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

A REPORT ON THE FINDINGS FROM THE ANNUAL OUTCOME REPORTING PROCESS

A Two-Year Review

2014-2015 & 2015-2016

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Produced by

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The members of the FTCS Evaluation Steering Committee

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REPORT CONTENTS

I) BACKGROUND AND METHODOLOGY:

1.1) The Federal Tobacco Control Strategy:[1]

This report provides the findings for the **First Nations and Inuit Component** of the **Federal Tobacco Control Strategy** (FNIC-FTCS) projects for 2014-2015 and 2015-2016. FTCS operates through **First Nations Inuit Health Branch, Health Canada.** This ***FTCS Annual Outcome Report*** has been completed by **Kaplan Research Associates Inc**. through the **National Aboriginal Diabetes Association** (NADA). This is the second of four annual outcome reports. The results of subsequent reports will replicate the findings from the current report and will be used as the basis by which to measure changes over time. Several questions have been added to the current analysis this year. These include:

- an additional smoke-free location (Sweat Lodges)
- the inclusion of a question to track the activities and services provided by each project in 2015-2016
- open-ended responses regarding barriers or challenges related to leadership, health promotion and smoking-cessation to complement 'promising practices' under these three headings

Because there are now data covering a two-year period, analyses have been undertaken to determine where statistically significant variations in responses, over time, emerged. A description of the statistical tests used in this study are provided as ***Technical Notes*** on pages 10 and 11 of this report.

The ***First Nations and Inuit Component*** of the **Federal Tobacco Control Strategy** 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 and 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

[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 One** of this report.

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

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

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

FNIC-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 two years of data collection across Canada. They include data provided by:

Projects (Funded recipients)	Reported in 2015	Reported in 2016
Battle River Treaty 6 Health Centre	✔	✔
Beaver First Nation	✔	✔
British Columbia First Nations Health Authority Tobacco Strategy	✔	✔
Chemawawin Cree Nation/Chemawawin Health Authority	✔	✔
Cree Board of Health and Social Services of James Bay	✔	✔
The Department of Health, Government of Nunavut, Tobacco Reduction		✔
File Hills Qu'Appelle Tribal Council	✔	✔ [7]
First Nations of Quebec and Labrador Health and Social Services Commission	✔	✔
Grand Council Treaty #3	✔	✔
Keewatin Tribal Council	✔	✔
Mawiw Council	✔	✔
Northwest Territories [8]		
Northern Inter-Tribal Health Authority	✔	✔
Nunavik Regional Board of Health and Social Services	✔	✔
Nunatsiavut Government Department of Health and Social Development	✔	✔
Nunee Health Board Society	✔	✔
Samson Community Wellness	✔	✔
Siksika Health Services	✔	✔
Southeast Resource Development Council	✔	✔

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

1.2) The Study Methodology:

In March, 2015, NADA sponsored a three-day conference, held in Winnipeg, Manitoba. Representatives

[6] Cited from http://www.hc-sc.gc.ca/hc-ps/pubs/tobac-tabac/fs-sf/index-eng.php
[7] **NOTE**: The completed form from **File Hills** arrived subsequent to the completion of the statistical analysis for this report. Open-ended responses from this project will be included in this report, and their quantitative data for 2015-16 will be included in the subsequent reports.
[8] Due to unique approaches in implementation, data for the project with the Government of the Northwest Territories was not available for inclusion in this report.

of the participating projects, Health Canada, NADA and Kaplan Research Associates were in attendance. In terms of the FTCS Annual Outcome process, 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 the 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.[9] The questions included:

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 was 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 initial draft report.

It was confirmed at the first steering committee meeting that data collected in 2014-2015 would constitute ***baseline data***. This is important since 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 have been unrealistic and unfair to expect these projects to have measurable outcomes at that juncture.

1.2.1) The Areas Of Inquiry:

The development of the ***Annual Outcome Reporting Form*** was a consultative process that required approximately seven drafts. The following questions were included in this form:

- Project name
- Provinces or territories served, project coordinators and their email addresses[10]
- Number of communities served by each project
- The target populations served by each project as of March 31st of each year
- The partners or 'champions' with which each project worked, as of March 31st
- The number of inside and outside smoke-free spaces identified by each project, as of March 31st
- The number of smoking-related resolutions passed by governance bodies 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

[9] The results of these group processes can be found in **Appendix One** of this report.
[10] Added to the 2015-2016 Outcome form.

- When these data were collected

- Whether each project collected information using a population or community-level survey. If 'yes':
  - 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
  - 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 description of each project's ***barriers or challenges*** as these related to:[10]
  - 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 2015-2016

The Annual Outcome Reporting Form was developed as an online survey. Each project was provided with a pdf of the form to use as a ***worksheet***. They were able to retain this worksheet as a hardcopy version of their responses. PDFs of the completed forms will be sent out to each project in 2016.

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. They include **Descriptive Statistics and Measures of Association**. The latter includes the use of **Chi-Square** and **T-Tests**.

Descriptive statistics include frequency counts and percentage breakdown; mean; median; and standard deviation (sd). 'N' designates the sample size (number of projects).

- 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 the degree to which the range of scores clusters around the mean, or is more widely ***dispersed***, 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.

Measures of Association:

Measures of association include statistical tests that show the direction and/or magnitude of a relationship between two or more variables. Depending upon the nature of the data, different statistical procedures are used to measure association.

