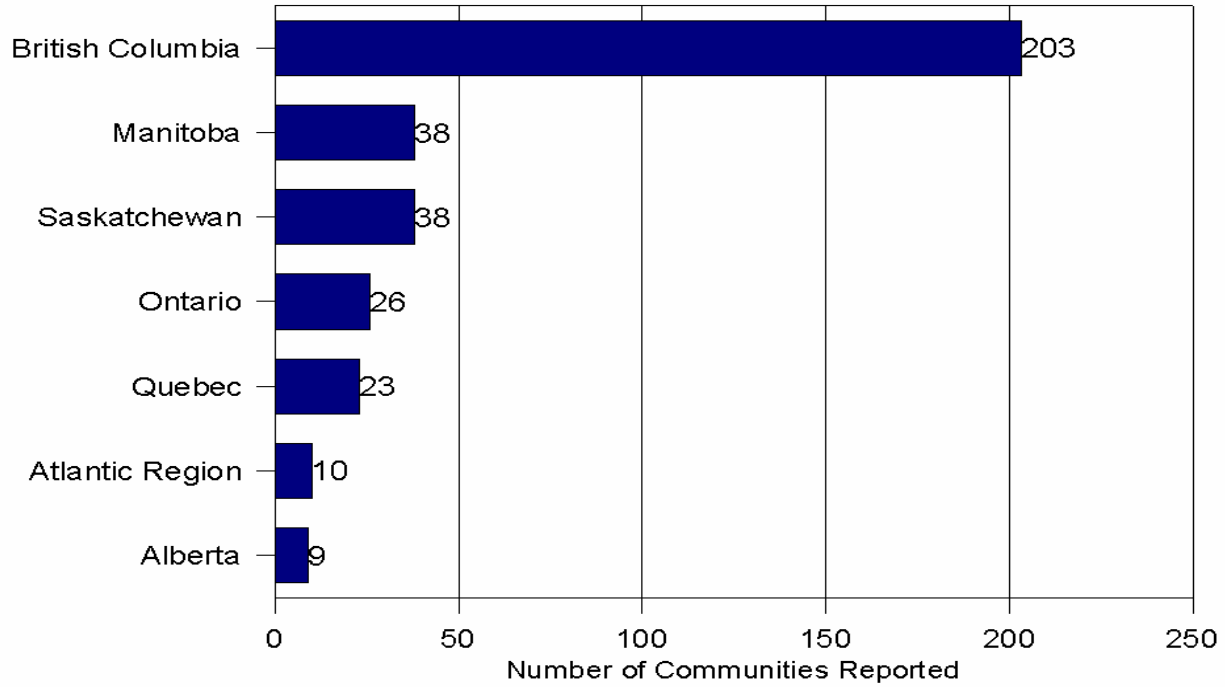
- The ***mean*** **(average)** is a measure of central tendency for continuous variables calculated as the sum of all scores in a distribution, divided by the number of scores.
- The ***median*** is the value or score that exactly divides an ordered frequency distribution into equal halves: the outcome associated with the ***50th percentile***.
- ***Standard Deviation*** is a measure of the degree to which the range of scores either clusters around the mean, or is more widely ***dispersed***, or spread, along a given scale. The value of standard deviation lies not only in describing the distribution of scores, but it assists in the comparison of the populations under review.

II) THE FINDINGS OF THE ANNUAL OUTCOME REPORTING PROCESS:

2.1) The Number Of Communities Each Project Serves:

The 16 FTCS projects reportedly serve 347 First Nations communities across Canada (Figure 1). British Columbia is planning to serve 203 communities, Manitoba and Saskatchewan 38 communities each, Ontario 26 communities, Quebec 23 communities, the Atlantic Region 10 communities, and Alberta 9 Communities.

Figure 1 Number Of Communities Served, By Province*



(Number of projects=16. *Estimates based on information provided by the projects and FNIHB.)

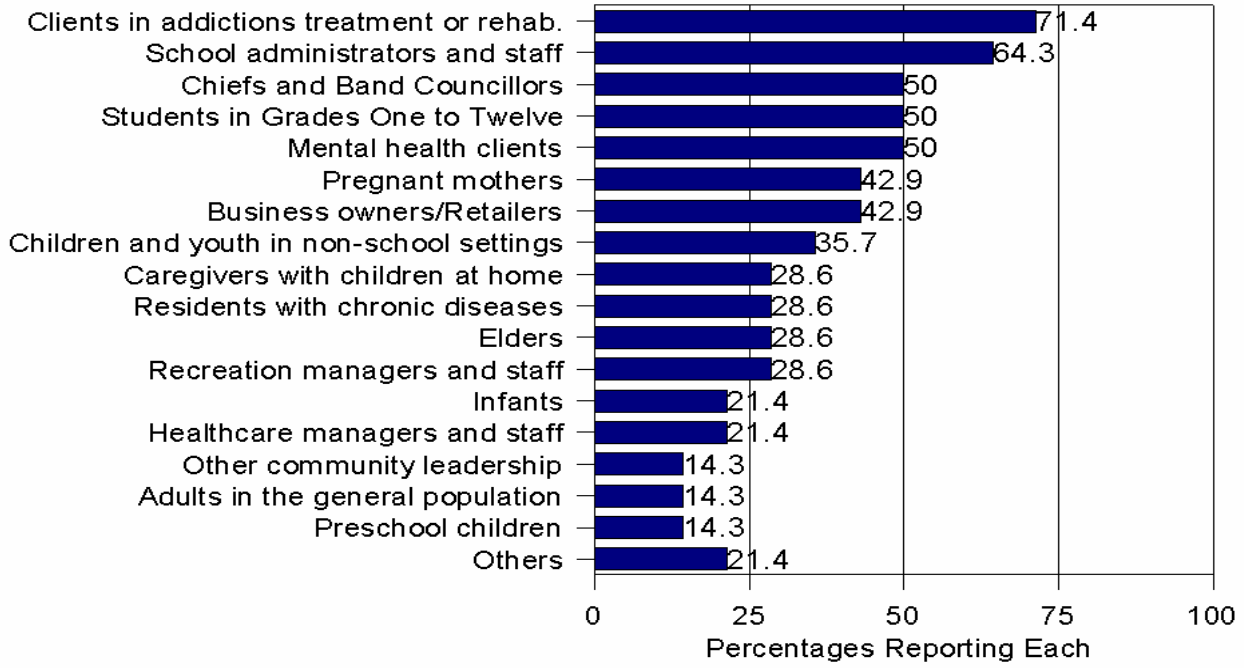
2.2) Target Populations Projects Reached:

Respondents were asked to identify the populations their projects reached up to March 31, 2015. The largest percentage of projects (71.4%) reached addictions treatment clients, followed by those reaching school administrators and staff (64.3%) (Figure 2). Half of the projects reached Chiefs and Band Councillors, students attending Grades One to Twelve, and/or mental health clients. Just under half of the projects (42.9%) reached pregnant mothers and/or business owners or other retailers. Smaller percentages reached the following target groups: children in non-school settings (35.7%), caregivers with children at home (28.6%), community residents with chronic diseases (28.6%), Elders (28.6%), recreation managers and staff (28.6%), infants (21.4%), healthcare managers and staff (21.4%), other community leaders (14.3%), adults in the general population (14.3%) and preschool children (14.3%). Three projects (21.4%) reached 'other' populations, including an addictions service provider, a mental health service provider, a senior government manager and a provincial-regional partner.

2.3) Projects' Community Partners:

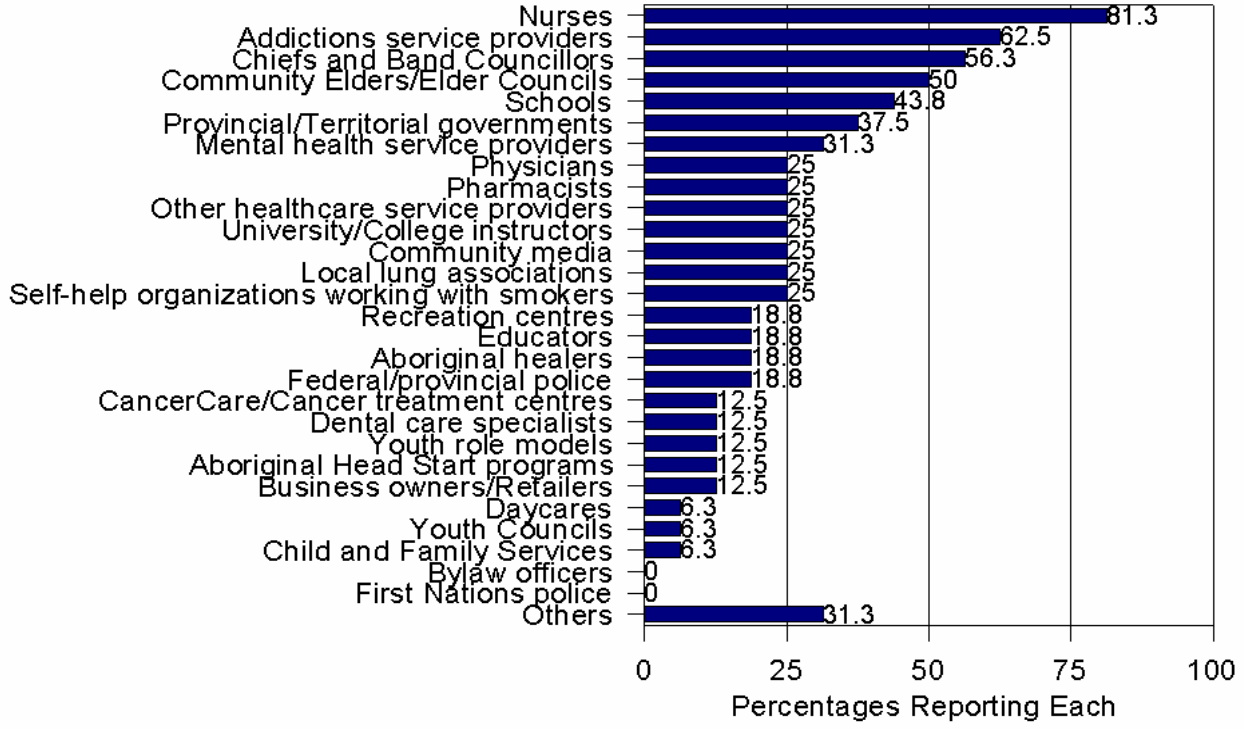
Respondents were asked to identify the community partners with whom they worked to begin to achieve their objectives. The largest percentage of projects identified nurses as their partners (81.3%), followed by addictions service providers (62.5%), Chiefs and Band Councillors (56.3%), and community Elders or Elders Councils (50.0%) (Figure 3). Other community partners included: schools (43.8%), provincial and territorial governments (37.5%), mental health service providers (31.3%), physicians (25.0%),

Figure 2 Populations That Had Been Reached By The Projects In 2014-2015



(Number of projects reporting=14. Multiple responses are allowed. Adjusted to exclude missing data.)

Figure 3 Community Partners With Which Projects Had Worked In 2014-2015



(Number of project reporting=16. Multiple responses are allowed. Adjusted to exclude missing data.)

pharmacists (25.0%), other healthcare service providers (25.0%), university and/or college instructors (25.0%), community-based media (25.0%), local Lung Associations (25.0%) and/or self-help groups that work with smokers (25.0%). Some of these community partners provided letters of support that assisted the projects to received funding from FTCS.