Chi-Square:

Chi-Square (χ^2) is used when comparing ***nominal variables***. Examples of nominal variables include gender, marital status, and so on. **Chi-Square** itself is a test of statistical significance based on a comparison of the observed cell frequencies of a ***cross-tabulation***, or ***contingency table***, with frequencies

that would be expected under the ***null hypothesis*** of no relationship. Where the resulting data conform to the ***expected distribution*** of cases across the cells of the contingency table, it is assumed that there is no statistical relationship between the variables being examined. That is, that one variable is not seen to affect the other. Where the actual distribution of cases varies from the expected distribution of cases across this table, a relationship between the variables under review is assumed.

To test whether there is a ***significant*** statistical relationship between the variables under review, two additional factors must be examined. These include the ***degrees of freedom*** (df) associated with this table, and its ***level of probability*** (p). **Degrees of freedom** is a factor of the construction of the contingency table. It is derived by calculating the number of rows in the table (minus 1) by the number of columns in that table (minus 1). The formula then reads df=(R-1)(C-1). A two-by-two contingency table has one degree of freedom (2-1)(2-1). A four-by-five contingency table has 12 degrees of freedom (4-1)(5-1). Degrees of freedom is an important element in this analysis in that it refers to the potential for cell entries to vary freely, given a fixed set of marginal totals (i.e., column and row marginals).

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

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

T-Tests:

T-tests are used to determine whether there is a statistically significant difference between the mean scores of two groups. There are three primary factors that play a part in t-tests: ***Degrees of Freedom***, ***Standard Deviation*** (sd) and ***Probability*** (p). ***Paired T-Tests*** are generally used in this study.

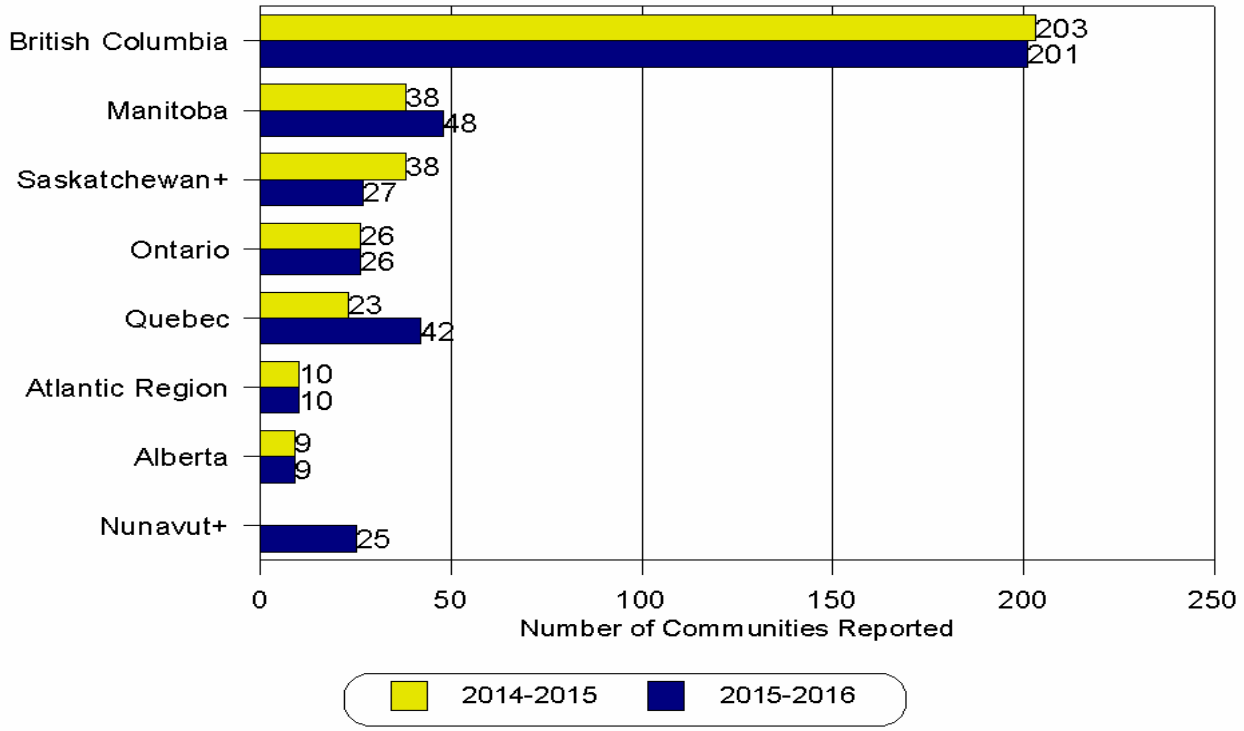
NOTE: There are differences in the percentages provided for some questions when the findings in the first report are compared with those in the current report. This is caused by the fact that, for 2014-2015, selected frequencies were tabulated using ***multiple response*** fields. In 2015-2016, because we are analyzing responses over time, frequencies reflect data provided through ***Chi-square contingency tables***. These differences are a one-time occurrence, as the subsequent analyses will be consistent with that used in the current analysis.

II) THE FINDINGS OF THE ANNUAL OUTCOME REPORTING PROCESS:

2.1) The Number of Communities Each Project Serves:

In 2014-2015 the FTCS projects served 347 First Nations communities across Canada. In 2015-2016 this number increased to 388.

Figure 1 Number Of Communities Served, By Province*



(Number of projects=17, 17. *Numbers based on information reported by funding recipients. +No response provided by Nunavut in 2014-15. Response from File Hills received subsequent to quantitative analysis being complete in 2015-2016. NWT data were unavailable for both years.)

British Columbia served 203 communities in 2014-2015 and 201 in 2015-2016 (Figure 1). Manitoba and Saskatchewan served 38 communities each in 2014-2015. The former served 48 communities in 2015-2016, and the latter served 27.[11] Ontario served 26 communities in both years. Quebec served 23 communities in 2014-2015 and 42 in 2015-2016. The Atlantic Region served 10 communities in both years, and Alberta served nine communities in both years. Nunavut served 25 communities in 2015-2016.

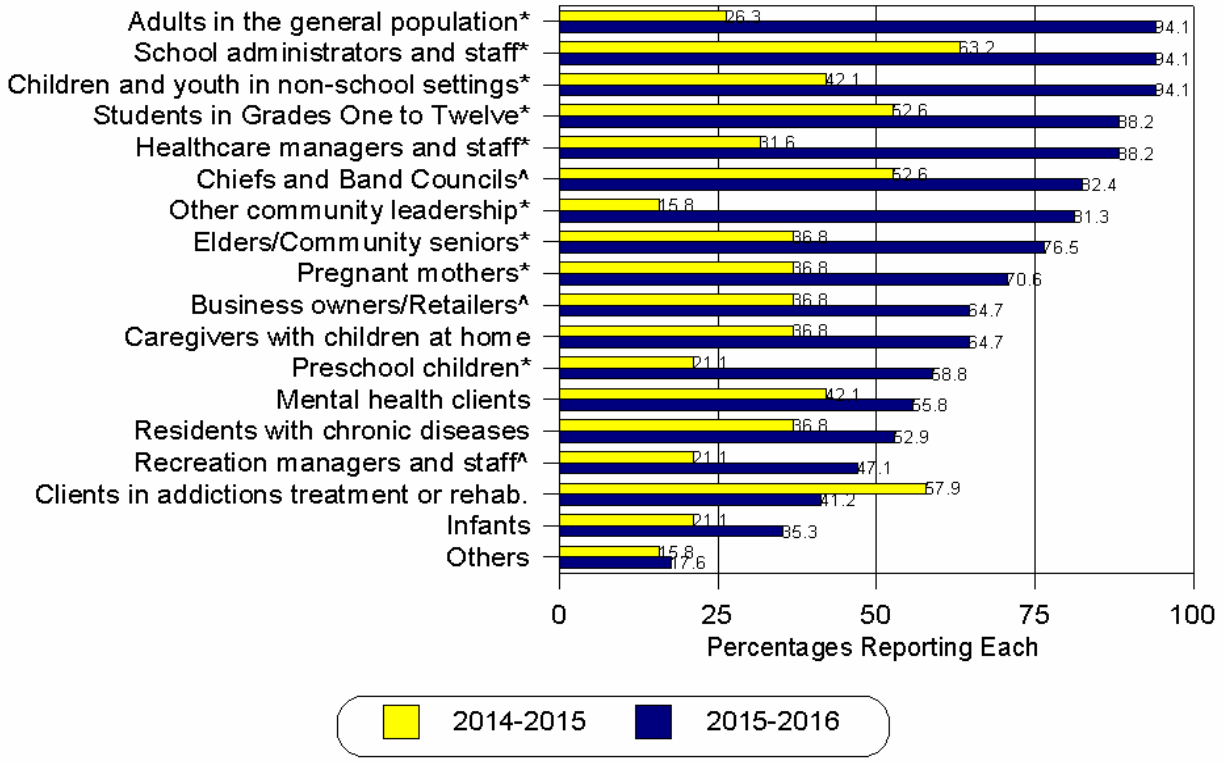
2.2) Target Populations Projects Reached:

Respondents were asked to identify the populations their projects reached up to March 31 of each respective year. In 2014-2015 the largest percentage of projects reached school administrators and staff (63.2%) and addictions treatment clients (57.9%) (Figure 2). About half of the projects reached Chiefs and Band Councils, and students attending Grades One to Twelve. In 2015-2016 large percentages of the projects reached a wide selection of populations. These most frequently included: adults in the general population (94.1%), school administrators and staff (94.1%), children and youth in non-school settings (94.1%), students in Grades One to Twelve (88.2%), healthcare managers and staff (88.2%), Chiefs and Band Councils (82.4%), other community leaders (81.3%), Elders and community seniors (76.5%), and pregnant mothers (70.6%). There were ***statistically significant*** increases, over time, in the percentage of projects reaching nine populations. These include, in ranked order of significance:

[11] The completed FTCS Outcome Form from ***File Hills Qu'Appelle Tribal Council*** in Saskatchewan was received subsequent to the completion of the quantitative analysis for this report. Quantitative data from this project will be excluded from this report, while its qualitative data (open-ended responses) will be included. As a result, the reported number of communities served in Saskatchewan is reduced by 11.

- **Adults in the general population**: From 26.3% in Year One to 94.1% in Year Two (N=36, χ^2=16.97, df=1, p=.00004)
- **Children and youth in non-school settings:** from 42.1% to 94.1% (N=36, χ^2=10.92, df=1, p=.0009)
- **Other community leaders**: from 15.8% to 81.3% (N=36, χ^2=13.38, df=1, p=.0003)
- **Healthcare managers and staff:** from 31.6% to 88.2% (N=36**,** χ^2=11.85, df=1, p=.0006)
- **Elders and community seniors**: from 36.8% to 76.5% (N=36, χ^2=5.71, df=1, p=.017)
- **Preschool children**: from 21.1% to 58.8% (N=36, χ^2=5.39, df=1, p=.02)
- **Students in Grades One to Twelve**: from 52.6% to 88.2% (N=36, χ^2=5.36, df=1, p=.021)
- **School administrators and staff**: from 63.2% to 94.1% (N=36, χ^2=4.97, df=1, p=.026)
- **Pregnant mothers**: from 36.8% to 70.6% (N=36, χ^2=4.10, df=1, p=.043)

Figure 2 Populations That Had Been Reached By The Projects, To Date



(Number of projects reporting=17,17. *Statistically significant variations over time. ^Borderline significance. Multiple responses are allowed. Adjusted to exclude missing data.)