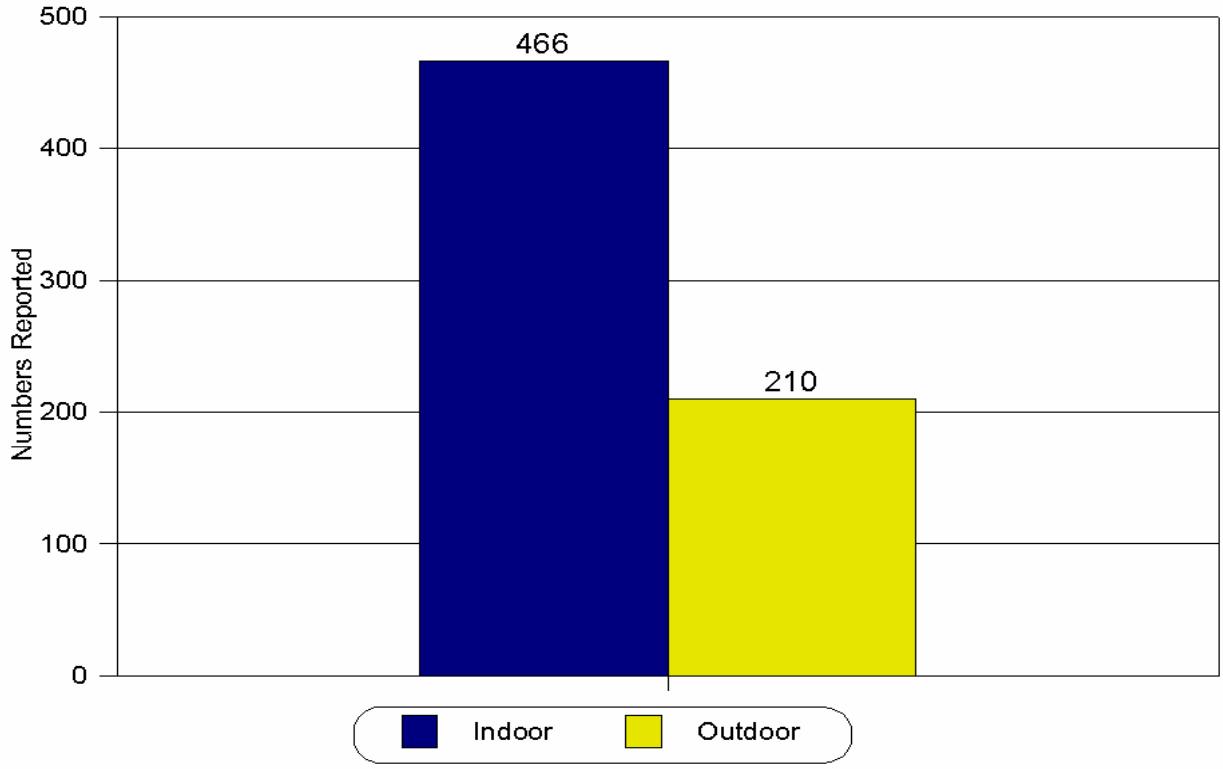
The smallest percentage of projects identified the following organizations or individuals as their partners: recreation centres (18.8%), educators (18.8%), Aboriginal healers (18.8%), federal and/or provincial police services (18.8%), *CancerCare* or cancer treatment centres (12.5%), dental care specialists (12.5%), youth role models (12.5%), Aboriginal Head Start Programs (12.5%), business owners and/or retailers (12.5%), daycare centres (6.3%), youth councils (6.3%) and/or Child and Family Services agencies (6.3%). Five projects (31.3%) identified 'other' community partners with which they worked. These included: municipal governments, an epidemiologist, a regional health authority, and a health director. No projects reported working with either bylaws officers, or First Nations police officers.

2.4) Smoke-Free Spaces In The Communities:

The development and enforcement of smoke-free spaces is a key goal of the Federal Tobacco Cessation Strategy, and one of the four key success indicators. As a baseline measure, respondents were asked to identify the number of indoor and outdoor smoke-free spaces that existed within their catchment areas as of March 31, 2015.

In the aggregate, and as a baseline, 466 indoor smoke-free spaces were identified by these 16 projects, along with 210 outdoor smoke-free spaces, totaling ***676 smoke-free spaces*** during the first year of the project (Figure 4). It is assumed that many of the outdoor spaces would be adjacent to their respective indoor spaces.[9]

Figure 4 Total Number Of Smoke-Free Spaces Reported



(Number of projects reporting=12, 9. Adjusted to exclude missing data.)

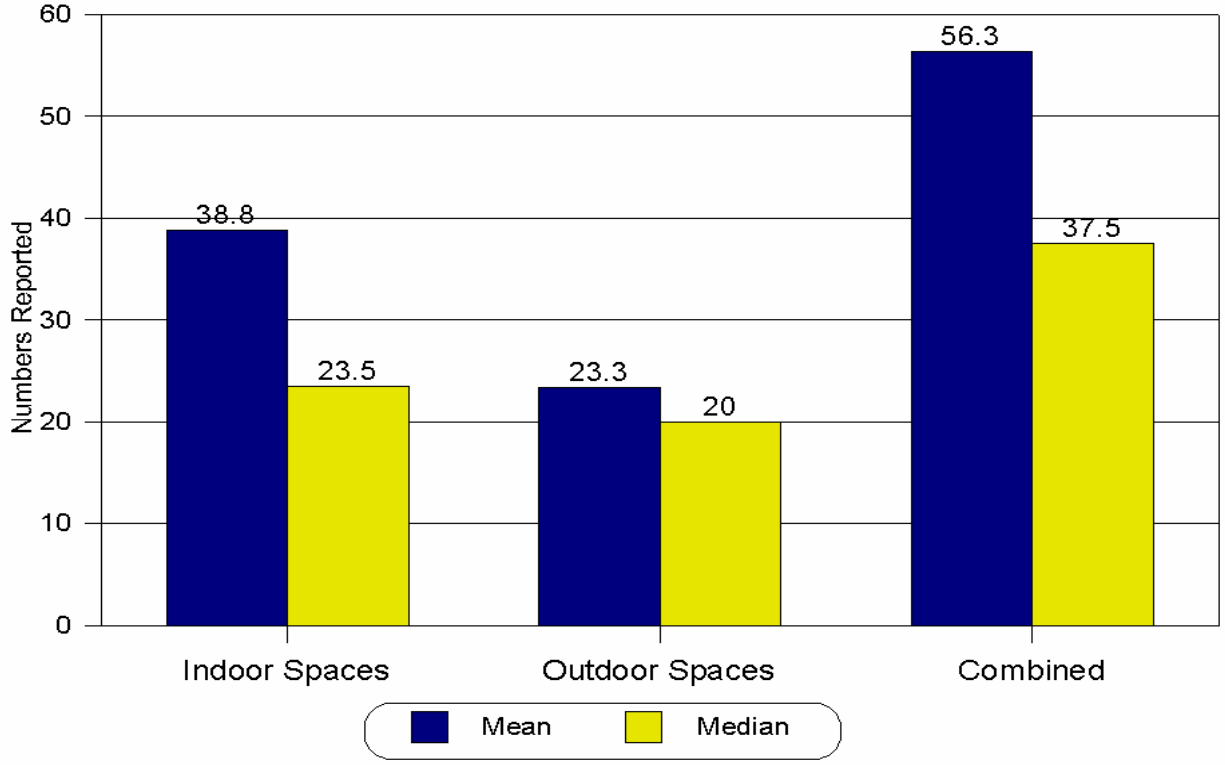
[9] When identifying outdoor smoke-free spaces, respondents were told that this should be based on their own provincial or territorial legislation, for example legislation banning smoking within 9 meters from a building's entrance.

On average, each project identified 38.8 indoor smoke-free spaces during this timeframe, with a median of 23.5 (sd=38.30) (Figure 5). The actual number of indoor smoke-free spaces ranged from a low of five and six in two project areas, to a high of 79, 84 and 123.

Fewer outdoor smoke-free spaces were identified by the projects. This included an average of 23.3, with a median 20.0 (sd=20.09). The actual number of outdoor smoke-free spaces in each project area ranged from a low of 3, 6, and 7, to a high of 44 and 63.

There was an average of 56.3 total smoke-free spaces reported across the 16 projects, with a median of 37.5 (sd=54.79). The actual total number of smoke-free spaces ranged from a low of 6 and 8, to a high of 79, 128 and 186.

Figure 5 Mean And Median Smoke-Free Spaces



(Number of projects reporting=12, 9, 12. Adjusted to exclude missing data.)

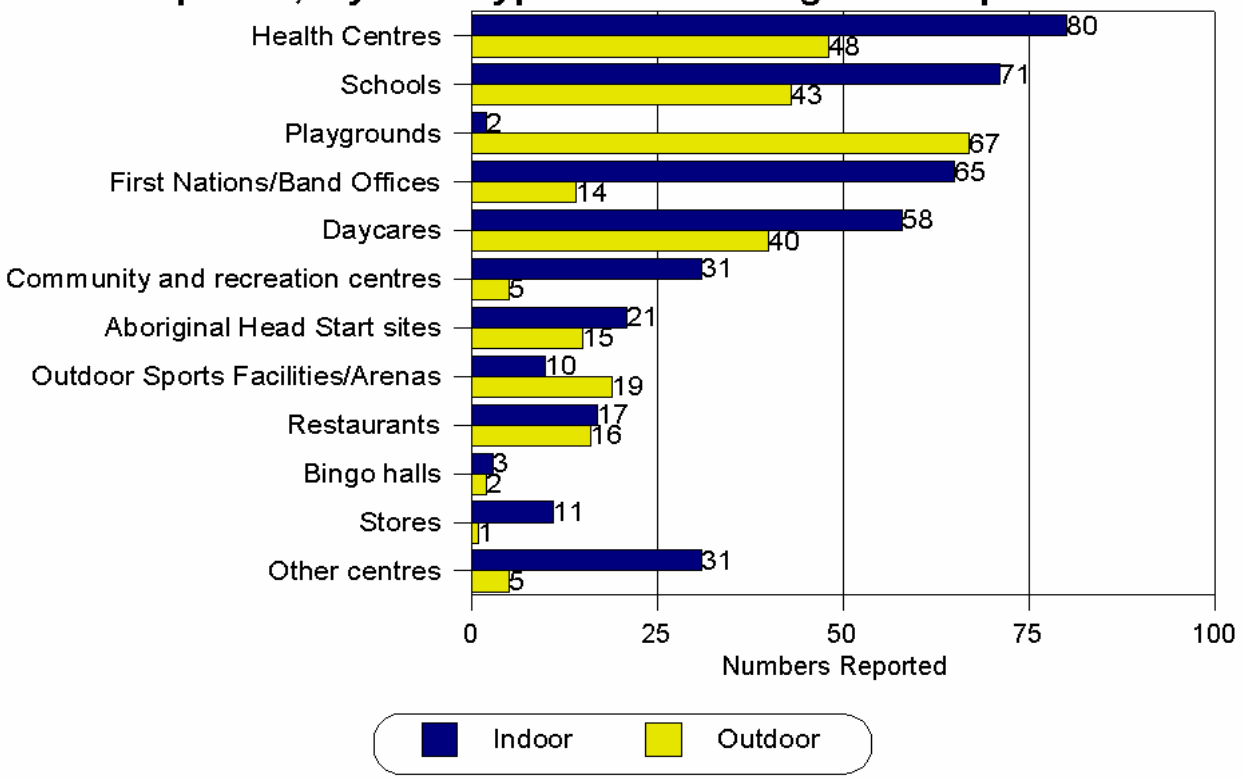
2.4.1) Smoke-Free Spaces By The Nature Of The Related Buildings And Spaces:

Respondents from each project were asked to identify the number of indoor and outdoor smoke-free spaces for eleven types of buildings or spaces. The largest number of ***indoor smoke-free spaces*** across the 16 projects, include, in ranked-order (Figure 6):

- Health centres (80)[10]
- Schools (71)
- First Nations Band offices (65)
- Daycares (58)
- Community and recreation centres (31)
- Aboriginal Head Start Program sites (21)[11]

[10] Numbers reported by all 16 project sites.
[11] Although the number of smoke-free AHS sites listed may appear relatively low, it is assumed that their absolute numbers across the 16 communities would be of a relatively equal size.