There were ***borderline significant variations*** in the percentage of three populations reached by the projects. These included:

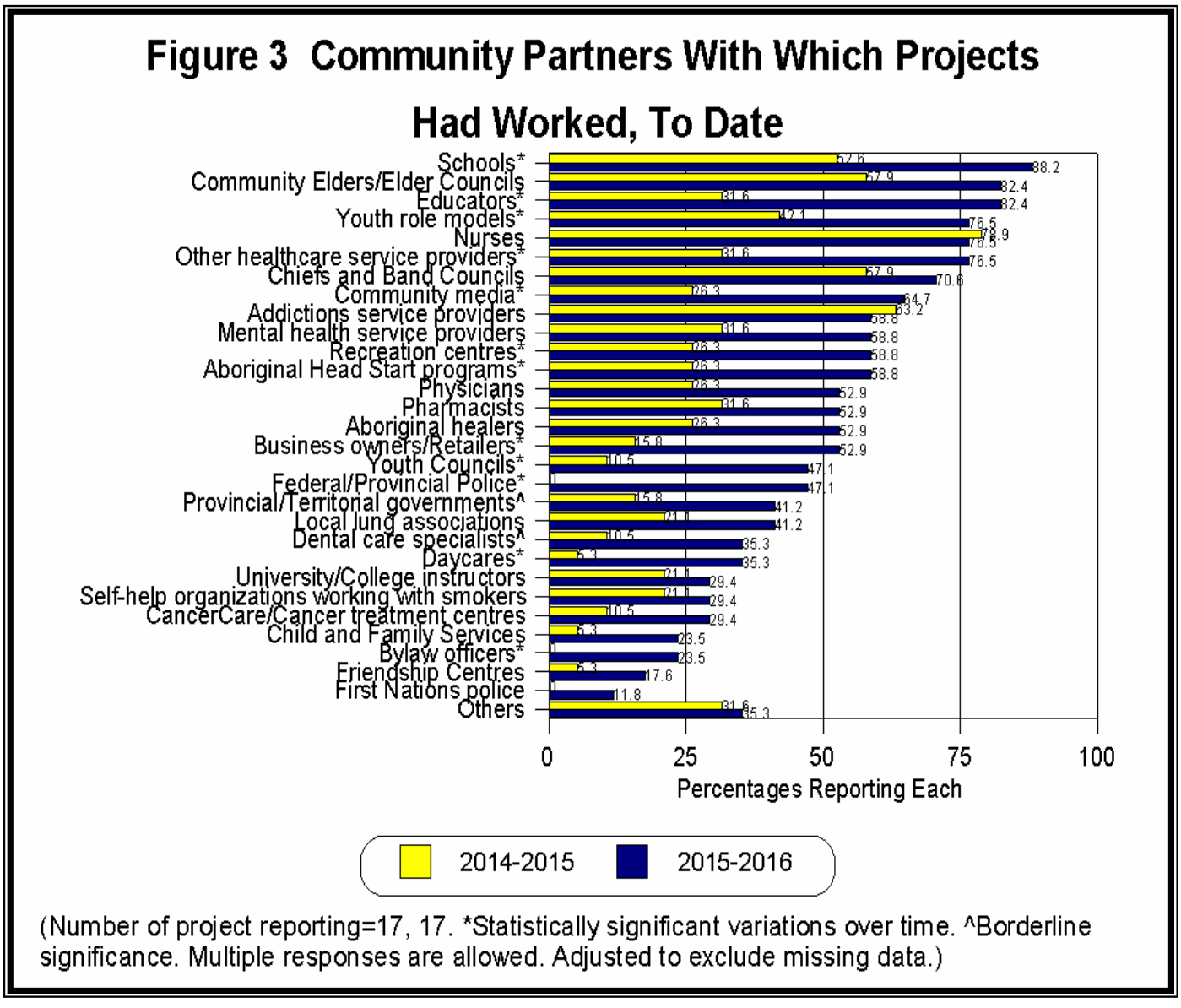
- **Chiefs and Band Councils:** from 52.6% to 82.4% (N=36, χ^2=3.57, df=1, p=.06)
- **Business owners and retailers**: from 36.8% to 64.7% (N=36, χ^2=2.79, df=1, p=.09)
- **Recreational managers and staff**: from 21.1% to 47.1% (N=36, χ^2=2.73, df=1, p=.09)

'Other' populations included: Nunatsiavut Government senior officials, traditional leaders, coaches, NNADAP and [addictions] treatment centre workers, regional partners, and maternal and infant health agencies.

2.3) Projects' Community Partners:

Respondents were asked to identify the community partners with whom they worked to achieve their objectives. In 2014-2015 the largest percentage of projects identified nurses as their partners (78.9%), followed by addictions service providers (63.2%), Chiefs and Band Councils (57.9%), and community Elders or Elders Councils (57.9%) (Figure 3). In 2015-2016 there were eight frequently identified categories of community partners. They included: schools (88.2%), community Elders or Elders Councils (82.4%), educators (82.4%), youth role models (76.5%), nurses (76.5%), other healthcare service providers (76.5%), Chiefs and Band Councils (70.6%), and community media (64.7%). There were ***statistically significant*** variations in the percentage of projects that identified twelve categories of community partners, over time. These included, in ranked order of significance:

- **Federal/Provincial Police**: from 0% to 47.1% (N=36, χ^2=11.50, df=1, p=.0007)
- **Educators**: from 31.6% to 82.4% (N=36, χ^2=9.37, df=1, p=.002)
- **Other health care providers**: from 31.6% to 76.5% (N=36, χ^2=7.25, df=1, p=.007)
- **Youth Councils**: from 10.5% to 47.1% (N=36, χ^2=5.97, df=1, p=.015)
- **Business owners/Retailers**: from 15.8% to 52.9% (N=36, χ^2=5.57, df=1, p=.018)
- **Schools:** from 57.6% to 88.2% (N=36, χ^2=5.36, df=1, p=.021)
- **Community media**: from 26.3% to 64.7% (N=36, χ^2=5.36, df=1, p=.021)



- **Daycares**: from 5.3% to 35.3% (N=36, χ^2=5.17, df=1, p=.023)
- **Bylaw Officers**: from 0% to 23.5% (N=36, χ^2=5.03, df=1, p=.025)
- **Youth role models**: from 42.1% to 76.5% (N=36, χ^2=4.36, df=1, p=.037)
- **Recreation centres**: from 26.3% to 58.8% (N=36, χ^2=3.90, df=1, p=.048)
- **Aboriginal Head Start Programs**: from 26.3% to 58.8% (N=36, χ^2=3.90, df=1, p=.048)

There were two categories of community partners for which there was ***borderline significance*** in the percentage of projects identifying each:

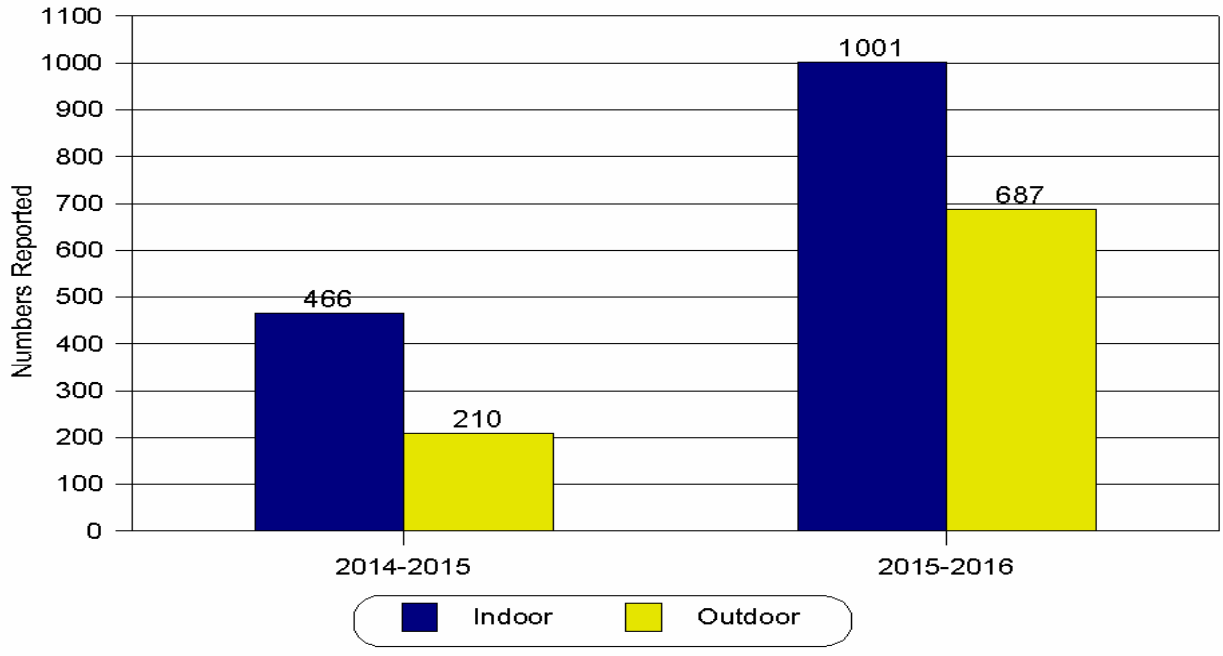
- **Dental Care Specialists**: from 10.5% to 35.3% (N=36, χ^2=3.18, df=1, p=.074)
- **Provincial/Federal Governments**: from 15.8% to 41.2% (N=36, χ^2=2.88, df=1, p=.089)

'Other' community partners included: Regional Health Authorities, youth centers, social media, Aboriginal sports organizations, Community health representatives, BC Heart and Stroke Foundation, Canadian Cancer Society, Community Health and Wellness Committees, and the McGill University Hospital Centre.

2.4) Smoke-Free Spaces in the Communities:

The development and enforcement of smoke-free spaces is a goal of the **Federal Tobacco Cessation Strategy**, and one of the four key success indicators. Respondents were asked to identify the number of indoor and outdoor smoke-free spaces that existed within their catchment areas as of March 31st of each year.[12] In 2014-2015 the projects were collectively able to identify 676 smoke-free spaces (Figure 4). Of these 466 were indoor smoke-free spaces and 210 were outdoor smoke-free spaces. In 2015-2016 the total number smoke-free spaces rose to 1,688. Of these, the number of indoor smoke-free spaces more than doubled to 1,001, and the number of outdoor smoke-free spaces similarly increased to 687.

Figure 4 Total Number Of Smoke-Free Spaces Reported To Date



(Number of projects reporting=12/9, 15/16. Adjusted to exclude missing data.)

[12] Designations of outdoor smoke-free spaces are based on each province's or territory's related legislation, for example legislation banning smoking within 9 meters from a building's entrance.