Figure 6 Number Of Indoor And Outdoor Smoke-Free Spaces, By The Types Of Buildings And Spaces



(Number of projects reporting each=12/8, 11/7, 7/3, 12/6, 11/7, 7/4, 10/6, 3/5, 4/3, 3/2, 5/3, 6/4. Adjusted to exclude missing data.)

The smallest number of indoor smoke-free spaces included, in reverse ranked-order:

- Playgrounds (2)
- Bingo halls (3)
- Sports arenas (10)
- Stores (11)
- Restaurants (17)

The largest number of ***outdoor smoke-free spaces*** across the 16 projects include:

- Playgrounds (67)
- Health centres (48)
- Schools (43)
- Daycares (40)
- Aboriginal Head Start Program sites (15)[12]

The smallest number of outdoor smoke-free spaces include spaces adjacent to:

- Stores (1)
- Bingo halls (2)
- Community and recreation centres (5)
- First Nations Band offices (14)
- Restaurants (16)
- Outdoor sports facilities and arenas (19)

Thirty-six ***other*** indoor and outdoor smoke-free spaces were indicated by respondents, with seven of these being identified. They include:

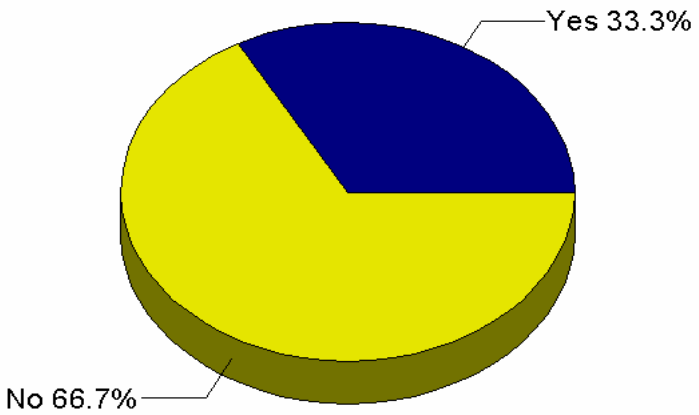
- An arcade
- A gas station
- A wellness centre
- A community hall
- A Social Development Building,
- The Chemawawin Water Plant,
- The TLE Building

[12] See footnote 11.

2.5) Communities Passing Smoking-Related Resolutions

Respondents were asked to indicate whether any of the communities within their catchment areas had passed smoking related resolutions as of March 31, 2015. This would include resolutions passed by Band Councils, Tribal Councils, or other governance bodies. In the aggregate, one-third of the respondents reported that this had occurred in their areas at that time (Figure 7).

Figure 7 Were Smoking-Related Resolutions Passed By Governance Bodies In 2014-2015?



(Number of projects reporting=15. Adjusted to exclude missing data.)

When all respondents were asked how many resolutions had been passed within their catchment areas, the number totaled 29 resolutions, with a mean of 1.9 and a median of 0 (sd=4.63) (Figure 8). Of the five projects that reported smoking-related resolutions within their catchment areas, the mean response was 5.6 resolutions being passed, with a median of 3.0 (sd=6.99).

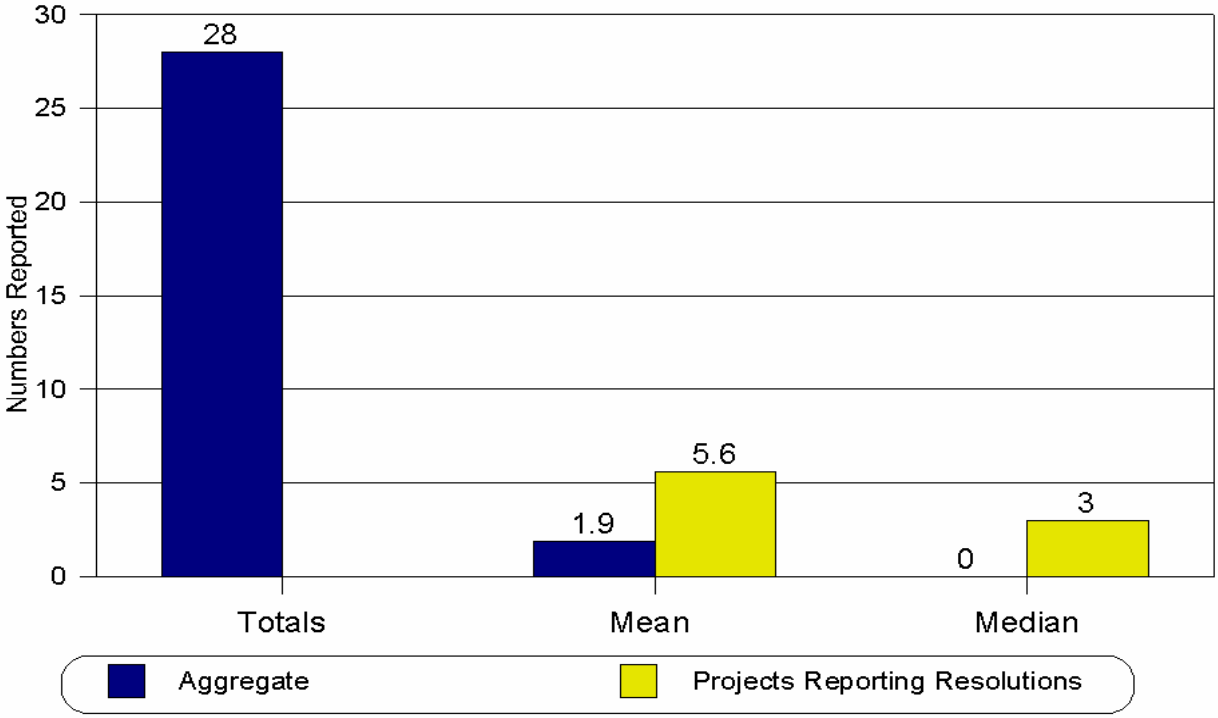
2.5.1) Types Of Smoking-Related Resolutions Passed By Governance Bodies:

Respondents, who reported that smoking-related resolutions had been passed by their governance bodies, were asked to identify the nature of these resolutions. The list of possible responses was developed in conjunction with the evaluation steering committee. They included (Figure 9):

- Designating smoke-free public spaces (80.0%, n=4)
- Using tobacco-related revenues to fund health promotion activities (40.0%, n=2)
- Enforcing smoke-free public spaces (20.0%, n=1)
- Promoting smoke-free homes (20.0%)
- Expanding smoke-free perimeters surrounding smoke-free buildings and spaces (20.0%)

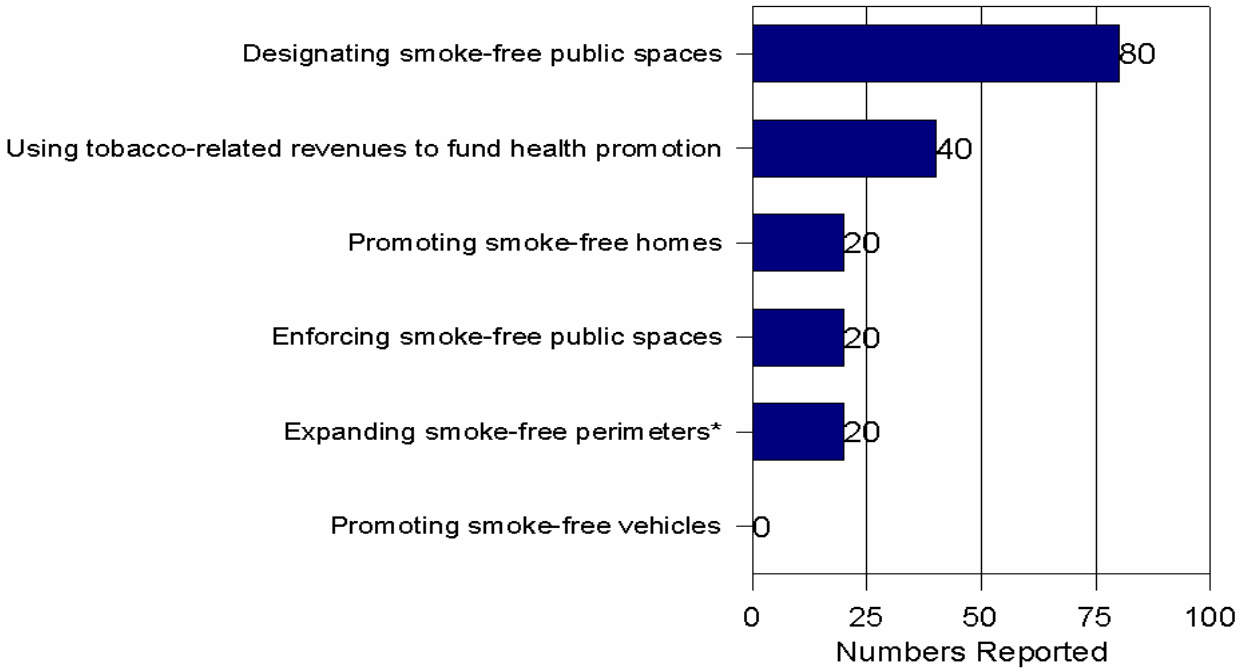
No respondents reported resolutions to promote smoke-free vehicles when young children are in the vehicles. No additional resolutions were identified by these respondents.

Figure 8 The Number Of Smoking-Related Resolutions Passed By Governance Bodies In 2014-2015



(Number of projects reporting=15, 5. Adjusted to exclude missing data.)

Figure 9 Types Of Smoking-Related Resolutions Passed In 2014-2015



[Of the projects reporting that resolutions had been passed (N=5). *Surrounding smoke-free buildings and/or spaces.]

2.6) Decreasing The Number Of Daily Smokers:

One of the success indicators of the FTCS is a decrease in the percentage of daily smokers compared to initial baselines. It was the intent of this preliminary study to establish the baselines against which future smoking rates would be evaluated. A matrix was developed in the survey that established nine intervention target groups, and posed five questions regarding each of these (see below[13]):

- The total number of people (from each target group) who were participants at the start of the smoking cessation program or intervention
- The number of these people who completed these smoking cessation programs or interventions
- The number of people (who attended the programs and interventions) who reduced their daily smoking rates (harm reduction)
- The number of people who quit smoking during or at the end of their participation in the smoking cessation program or intervention
- When these data were collected

From their responses it appears that most of the programs had not had sufficient time, during their first year of operation, to begin offering smoking cessation programs or interventions. Only three of the 16 projects provided any data for this question. Their related data are provided on the following page.