In 2014-2015 the projects identified an average of 38.8 indoor smoke-free spaces, with a median of 23.5 (sd=38.30) (Figure 5). The number of indoor smoke-free spaces ranged from a low of five and six to a high of 79, 84 and 123. Fewer outdoor smoke-free spaces were identified by the projects, for 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 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.

In 2015-2016, the projects identified an average of 64.6 indoor smoke-free spaces, with a median of 50.0 (sd=52.53). The projects also identified an average of 41.6 outdoor smoke-free spaces, with a median of 40.5 (sd=28.66). The projects identified an overall average of 102 total smoke-free spaces this year, with a median of 89.5 (sd=73.35).

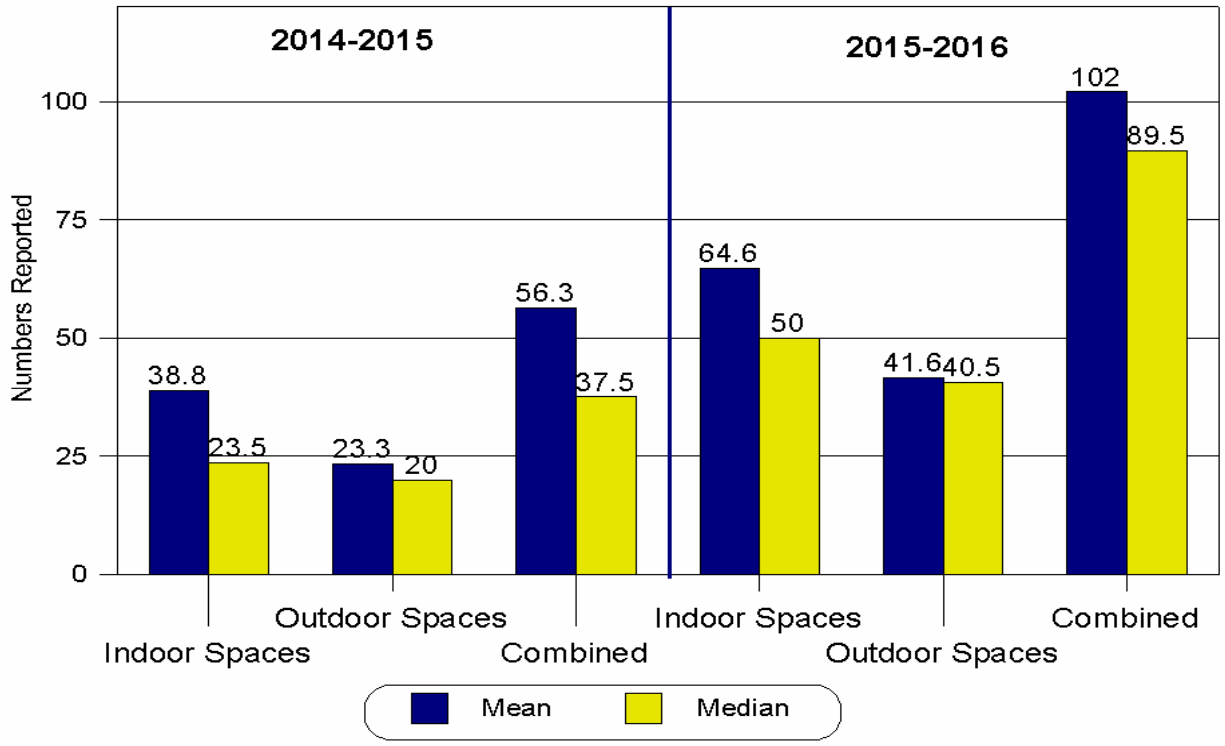
While the increases in smoke-free spaces over time are notable, they are not statistically significant:

- Mean number of **indoor smoke-free spaces**, over time: N=30, t=1.63, p=.115
- Mean number of **outdoor smoke-free spaces**, over time: N=28, t=1.46, p=.156

The variation in the total number of smoke-free spaces, over time, has ***borderline significance***:

- Mean number of **total smoke-free spaces**, over time: N=31, t=1.82, p=.079

Figure 5 Mean And Median Smoke-Free Spaces



(Number of projects reporting=12/9/12, 15/16/16. Adjusted to exclude missing data.)

2.4.1) Smoke-Free Indoor Spaces By the Types of Related Buildings and Spaces, Over Time:

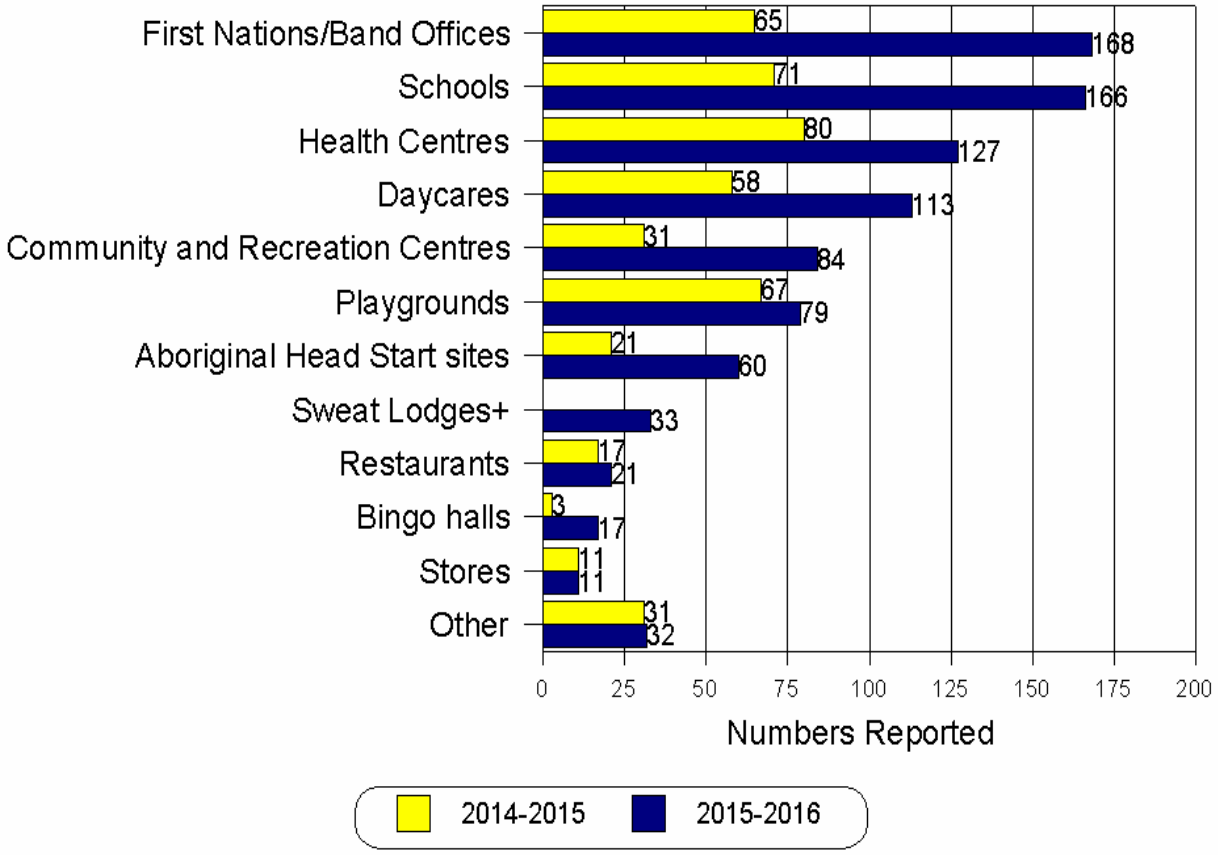
Respondents were asked to identify the number of indoor and outdoor smoke-free spaces for eleven types of buildings or spaces in their communities. In 2014-2015 the largest number of ***indoor smoke-free spaces*** collectively included (Figure 6.1):

- Health centres (80)[13]
- Schools (71)
- First Nations Band offices (65)
- Daycares (58)
- Community and recreation centres (31)
- Aboriginal Head Start Program sites (21)

There was a notable increase in the number of many smoke-free indoor spaces in 2015-2016. These most frequently included:

- First Nations Band offices (168)
- Schools (166)
- Health centres (127)
- Daycares (113)
- Community and recreation centres (84)
- Playgrounds (79)[14]
- Aboriginal Head Start Program sites (60)
- Sweat lodges (33)[15]

Figure 6.1 Number Of Indoor Smoke-Free Spaces, By The Types Of Buildings And Spaces, To Date



(Number of projects reporting each=12/14, 11/14, 12/13, 11/14, 7/13, 7/9, 10/12, 4, 4/5, 3/4, 5/7, 6/5. +Item added in 2016. Adjusted to exclude missing data.)

2.4.2) Smoke-Free Outdoor Spaces by the Types Of Related Buildings and Spaces, Over Time:

In 2014-2015 the most frequently identified outdoor smoke-free spaces included (Figure 6.2):

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

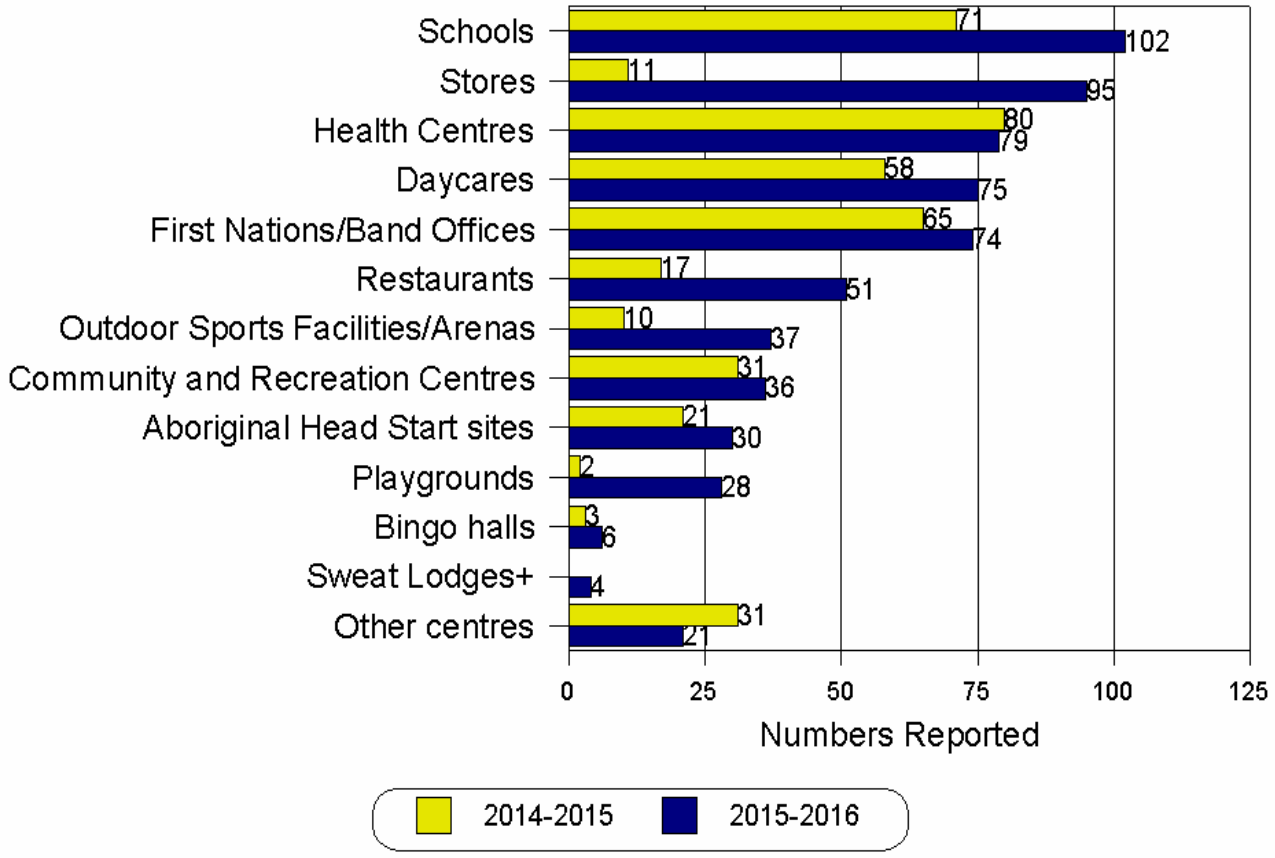
[13] Numbers reported collectively by all project sites.
[14] These assumedly refer to buildings located on, or adjacent to, the playgrounds.
[15] Added to the list in 2016.