III) Decrease in the Percentage of Daily Smokers

7) For each group below for which your project will obtain smoking-related data, please provide the following information, if available at this time: *NOTE: If the program/intervention is occurring in ***multiple communities***, please ***combine the results. If you are unsure, please leave the corresponding box empty. If the answer is 'none,' please enter "0."***

Prior To March 31, 2015

Intervention Target Groups	Total # of participants at the start of the smoking cessation program/ intervention	Number of participants who completed the smoking cessation program/ intervention	(If available) # of smokers who reduced daily smoking during the smoking cessation program/ intervention, but did not quit	Number of participants who quit smoking during or at the end of the cessation program or intervention	When were these data collected (MM/YYYY)
Pregnant women					
Caregivers of infants/young children (less than 3 years of age)					
Program participants in community-based smoking cessation programs					
School-aged children and youth					
Caregivers participating in community-based programs					
Health care workers in specific settings (e.g. community health centres)					
Elders					
Clients in addictions treatment/rehab					
Adults in the general population					
Others (specify)					

[13] PDF of the question taken from the ***FTCS Annual Outcome Reporting Form*** for 2014-2015.

- One indicated that, as of March 31, 2015, ***26 program participants*** had participated in their smoking cessation programs or interventions, and ***11 of these had completed them***
- The other two respondents provided the number of people who participated in 'other' types of interventions:
  - One indicated that ***1,275 clients*** in their catchment area had accessed smoking cessation aids through health benefits
  - A second indicated that ***147 people*** had participated in and completed their 'Quit To Win' challenge

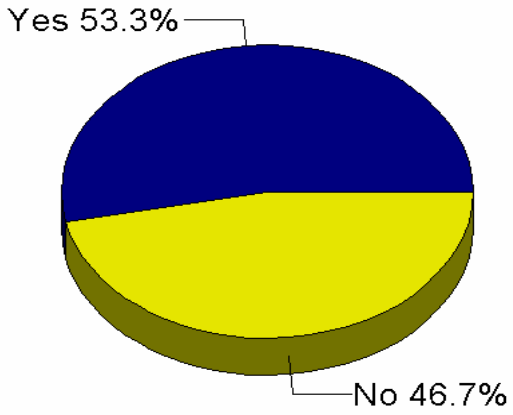
2.7) Developing Smoking Cessation Baseline Data:

One of the six ***essential elements*** of the FTCS, established by the **First Nations and Inuit Health Branch**, is the collection and monitoring of smoking-related research and evaluations. This included the "collection of baseline data on smoking statistics within the regions [and] communities, such as rates of smoking, views of community members toward tobacco use, community needs assessments, etc." It also included "monitoring and reporting on the project, including data collection sources and reporting mechanisms that align with First Nations and Inuit principles for information and research governance, such as OCAP and others." This is to be followed up by projects sharing their "best/promising practices and knowledge gained from the project with partners and other communities." A series of related questions was asked of the project respondents.

2.7.1) Projects Collecting Smoking Cessation Data:

Just over half of the projects in this study (53.3%) reported that their projects were collecting cessation information using a population or community-level survey (Figure 10).

Figure 10 Are Projects Collecting Smoking Cessation Information Using A Population/Community Survey?

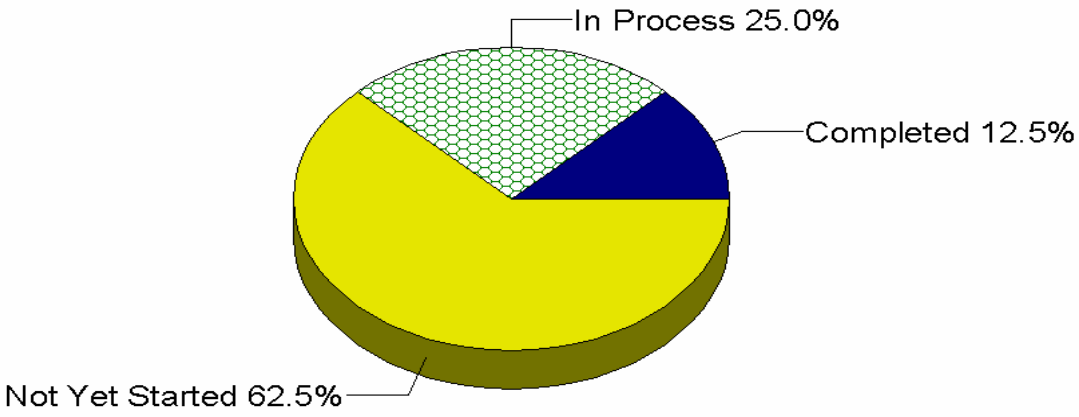


(Number of projects reporting=15. Adjusted to exclude missing data.)

2.7.2) The Current Status Of Their Studies:

Of the eight projects that are collecting cessation information, one said that the related study was completed (12.5%), two (25.0%) said that their studies are in process, and the remainder (62.5%) said that they had not yet started to collect related data (Figure 11).

Figure 11 If Projects Are Collecting Smoking Cessation Information, What Is The Status Of Their Studies?



(Number of projects reporting=8. Adjusted to exclude missing data.)

2.7.3) The Studies' Sample Sizes:

When respondents were asked to provide the actual or planned sample sizes for their studies, five did so. Of these, they ranged from a low of 20 to a high of 1,000. The mean sample size was 424, with a median of 200 (sd=426.18) (Figure 12).

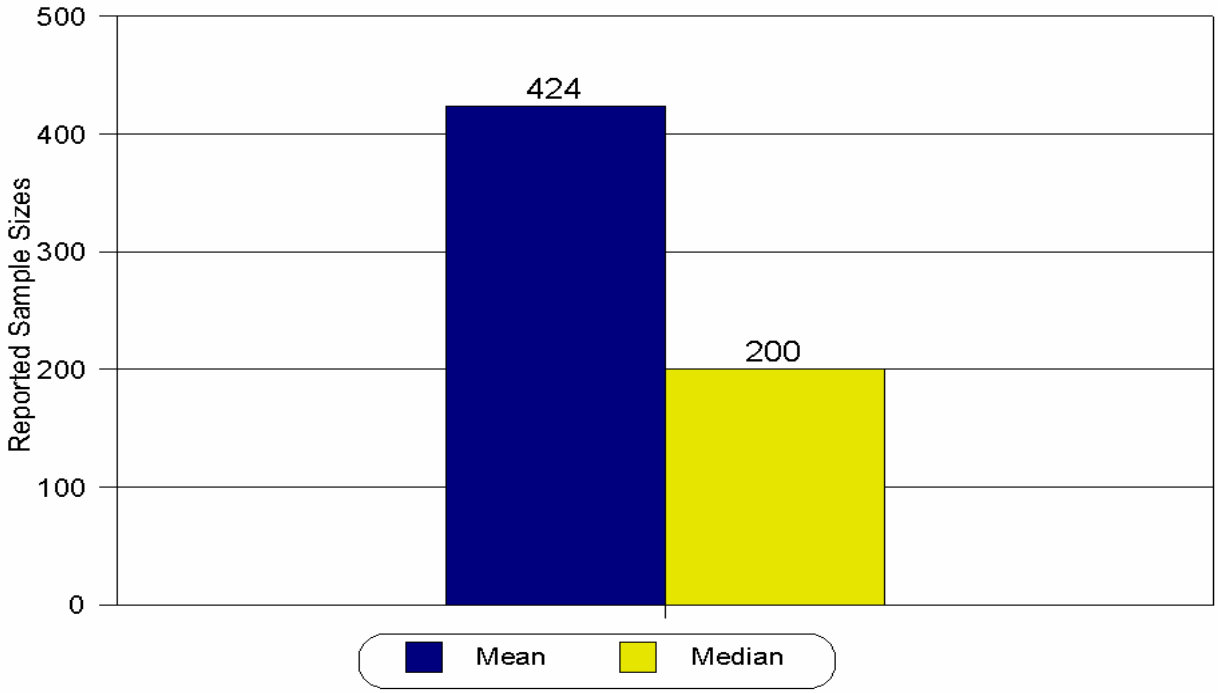
2.7.4) The Study Populations:

Respondents identified ten different study populations:

- Four are planning to survey school-aged youth
- Three are planning to survey pregnant mothers
- Three are planning to survey adults in the general population
- One is planning to survey post-natal mothers
- One is planning to survey clients with chronic illnesses
- One is planning a household survey
- One is planning to survey Elders in the community
- One is planning a survey of healthcare workers
- One is planning a staff survey
- One is planning to survey program participants

One respondent noted that a community-health assessment, including smoking-related questions, was undertaken in 2014, prior to the advent of the FTCS. It surveyed students in Grades 7 to 12 and com-

Figure 12 If Projects Are Collecting Smoking Cessation Information, What Are Their Actual/Planned Sample Sizes?



(Number of projects reporting=5. Adjusted to exclude missing data.)

munity members. An upcoming survey is planned for September 2015, which will focus specifically on students' smoking patterns. This project has not determined if it will also do a community-wide survey.

2.7.5) Projects Replicating Their Initial Surveys:

Of the respondents who reported that studies were completed or underway, seven (87.5%) said there were plans in place to replicate their initial studies. One respondent was unsure about this (Figure 13).

2.7.6) When Replicated Studies Will Be Undertaken:

The final question in this series asked respondents when they planned to administer their replicated studies. Four reported that this would occur in 2015 (either in September, October or November). One reported that this would occur in December 2016. The remainder gave 2017 as the year in which the replicated studies would be undertaken.

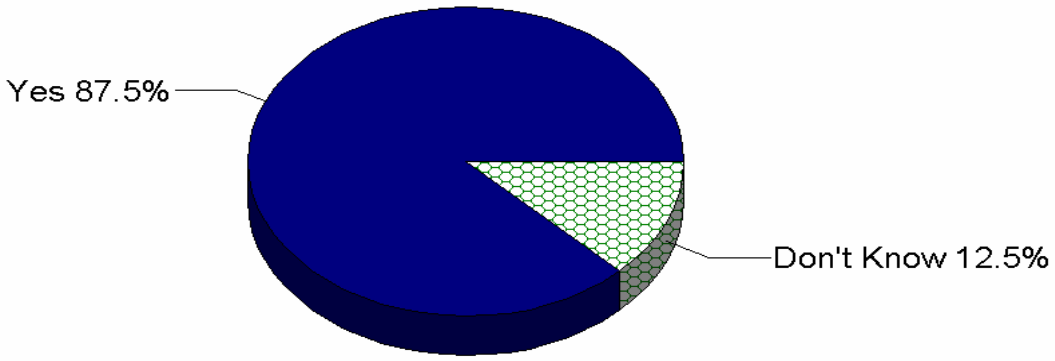
2.8) Promising Practices:

Respondents were asked to describe any promising practices they had achieved during the 2014-2015 fiscal year under the following three pillars of the FTCS: ***Leadership***, ***Health Promotion***, and ***Smoking Cessation***. Promising practices can include lessons learned by the projects, innovative ideas they have come up with, along with new concepts or successful activities. These were open-ended questions.

2.8.1) Promising Practices In Leadership:

Seven respondents commented regarding their promising practices related to ***Leadership***. Three were not able to develop related promising practices in 2014-2015, as they were still in the planning phase at the end of the last fiscal year:

Figure 13 Are Projects Planning To Conduct Surveys, Also Planning To Replicate These Studies In The Future?



(Number of projects reporting=8. Adjusted to exclude missing data.)

Because we received our funding very late we have only been able to hire our staff to deliver the program and develop a comprehensive work plan.

Data not available. Approval date was too close to year end to implement activities.

[We] need to identify new spaces to designate as smoke free. We need to develop a better tracking system for use by bi-law officers to monitor calls, complaints and actions regarding smoking in smoke-free areas.

Three respondents cited new information they were able to access during the first year of the project, and new lessons they had learned. Two projects were able to identify smoke-free spaces in their communities, and one began to identify related best practices.

Connecting and establishing a positive relationship with leadership is key. This project will identify best and promising practices already established in the region. These practices will then encourage other communities to create their own BCRs and policies. Some chiefs and councillors were present at our conference gathering in March and it is assumed there is an increased motivation to increase smoke-free public places.

[We] found out that some band offices have already implemented smoke free environments.

I attended the Tobacco Cessation workshop and learned new ways to give out information in the community. I also led a NO TOBACCO DAY walk and handed out 'quit kits' to people who asked for them, and information on smoking to other members of the community.

One respondent identified five promising practices related to Leadership that her or his project achieved in its first year. These included developing partnerships with other initiatives or organizations already attempting to reduce smoking, developing partnerships with regional health authorities, inviting youth to

attend smoking cessation workshops, increasing knowledge and awareness regarding the health risks associated with smoking, and developing a smoke-free home initiative:

1. A strong partnership has been created with the BC Lung Association and QuitNow BC. This partnership has allowed for a contract to be created between FNHA and BC Lung, with key objectives in the required areas of tobacco control [regarding] protection, prevention, cessation, education, evaluation.

2. Partnerships have been created or strengthened with each of the five Regional Health Authorities in BC. FNHA staff have strengthened relationships with tobacco control staff at each RHA. The RHA staff were invited to participate in the 6 regional tobacco training sessions that were held in the 2014-2015 fiscal year and community health workers and leaders created relationships with the RHA staff as well. Lastly, the RHA tobacco control leads have had the opportunity to provide input into the priorities of the FNHA tobacco project moving forward.

3. At Gathering Our Voices, youth leaders were invited to a workshop where they created small groups and brainstormed ideas for a youth-focused tobacco prevention/cessation commercial. Youth were supported to be creative, practice their commercial, and then pitch the idea to some judges. The best pitch will be made into a commercial in the 2015-2016 fiscal year.

4. Engagement has confirmed key priorities in relation to protection including increasing knowledge about second-hand smoke, support for the development of community based policies, and awareness-building and support of economic approaches to reducing access to tobacco products.

5. Early development of a smoke-free homes campaign targeting young children and families is to be hosted at community events or as a part of child and family programming. The "Inside Out" campaign's™ key message is: When children are inside, smoking goes out. The campaign materials in development include a game board, playing cards, tattoos, information pamphlets about second-hand smoke and table covers, etc. The intention is for these materials to be packaged in a kit that can be loaned to communities who request them. Activities will be rolled out in 2015-2016 in one specific geographic area of BC with potential to expand.

2.8.2) Promising Practices In Health Promotion:

Fourteen respondents commented on promising practices related to health promotion. As above, three of these were unable to identify promising practices related to health promotion, due to the date upon which their funding was received:

Data not available: approval date was too close to year end to implement activities.

Not available.

NIL.

The remaining respondents described a wide range of media and processes that they had incorporated into their health promotion activities. These included:

- Setting up a related ***Facebook*** page
- Promoting smoke-free contests on ***Facebook***
- Setting up dedicated websites
- Working in partnership with other community health professionals
- Developing educational materials appropriate for their target populations
- Developing poster campaigns and/or contests highlighting health-oriented role-models and messages
- Renewing a previous contest to encourage people to quit smoking (the '***Quit to Win Challenge')***
- Educating community members about healthier ways to relieve their stress other than smoking
- Facilitating school- and community-based initiatives, based, in part, on the 'tar pact' and 'catching your second wind'

- Facilitating strategic planning sessions with health managers
- Facilitating staff training and development regarding the respectful use of tobacco
- Developing public service announcements (PSAs) focusing on health promotion and smoking
- Encouraging community residents to avoid smoking at home (Blue Light Campaigns)

Respondents' verbatim comments are provided below and on the following page.

Facebook site set up [which is] continually updated with education and program information. Research started into appropriate prevention. We have started ordering education materials. [Their] focus is on interactive "fun" materials which youth can relate to. A program coordinator and two youth workers were hired for the program.

The use of a website and multi-media is emerging as a promising strategy as more youth and young adults have increasing access to internet. A role-model campaign is in preliminary stages with the hopes of role-model posters, calendars and public service video announcements to be distributed in the region. There is a stronger impact utilizing our own people in this messaging.

Poster contest for school age children surrounding the Traditional Uses of Tobacco. Posters will form an awareness campaign through the life of the project. Messages from our children to our Adults and Elders surrounding Non-Traditional uses of Tobacco

We actually worked to revise the Quit to Win Challenge to renew the interest of the population for this challenge.

I purchased no smoking aids for information and to give out to people who may want to try. Things like no smoking gum or the tangles and stress balls. I also give out brochures and teach youth with my tobacco cessation tools here at the office as they come in.

We are using the 'tar pact' and 'catching your second wind' curriculum and programs to relate to the variety of participants we have in each group.

[We have provided] education on the harmful effect of tobacco. Presentation in schools and health centres. Good response at 9 schools. They are interested in a presentation on prevention in the future.

There was a previous project in tobacco reduction [involving] health promotion, prevention and education. The communities are still putting these into practice.

One respondent shared the following four related Promising Practices:

1. ***FNHA, in partnership with the First Nations Health Directors Association, organized and led six regional tobacco training sessions in February to March 2015. These two day training sessions had three components: One full day for Brief Action Planning training delivered by FNHA in house nurses, community health staff, and in partnership with the Centre for Collaboration, Motivation and Innovation; and then one day for knowledge exchange with and engagement of participants.***
2. ***As a part of the annual All Native Basketball Tournament, a poster was created in partnership between Northern Health Authority and FNHA. This poster was important because it was one of the first educational resources created by FNHA with the Respecting Tobacco title. Interest has been expressed by all other Regional Health Authorities to share and rebrand this poster to be inclusive of other RHAs and partners.***
3. ***Including recreational activities and stress management.***
4. ***Engagement has confirmed a need for increased staff training and knowledge exchange, increased awareness about respectful use of traditional tobacco, engagement of Elders and families as role models and leaders, and supporting the holistic wellness of youth.***

One respondent shared the following five Promising Practices:

1. ***Radio Spots: Ran 60 second health promotion messages on radio for the month of January. Scripts were on youth and tobacco use; smokeless tobacco and flavored tobacco; second hand smoke and infants; and prenatal smoking.***
2. ***Blue Light Homes as part of the non-smoking week activities Jan 18th-24th 2015. Blue lights were given through community clinics, Head Start and homecare to community members interested in keeping their homes smoke free for 3 months from February to April 2015. Fifty-three homes registered and picked up a blue light. Certificates were given to all registered homes on completion and a fruit basket was drawn per community. Lesson learned: Going forward we would partner with the Band Office and engage more community Elders to increase community participation.***
3. ***Partnering with the community nurses, family health workers, homecare nurses/aides and Head Start was effective in spreading the message about smoke-free homes, while they provided services to their clients.***
4. ***Classroom education session: In the 6 communities [we] facilitated an hour long session with Grades 6 to 8 in the schools. 141 students were reached overall. Watched a youth video related to smoking prevention; educated the students on the difference between commercial tobacco and traditional tobacco use; had group activities; asked the students to write their views on smoking and their message to the Elders if they were members of the youth council concerned about smoking in their communities. Lessons learned: The youth enjoyed working in various groups. The youth were enthused about having their message sent across to their Chief and Council concerning tobacco use in their communities.***
5. ***The Share Your Quit Story Contest: A Facebook Contest to get people sharing their quit story to encourage others that they can quit. The contestants shared their successes, their challenges and their method of quitting. The contest ran from January 18th to 31st. Prizes were three $20 Co-Op gift cards. Lessons learned: Have a longer duration for such contests. Get other community partners involved in promoting social media contest, on their social media pages and also by word of mouth to their clients. Make provisions for those who do not have social media but would also like to share their stories. For example, a participant wrote their story and gave it to our staff to post directly on our Facebook page because they weren't Facebook savvy.***

2.8.3) Promising Practices In Smoking Cessation:

As we found when asking respondents to provide baseline data regarding their initial smoking cessation activities, this is an area that was still in development toward the end of the 2014-2015 fiscal year. The promising practices they identified largely reflected this reality. Some of their related promising practices focused on program development activities, such as conducting health assessments, developing related resource materials, launching a Blue Light campaign to encourage smoke-free homes, and attending conferences to promote their projects. It is anticipated that the follow-up studies will provide more direct related promising practices. Respondents' verbatim comments are provided below and on the following page.

In partnership with QuitNow, a one page resource [sheet] with information about smoking cessation programs available in BC was created. This includes information about the First Nations Health Benefits smoking cessation products, the BC Smoking Cessation Program (provincial program for all BC residents), and the cessation services available by QuitNow. Two versions of the resource were created - one for the clients and one for health providers. Engagement has confirmed a need for training to support tobacco cessation, youth-focused cessation programming, increasing community involvement and leveraging of community events, and increasing awareness about and access to traditional tobacco.

As part of community health assessment in 2014, [we conducted] focus groups with community members. Smoking was identified as a key health concern and the need to help people quit smoking.

TEACH will be utilized, incorporated into the strategy and training to be made available to all addictions workers. Traditional Elder techniques are encouraged. Drinking water to help detox the body, partaking in sweat lodges to help cleanse the body of toxins.

I launched a new Blue Light project. Purchased 200 blue light bulbs to give out to community members who do not smoke in their houses. They switch their current lights to the blue ones I provide. This creates awareness in the community that people are choosing to not smoke in their homes.

Promoting more [of] the alternative treatments for smoking cessation. The information received from the participants is they are not necessarily aware of the different ways to stop smoking.

Attendance of health care providers from three communities to Ottawa Conference: State of the Art Clinical Approaches to Smoking Cessation. This information has promoted smoking cessation in communities.

One respondent noted that healthcare workers are good resources to encourage smoking cessation:

Health workers are more cognizant about improved health and promotion in their work, homes and community.

2.9) Projects' Successful Processes For 2014-2015:

Respondents were each asked to describe, in detail, one successful process their projects completed in 2014-15. They were asked to include the related objectives of their processes, their target populations, other community partners or champions who were involved, their related activities associated with this process, and their related outcomes to date. Fourteen respondents provided a response.

Consistent with some responses to other questions, one respondent noted that with funding starting toward the end of the last fiscal year, this impacted their ability to complete a successful process:

Because the funding [for our project] was confirmed on February 25th 2015, we were not able to put in place activities with all the details you are requested.

Three respondents reported on program development activities that their projects have completed to prepare for service delivery in 2015-2016:

[We] hired the staff necessary to deliver the program and developed a comprehensive work-plan that outlines all activities going forward. All activities will be moved to 2015-2016.

We have developed a logic model and evaluation framework for our project. This is one of our project objectives in year one (2014-2015). We have worked with the Project Steering Committee and [this work] will be used in year two.

We identified and established a "cessation team" in one of our communities. Future events to include tobacco education and [the] provision of cessation information.

Several others described materials they had developed in 2014-2015. They included the completion of a tool-kit for retailers; a poster campaign highlighting the traditional uses of tobacco; and a database to track smokers' risk factors and outcomes for people attending their smoking cessation programs:

We have successfully completed the 'retailers tool kit' revamp, and the creation of the tobacco and wellness community manual.

Poster Campaign of Traditional Uses of Tobacco (contest) let our children speak to our Community Members about keeping Tobacco Sacred.

[Developed an] Electronic Data Base to collect client information regarding the number of smokers linked to risk factors (pregnant, chronic illness, age), smoking cessation programs offered, and success rates. Data [are] being collected & intervention programs offered to assist clients is being approached by various providers [including] Physicians, Community Health, Homecare, Mental Health & NAADAP.

In one case, the advent of a research process resulted in community residents quitting smoking and assisting the project:

[Our] community-based research process, [as a result of] survey distribution, encouraged four individuals to quit smoking and be role models for the project.

Two respondents briefly described gatherings or community engagement processes they had undertaken last year, and the positive impact they had:

A Gathering was held and over 200 people attended. A presentation on the project was held to create awareness about tobacco cessation.

[We held a] regional engagement session in HUGB for community, regional [and] provincial partners, youth, elders, public health nurses, mental health and addictions workers, senior management (DHSD), and community health workers. Great engagement. Ideas [were] brainstormed. [There was] community buy-in and ownership.

One respondent noted that, by sharing the results of a community health assessment undertaken in 2014 to an audience of health workers, collateral staff, and community leaders, the project was able to gain significant support for future activities. This respondent also highlighted program development activities that her/his project had completed in preparation for 2015-2016:

[We] used the results of our 2014 Community Health Assessment as evidence to show the need for this program in our community. Presentations [were] held with health workers, other staff and Chief and Council to show results of Community Health Assessment and smoking prevalence in community. [We] gained support for our program. [In addition, we] cleared job descriptions, [and] a program coordinator and 2 youth workers were hired. Purchasing of program materials and developing content for the Youth Conference that was held in April. Identification of space for the majority of program activities took place, negotiation of contract to take over space occurred.

Another respondent described a conference her or his project sponsored in 2014-2015 that was seen to be very inclusive and successful:[14]

[We held the] Southern Manitoba First Nations Commercial Tobacco Prevention Strategy Conference [on] March 17-19, 2015 at Viscount Gort Hotel. [This] two-day conference included a one-day brief intervention cessation training [session]. 205 sponsored conference participants attended. [The conference included] displays from the Manitoba Lung Association, CancerCare, Heart and Stroke Foundation, National Aboriginal Diabetes Association, [and the] South-East Child/Youth Sexual Exploitation Committee. Program Highlights [included presentations by] Commercial tobacco experts: Dr. Dean Kriellaars, Dr. Jonathan Archer, Roger Tam, Murray Gibson and Trevor Hach; and Traditional tobacco speakers: Carl McCorrister, Louis Young, Isca Spillett, Virginia Thomas and Eliza Beardy. The evaluation feedback was overwhelmingly positive! Special regards to Traditional Dance Showcase and Sagkeeng's Finest, both noon hour entertainment.

One respondent described her or his project's engagement process with collateral organizations and professionals, and with community leaders. This respondent also described the collaboration process that was undertaken to develop community partnerships.

[14] The names of presenters at this conference have been provided as a potential resource to other projects. Because their participation at this conference would have been publicized by the project sponsors, no confidentiality has been breached.

As [the] First Nations Health Authority is a new organization, it is very important to us that we honour and demonstrate our seven directives. The number one directive is community driven, nation based. For this reason, our most successful process during the past fiscal year has been engagement with communities and community leaders. Through the six regional tobacco training sessions and key informant interviews, 186 participants were engaged and provided the opportunity to provide input into the priorities of the tobacco control project. The intended outcome is to have a 'Respecting Tobacco Framework' that is informed by and resonates with BC First Nations.

Another key success to highlight is the strengthened collaboration across FNHA staff in different departments. The collaborative development of the 'Respecting Tobacco Training' and the 'Inside Out' campaigns are two key examples. At an internal update session with cross-departmental participation, staff across nursing, wellness programming, research and evaluation, and policy and planning, all expressed positive feedback in relation to how tobacco work has pulled together our teams in a new way; leading to greater communication and ongoing collaboration. Collaboration between FNHA and the First Nations Health Directors Association -an external partner- has also been a positive result of this work.

One respondent provided a detailed description of a process to gain youth input to increase their awareness of the health risks associated with smoking, and to develop strategies and messages to encourage Chiefs and Councils to pass smoking-related resolutions. This account provides the processes' objectives, target populations, community partners, related activities and outcomes.

Process:
Youth input on tobacco use in their communities

Objectives:
- ***To gauge youth awareness of tobacco use in their communities***
- ***To get youth thinking about tobacco advocacy and stimulate their thoughts***
- ***To get their message in writing which would be used when proposing no-smoking policy to the Chiefs and Council***

Target population:
Youth in Grades 6 to 8

Community Partner:
Schools

Activity:
In each of the six communities, students in Grades 6 to 8 were assembled for a non-smoking week session in their schools. Besides the teaching component, we sought to get youth feedback on tobacco use in their communities. The students were divided into different groups to answer questions that were picked from a box. One question was:

'Imagine that you and your team members are the youth council representatives of your school and community. Smoking is an issue that affects the young people in your community. You have a meeting with your Elders Council and Chiefs tomorrow. What messages would you and your team come up with to tell them? For example, ban sales of cigarettes to minors.'

The students in the group were given about 10 minutes to think and put their thoughts down on flip chart paper. They assigned a scribe and put their minds together to come up with their messages.

Outcome:
From the activity we got over 6 groups who wrote down their messages to the Elders. These messages were photographed and put up on Facebook to show the communities what their youth are saying about tobacco use. Their messages would also be used when proposing the draft smoking related policy to the Chief and Council in the summer-fall of 2015.

III) SUMMARY AND CONCLUSIONS:

3.1) Introduction:

This report provides the findings of the first annual outcome reporting process for the ***Federal Tobacco Control Strategy*** (FTCS) of the **First Nations Inuit Health Branch**, **Health Canada**. The research was conducted by **Kaplan Research Associates Inc**. under the auspices of the **National Aboriginal Diabetes Association** (NADA). The results of this current study will serve as a ***baseline***. Comparative analyses of the replicated questions will be undertaken in 2015-2016 and 2016-2017. While each project is responsible to carry out an evaluation of its own, the purpose of this outcome report is to provide global information regarding all projects collectively. Sixteen FTCS projects, representing most regions of Canada, provided responses. These are all of the projects able to respond by the end of June 2015.

The current questionnaire was developed in conjunction with an evaluation steering committee. This was an online form that captured both quantitative and qualitative (open-ended) data. All quantitative data were analyzed using ***SPSS***, and all qualitative data were subjected to a ***content analysis***.

3.2) The Study Findings:

3.2.1) Communities Served:

The sixteen projects collectively serve 352 First Nations communities, spread across most regions of Canada. The number of communities served by each project varied broadly: from 1 and 2, up to 203. On average, each project served 22 communities, with a median of 8.

Conclusion One: ***There are several projects excluded from this analysis, as described above. As such the number of regions represented in subsequent analyses, and the number of communities served by the FTCS, will increase accordingly.***

3.2.2) Target Populations Reached In 2014-2015:

Even though many of these projects had just begun to provide services toward the end of 2014-2015, they were still able to reach a range of target populations. The eight most frequent target populations reached included, in ranked-order: clients in addictions treatment, school administrators and staff, Chiefs and Band Councillors, students in Grades One to Twelve, mental health clients, pregnant mothers, business owners and/or retailers, and/or children and youth in non-school settings.

3.2.3) Community Partners Engaged In 2014-2015:

Similarly, projects were able to engage a range of partners during their first year of operation. Examples of partnerships and collaborations are also illustrated in the ***Promising Practices*** component of the study, and the descriptions of ***successful processes*** shared in this report. The six most frequently noted community partners included: nurses, addictions service providers, Chiefs and Band Councillors, community Elders and/or Elders' Councils, schools and/or provincial and territorial governments.

3.2.4) Smoke-Free Spaces in 2014-2015:

Across the 352 communities served by these 16 projects, a total of 676 smoke-free spaces were identified by respondents. This includes 466 indoor spaces and 210 outdoor spaces. On average each project identified 38.8 smoke-free indoor spaces and 23.3 smoke-free outdoor spaces, with respective medians of 23.5 and 20.0.

Across projects, the most frequently identified types of smoke-free indoor spaces were health centres, schools, First Nations Band offices and daycares. The most frequently identified smoke-free outdoor spaces included: playgrounds, and areas adjacent to health centres, schools and daycare centres. Conversely, the least frequently identified smoke-free indoor spaces are restaurants, arenas, stores and bingo halls. The least frequently identified smoke-free outdoor spaces adjacent to indoor spaces, are First Nations' Band offices, community and recreational centres, restaurants, bingo halls and stores.

Conclusion Two: ***These figures present the estimates of project representatives in the early days of FTCS project, assumedly based on their observations and information from collateral service providers and project partners. It is assumed that the number of smoke-free spaces will increase over time as the projects have time to disseminate their messages, and project staff have the opportunity to interact with residents, other service providers, community representatives and community leaders.***

3.2.5) Few Smoking-Related Resolutions Were Passed In 2014-2015:

Only five of fifteen respondents reported the passing of smoking-related resolutions by their governance bodies. Of these, 28 resolutions were passed. On average each of these five projects reported 5.6 different resolutions, with a median of 3.0.

There were four reported resolutions to designate smoke-free spaces, but only one to enforce their smoke-free public spaces. Two project representatives reported resolutions to use tobacco revenue to fund health promotion activities, and one each reported resolutions to promote smoke-free homes, and to expand the parameters of outdoor smoke-free spaces. No resolutions were passed regarding smoke-free vehicles when young children are in them.

Conclusion Three: ***The small number of smoking-related resolutions passed to date, and the fact that two-thirds of the respondents to this study reported that none had been passed by their governance bodies, is notable. However, the fact that 50.0% of the projects listed their Chiefs and Band Councillors as people they have reached during the first year of the Federal Tobacco Control Strategy, and the fact that 56.3% listed them as community partners, will hopefully translate into significantly higher numbers of smoke-free spaces, and the passing of significantly more smoking-related resolutions, in the future. Given the lack of resolutions to enforce smoke-free spaces, it is not surprising that relatively few smoke-free spaces have been reported.***

It is also notable that none of the 16 projects reported having bylaw officers or First Nations' police officers as their community partners. This may mean that these positions do not exist in some jurisdictions, or that they exist but have not yet been contacted. The participation of these officers would likely be important to effectively monitor and enforce smoke-free spaces.

3.2.6) Decreasing The Number Of Daily Smokers Is A Work In Progress:

It is apparent from the lack of related data that none of these projects had time to implement their smoking cessation programs in 2014-2015. Only three of the sixteen projects provided even partial related data.

Conclusion Four: ***Given that a reduction in the number of daily smokers is a key intervention pillar of of the FTCS, and given that the projects are in an early stage in their development, it is anticipated that 2015-2016 will see a significant increase in the number of smoking cessation programs and activities implemented nationally by the projects. It is also anticipated that there will be a commensurate increase in the number of residents served by these programs, and the number of former smokers reported.***

3.2.7) Just Over Half Of The Projects Will Be Collecting Smoking Cessation Information:

Although one of the key intervention pillars relates to data collection and monitoring to facilitate research and evaluations, 53.3% of the projects reported that their projects are collecting data regarding smoking rates and rates of smoking cessation, based on population or community surveys. Of these, one study has been completed, two are in process, and five have not yet started.

The projects planning to undertake studies have described a broad range of research subjects. They include school-aged children, adults in the general population and those attending smoking cessation

programs, Elders, pregnant and post-natal mothers, and healthcare workers. Planned sample sizes ranged from 20 to 1,000, with a mean of 424 and a median of 200. With the exception of the project that has completed its research process, the remaining projects plan to undertake their studies between 2015 and 2017. Seven of the eight projects planning to conduct these research studies also plan to replicate this process in the future.

Conclusion Five: ***Given the importance of research and evaluation to the FTCS regarding rates of smoking, the views of community members toward tobacco use, and related community needs, and given the fact that only one of the studies has been completed to date, there may be an opportunity to coordinate the development of consistent (key) research questions across the projects so that these data can be aggregated to facilitate a national database. This would not preclude projects including their own questions as well to meet the specific informational needs of their communities. [As an aside, it has been noted by FNIHB that it is currently working with its First Nations and Inuit partners to fund related research studies. Therefore the studies taken on by the FTCS projects may provide an additional data source for FNIHB.]***

3.2.8) Promising Practices:

Most respondents were able to identify promising practices that their projects had achieved related to Leadership and Health Promotion. Fewer respondents were able to identify promising practices related to smoking cessation, as their projects had not had time to begin implementing their smoking cessation programs or activities.

i) Leadership:

Four respondents provided examples of promising practices related to leadership that their projects have achieved. These included:

- Developing relationships with community leaders, including Chiefs and Band Councillors
- Developing partnerships with allied social service organizations
- Encouraging youth participation to create positive messages promoting the primary prevention of smoking, and smoking cessation
- Identifying best practices and promising practices related to smoking cessation
- Developing strategies, through research, to disseminate related information at the community level
- Developing strategies to increase knowledge regarding the dangers of second-hand smoke
- Developing economic approaches to reduce access to tobacco products
- Developing campaigns to encourage smoke-free homes, including the creation of effective slogans
- Developing and implementing creative ways to disseminate the smoke-free message, including board games, playing cards, tattoos, table covers, and effective brochures

ii) Health Promotion:

Eleven respondents provided examples of health-promotion-related promising practices that their projects have achieved. These included:

- Working in partnership with other healthcare service providers to promote smoking-related education and prevention
- Communicating with residents and prospective participants through ***Facebook*** and dedicated websites
- Communicating with a range of audiences using posters
- Using First Nations youth as role-models on poster campaigns and calendars
- Purchasing radio spots (PSAs) to promote no smoking messages
- Using multi-media approaches to reach youth and young adults
- Holding contests to educate people about the dangers of smoking
- Hosting youth-oriented poster contests regarding traditional uses of tobacco

- Holding contests to see which communities or groups have the highest number of people quitting smoking
- Sponsoring contests focusing on former smokers sharing their 'quit stories'
- Providing classroom presentations regarding the dangers of smoking
- Providing regional training sessions for community-based healthcare professionals
- Using recreational and stress-reduction techniques to help people quit smoking
- Providing free no-smoking aids to the public as part of a public communication strategy

iii) Smoking Cessation:

Six respondents offered promising practices regarding smoking cessation. These included:

- Providing a list of smoking cessation programs and services across the province, with a focus on those serving First Nations people
- Providing a youth-focused resource sheet
- Encouraging the use of traditional techniques to help people quit smoking, with the active participation of community Elders
- Informing smokers, who are seeking to quit, to drink water and use sweat lodges to help them to detoxify
- Promoting the Blue Light campaign to encourage the reduction of people smoking in their homes
- Promoting "alternative treatments" for smoking cessation [not specified]

Conclusion Six: ***Given that many programs were just beginning to deliver programs and services toward the end of 2014-2015, respondents were able to offer an impressive list of promising practices that their programs provided during that time period. All project managers should be encouraged to review this list and determine whether they can incorporate any of these practices into their own projects.***

As an aside, it will be interesting to see what new promising practices are shared in the second annual outcome report.

3.2.9) Successful Processes Reported:

Respondents were asked to share one successful process that their projects had undertaken in 2014-2015. Some of these were process-oriented, relating to projects being established and staffed, while others related to successful activities that the projects undertook. It is apparent that many of these processes relate to initial project development activities. This included the sponsorship of gatherings and conferences to promote the projects. A synopsis of these successes included:

- Completing staff job descriptions
- Completing the staff hiring process
- Completing a comprehensive work plan
- Completing a project logic model working through a steering committee
- Establishing a community-based smoking cessation team, and planning future activities through it
- Completing a 'retailer's tool kit' and a tobacco and wellness community manual
- Completing a poster campaign promoting the traditional uses of tobacco
- Holding a Gathering to create awareness of the project, with 200 people attending
- Sponsoring a youth conference
- Sponsoring a two-day First Nations Commercial Tobacco Prevention Strategy Conference, including a one-day brief intervention smoking cessation training session. Presentations were given by commercial tobacco experts and traditional tobacco speakers. Representatives from many allied community-based organizations attended.
- Engaging with staff from different departments regarding the provision of 'Respecting Tobacco Training' and the 'Inside Out' campaign
- Engaging with communities and community leaders to develop a 'Respecting Tobacco Framework.' Six regional tobacco training sessions were provided along with key informant interviews. 186 participants were involved in this process.

- Conducting an inter-departmental update session involving healthcare staff, researchers and evaluators, and policy and planning personnel
- Facilitating collaboration between First Nations Health Authority and the First Nations Health Directors Association
- Holding a regional engagement session for collateral professionals and organizations. Attendees included: community and regional partners, youth, Elders, nurses, mental health workers, addictions workers, and community healthcare workers.
- Creating support for the FTCS project by using the 2014 Community Health Assessment to demonstrate the need for the project in their communities. Shared smoking prevalence rates.
- Encouraging four smokers to quit smoking, and agree to become role-models, through their exposure to a community-based research process
- Developing a database to collect client information, smokers' risk factors, related programs offered, and their success rates
- Facilitating a successful process for youth input on tobacco use in their communities. This was a school-based project involving students in Grades Six to Eight. Its objectives were to gauge youth awareness of tobacco use in their communities, get youth thinking about tobacco advocacy, and help them put their related messages in writing. The messages were posted on a Facebook page to show their communities what youth are saying about tobacco use. Their messages will also be used when proposing draft smoking-related policies to Chiefs and Councils.

Conclusion Seven: **Again, many of the successful processes shared by respondents reflect the fact that most of these projects were still in the developmental phase. However, a few projects have developed materials, sponsored community-based gatherings and conferences, and begun the process of orienting and educating their community residents and their collateral service providers.**

It is notable that, with one small exception, none of these successes related to smoking cessation. This is an anticipated finding given the 'newness' of the projects. It is further anticipated that many of the successes shared in 2015-2016 will relate to the outputs and outcomes of projects' smoking cessation programs and interventions.

3.3) Some Final Thoughts:

The results of this study provide a picture of FTCS projects in their initial year of operation. This includes: hiring staff, developing logic models, developing materials and other resources, and marketing their projects within their communities. Both programmatic challenges and achievements were described through this study. The challenges are similar to those of many new programs: finalizing their funding, developing program structures, accessing human and material resources, getting their messages out, and initiating program delivery. The initial achievements were many. They included: beginning to reach a broad range of community residents and professionals, beginning to develop strategic partnerships within their communities, sponsoring conferences and community-wide consultations, beginning to develop smoking cessation campaigns and processes, enlisting youth in this endeavour and, in a few cases, expanding upon community-based smoking prevalence data.

Conclusion Eight: **The findings reported in this study will serve as an effective baseline against which to measure significant growth over time, regarding the populations reached by the projects; their community partners; the numbers and types of smoke-free spaces reported; the numbers and types of smoking-related resolutions made by their governance bodies; and the numbers of community residents who started attending smoking cessation programs or activities, the numbers who completed them, the numbers who reduced their daily smoking rates as a result, and the numbers who quit smoking all together.**

APPENDIX A
ESSENTIAL ELEMENTS OF FTCS PROJECTS[15]

The approach to comprehensive tobacco control is organized around four key intervention pillars: Leadership, Health Promotion, Cessation, and Research and Evaluation. Linked to these pillars are 6 essential elements, **all** of which need to be addressed in project proposals in order to be eligible for funding.

Essential elements can be gradually implemented over the funding timeframe to accommodate varying levels of community capacity and readiness. Funding can be used to build on, strengthen and enhance existing activities and infrastructure. The 6 essential elements of the FTCS projects are outlined in the following chart:

Intervention Pillar	Essential Element* (all 6 need to be addressed in proposals)	Examples of Activities (non-exhaustive sample of activities)
Leadership	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 to second hand smoke in homes).
	2. **Reducing the Access to Tobacco Products:** Actions to reduce access to and availability of tobacco products within communities	➢ Community leadership taking 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.
Health Promotion	3. **Prevention:** Innovative prevention approaches at the group or population level that engage and target community members and their 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 recreation centres), targeting specific age-groups. Strong focus on children, youth and families, including youth engagement/youth-led activities. ➢ Elder engagement/elder-led activities.

[15] cf. ***Guidelines to the First Nations and Inuit Component of the Federal Tobacco Control Strategy: 2014-2017***, pages 5-7

	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 non-traditional/recreational tobacco use (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.
Cessation	5. **Cessation:** Tools, programs and activities to support community members to quit smoking	➢ 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.
Research and Evaluation	6. **Data Collection and Monitoring:** Use of tools and strategies to collect data; and, sharing 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.). Monitoring and reporting on the project, including data collection sources and reporting mechanisms that align with First Nations and Inuit principles for information and research governance, such as OCAP™ and others. ➢ Plans to share best/promising practices and knowledge gained from the project with partners and other communities.

** As part of the application process and to be eligible for funding, applicants will be required to demonstrate that they have support from community leadership to implement all 6 essential elements. This is in recognition of the fact that community leadership make the decisions around implementing comprehensive tobacco control measures in communities.*

APPENDIX B
RESULTS OF THE SMALL GROUP PROCESSES AT THE FTCS CONFERENCE

Building the Evaluation Framework Regarding FTCS Annual Reporting Template
Success Indicator 1) An increase in the percentage of smoke free public spaces

1) Available related baseline data regarding your community, prior to the advent of the FTCS funding. (What baseline data currently exist and how would they be accessed?)

Regional health surveys: Most recent updated version?

Anecdotal health from Health Directions: Observed data

Community based reporting template (CBRT) for FNIB (NDAP/CPNP)

Public school data

School based dental program: Compiled?

Tax rebate forms, when you purchase cigarettes

Look at store tobacco sales

NIHB data? – NRT stats

2) Related project objectives (measurable outcomes that your projects are designed to achieve).

More smoke-free spaces (childcare, school-grounds etc)

How many bylaws in place

How many signs (pre/post) are posted?

To see if tobacco cessation planning has been added in future strategic plans

Count how many people we train to deliver programs

How do we measure current smokers (pre/post)?

How do you measure how much people reduce cigarettes?

NRT increases

How many resources are delivered; type

How many referrals to NRT

Attitudes/perceptions using blogs/Facebook/contemplation model

How many people view a certain link that we post or “like” a Facebook Page?

Measure individual groups separately (youth/school etc.)

3) Target populations that your projects are designed to impact (e.g. Prenatal parents, infants, school-age children, seniors, organizations, departments, etc.).

Everyone

Think about how to impact individuals who have concurrent medical disorders

4) Community partners or champions who you plan to involve in your projects.

Youth teaching youth

Elder representation

CAMH (Canadian Assoc Mental Health)

Cancer Care Ontario

Lung Association

Asthma Society

Pharmacists Association

Universities

Dental teams

Nurses (prenatal/diabetes/homecare etc.)

Physicians (Residents)

Community workers

Addiction support

NNADP – counselling and addictions

Aboriginal healing wellness workers

Teachers/schools

Daycare

Tribal councils (environmental health safety)

RCMP – laws, vehicle smoking

BCR (Band Council Resolution)

5) Related activities, services or materials that your projects are designed to deliver.

Cessation programs/prevention

- Cessation manual
- Maternal
- Youth
- Elementary school module
- Template/shareable/portable -> posters etc.

NRT

Retailers Ed toolkit

Peer helpers

Blue/green light

Backpack/luggage tags/pledges

Intercommunity challenges for smoking cessation

Traditional tobacco demonstrations (greenhouse)

Use Chief and council as speakers/enforcers of bylaws

- Build relationships with RCMP (positive reinforcement) e.g. cards for good behaviour, community incentives
- Advocacy

Put up distance posters (policy)

Make designated smoking areas further away to encourage smokers to stay away from door

Mandatory smoking policy meetings

- Education to staff

Smoke-free events -> advertising on posters

- Coordinators enforced (remind of rules during introductions)

Personal story speaking sessions/smoking wall etc

Partner with pharmacists/nurse practitioners to prescribe NRT

- NRT workshops/info sessions
- Cessation pregnant mothers?

Create Facebook page/update with info, quizzes, prizes, contests (poster contest, vines, raps, logo making, artists, etc…)

6) Anticipated challenges or barriers that your projects may experience.

Enforcing smoking distances

Whose responsibility?

- Teachers
- RCMP
- Parents
- Managers of buildings

Community participation

Support from Chief and council

- One thing to write and one thing to invest

Funding/$

Schools are stretched for time

- Hard to get “buy-in” from teachers
- Resistance of designating roles to teachers due to other important subjects

Evaluation

- Getting accurate data
- Participation of people to participate in surveys (#’s)
- Hard to get follow-up (post data)

Resistance of community

- How to prioritize smoking cessation vs. other health issues

Training coordinators/professions

Support from facilitators

Building the Evaluation Framework Regarding FTCS Annual Reporting Template Success Indicator 2) <u>An increase in the number and type of smoking related resolutions and policies (by Band councils, Tribal councils, governance bodies, etc.) are in place</u>

1) Available related baseline data regarding your community, prior to the advent of the FTCS funding. (What baseline data currently exist and how would they be accessed?)

Saskatchewan.

- There are no community specific data
- Provincial data
- Reserve populations
- Prescription tracking
- E Health
- Status #
- Tobacco sales/both

Alberta.

- NHIB – cessation tools access
- Number of smokers via health Canada data

Newfoundland.

- Smoking, gambling, substance abuse
- Mental health wellness
- Harm reduction, alcohol and drugs

Manitoba.

- 0 data to use

General data of smoking rates of new mothers (birth) from health services

Quebec.

- 2008 – Health survey/by commission

School based data

2) Related project objectives (measurable outcomes that your projects are designed to achieve).

Alberta – reduction is smoking rates

Smoke-free entryways and homes

Host blue light campaign

Less second hand smoke exposure

Increase tobacco awareness and education

Posters available and visible in government and public spaces

Signs

More physical activity

Fill a calendar of “quit” models (people)

Carbon monoxide data/Spiromentry data

More youth role models

Publish youth community involvement posters

More policies/bylaws

Social media campaigns

Focus on traditional tobacco use

Prevent youth from starting smoking

Higher self esteem

Staff training

Increased number of people trained in tobacco cessation

Increase in tobacco related initiatives (bylaws/BCR)

Decrease in related chronic diseases

3) Target populations that your projects are designed to impact (e.g. Prenatal parents, infants, school-age children, seniors, organizations, departments, etc.).

Community members over the age of 18

Youth/pregnant moms/young moms

Members with chronic disease

Beneficiaries focus on youth

Youth and adults

Youth and pregnant women

Healthcare staff

Children

Elders

Teachers

Community stakeholders

Org. buildings – spaces

Retailers

4) Community partners or champions who you plan to involve in your projects.

PACT/TAP/Pharmasave

Physicians – Health Canada

Education

Alberta Health Services

Community Member campaign

Smokers Help

NNADAP
Outreach workers
Chief and Council
Schools
Health Authority
CFS worker
Gov. Staff
Sport and Leisure
Head Start
Tribal Council
Health Director
Elders
NGO's
CAMCU Agencies
Leaderships of Organizations

5) Related activities, services or materials that your projects are designed to deliver.

Community toolkit
Retailer's toolkit
Posters
Calendars
T-shirts
Cookbook
Challenges
Health Ed days
Workshops
Health fairs
Youth education
Videos/newsletter
PACT Certified
TAP Certified
Alberta Health Services tobacco cessation certification
Catching your second wind
Growing tobacco
Learning culture
Smudging

Textbook
Nutrition
Youth camp
Traditional teachings
Social media
Kick-off events
“Student lounge”
Meeting with C+C
Community smoke-free events BCR

6) Anticipated challenges or barriers that your projects may experience.

Data collections
Community buy-in
Resisting change
Funding
Support Chief and Council
HR
Short timeframe
Research
Medical equipment and staff
Leadership
Deaths
Alberta Health Services
Scheduled Boards
Sustainability – C+C turnover
Health director
Managers
Social/community culture
Normalization of tobacco
Lack of resources/partners
Healthcare providers who smoke
Teachers
Professionals
Transportation
Isolated communities
Shared facilities

Infrastructure

Meeting spaces

“Healthy” elders

Tribal councils

Building the Evaluation Framework Regarding FTCS Annual Reporting Template

Success Indicator 3) <u>The number and type of promising practices that are identified (both new and existing) and shared with other communities</u>

1) Available related baseline data regarding your community, prior to the advent of the FTCS funding. (What baseline data currently exist and how would they be accessed?)

Nunavik gets their data from ITK targeting the adult (female and male) 2011

Youth surveys

New Brunswick wellness (surveys student)

RHA's surveys RHS (FN) (FNIGC)

Inuit health surveys (for community health planning)

Labour market survey

Previous health surveys

NB health council

2) Related project objectives (measurable outcomes that your projects are designed to achieve).

Reducing smoking rate

Number of smoke-free places

Number of smokers in the house

Number of people using the quit lines

Increase in number and type of smoking related resolution and policies

Number and type of promising practices identified and shared with our communities

Number of retailers toolkit developed and distributed to the retailers

Increased knowledge and awareness of smoke-free places

3) Target populations that your projects are designed to impact (e.g. Prenatal parents, infants, school-age children, seniors, organizations, departments, etc.).

Youth

General public

Pregnant women

Infants

School-age children

Seniors

Prenatal parents

Healthcare organization/facilities

Schools

Band offices

Mental health client
Recreation centres
Stores
Leadership

4) Community partners or champions who you plan to involve in your projects.

RCMP
Youth role models
Elders
Ex-smokers
Education
Chief and Council
Leadership
Retailers
Community media
Treatment centres
Health authorities
Cancer society
Mental health and addiction

5) Related activities, services or materials that your projects are designed to deliver.

Youth awareness campaign
Retailer's toolkit
Youth modules
Poster and logo contest
Maternal modules
Elementary school modules
Health fairs
Counselling
Helpline (Quit line)
Physical activities
Youth cultural camps
Develop youth groups "TATU"
What's tobacco for? (Youth Program)
Train the trainer
Develop project communities

Sports – i.e. minor hockey
Develop social media (Facebook account)
Elder's teaching/traditional teachings
Blue or green light campaign
Resources kit
Community steering groups and special project communities
Development of programs – holistic wellness
Stepping stones to wellness, matrix
Output treatment program

6) Anticipated challenges or barriers that your projects may experience.

Resistance
Chief of Council buy-in (in some communities)
Buy-in
Lack of baseline data
Human capacity
Hard to reach communities (isolated?)
Finances
Volunteers
Access to cessation products
Enforcement

Building the Evaluation Framework Regarding FTCS Annual Reporting Template:

Success Indicator 4) A Decrease In The Percentage Of Daily Smokers (In One Or More Sample Population Groups, Such As Adults, Youth, Pregnant Women, etc.) In Comparison To Initial Baseline

1) Available related baseline data regarding your community, prior to the advent of the FTCS funding. (What baseline data currently exist and how would they be accessed?)

Surveys in community

Clinic visits

NIHB data for cessation aides

Public health program update

Regional health survey data? Aboriginal People's survey

- Population data

Canadian community health survey

- (off reserve) Stats Can

Regional Health Authority data

Community health plans

Regional Health plan

2) Related project objectives (measurable outcomes that your projects are designed to achieve).

Household surveys data

Cohort study – measure decrease in smoking

Update in cessation aides

Qualitative interviews with CHW's, counsellors etc. about change (perceived) about people asking/inquiring about quitting

Numbers of people quit

Participant #'s (e.g. Blue light # of light bulbs)

Number of households reporting as smoke free

Training MH&A staff- measure awareness of cessation aides/supports that are available for program use and their importance (long-term impacts)

3) Target populations that your projects are designed to impact (e.g. Prenatal parents, infants, school-age children, seniors, organizations, departments, etc.).

All of the above

Specific:

Retailers

Health leaders/providers

Band council members

Practitioners/CHW's
Powwow community members
Land-based and cultural events (cultural vs. commercial application)
Bingo halls
Casinos
Organizations:
(Specific)
Maintenance shops
Garages
Look at infrastructures on First Nations and isolated communities
Construction sites
In equipment:
Plows, trucks, etc.
Taxis

4) Community partners or champions who you plan to involve in your projects.

Principles and school boards
RCMP
Health Directors
Chief and Council
Retailers
By-law officers/Justice
Peer leadership groups
NGO's (Lung Assoc.)
RHAs
Nursing supervisors, CHW's, Health Professionals
Specialists (community, addictions, etc.)
Dentists/pharmacists etc.
Elders and elders councils
Youth Council and Youth Centres
Management in workplaces
Coordinators (program)
Women's Groups
Friendship Centres
Local Businesses
Cancer Society

5) Related activities, services or materials that your projects are designed to deliver.

Education (prevention and cessation)

- Incentives for programs (April Aging)

Cessation (treatment)

- Incentives (Blue Light)

Training (how to champion cessation and prevention)

Awareness and promotion (health fairs)

Protection (incentive: Blue Light)

- (Policies, legislation, signage)

Reduction (toolkits to relatives)

Policies and by-laws (Around NRT)

6) Anticipated challenges or barriers that your projects may experience.

Baseline data (NEXT FNRHS used from 2008-10, follow-up for comparative is after project is done)

Project by in and commitment from partners and communities

Resistance to change

Limited timeframe to administer project and measure change. Two years is a heartbeat away! (pre-test and post-test results)

Not only challenges it's the reality – needs a long term strategy not a two year

Ranking of priority in chronic illness in communities

- Competing priorities that Health Director can focus on
- Look at ways to integrate tobacco messaging into existing programs (*Program clustering)

Training – Health Worker's training (*Sunsetting programming)

- 2-3 years and it disappears
- Lack of consistency and continuity in funding/training

Balancing act of meeting funding expectations and community level programming

Changing workforce (corporate knowledge loss)

Demand for product (natural product)

- What are alternatives available

Reviewing/re-examining the tobacco industry