In 2015-2016 the most frequently identified outdoor smoke-free spaces included:

- Schools (102)
- Stores (95)
- Health centres (79)
- Daycares (75)
- First Nations Band offices (74)
- Restaurants (51)
- Outdoor sports facilities/Arenas (37)
- Community and recreation centres (36)
- Aboriginal Head Start Program sites (30)

Not only was there a notable increase in the number of smoke-free outdoor spaces, but commercial spaces were among the top six types of locations in 2015-2016. 'Other' smoke-free spaces included: maintenance buildings, a provincial nursing station, an Inuit government building, a heavy equipment industrial site, supportive housing buildings, a fire hall, a social service centre, a youth centre, a radio station, a 'readaptation' centre, and local businesses.

Figure 6.2 Number Of Outdoor Smoke-Free Spaces, By The Types Of Buildings And Spaces, To Date

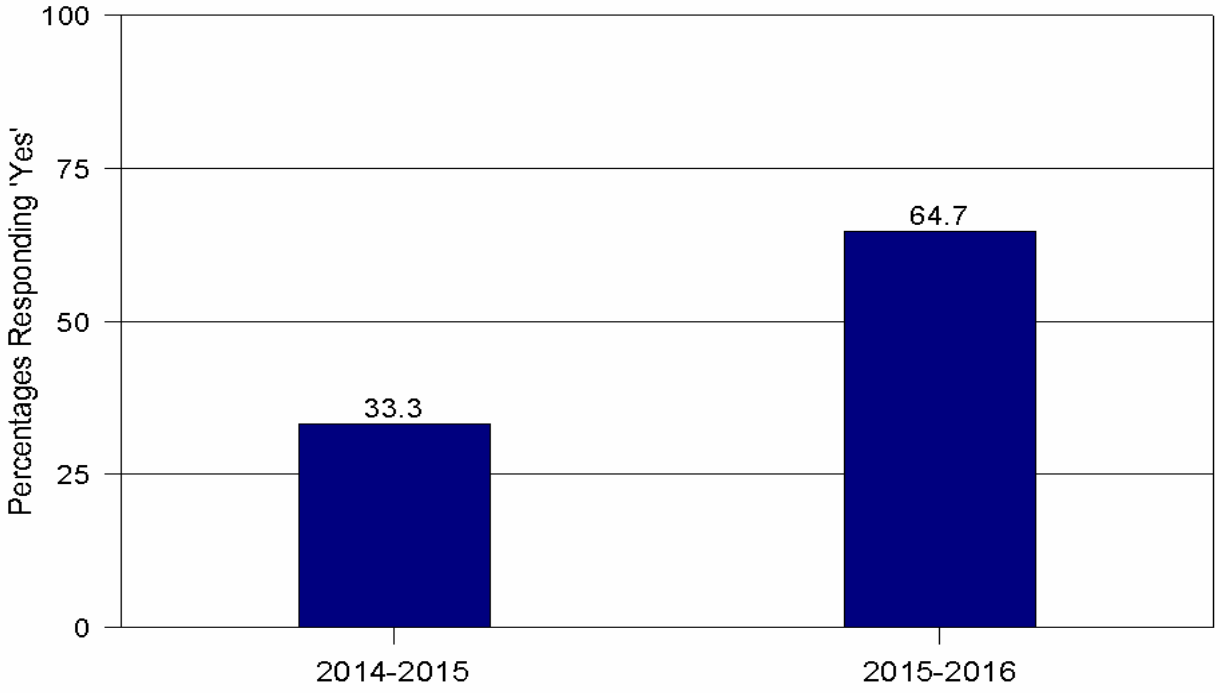


(Number of projects reporting each=7/12, 3/10, 8/12, 7/12, 6/12, 3/8, 6/9, 4/8, 5/10, 3/5, 2/3, 4, 4/5. +Item added in 2016. Adjusted to exclude missing data.)

2.5) Communities Passing Smoking-Related Resolutions:

The number of projects that reported passing smoking-related resolutions by their governance bodies doubled over time (Figure 7). This included 33.3% of the projects responding in 2014-2015 and 66.7% of the projects responding in 2015-2016. This variation is considered statistically significant (N=32, χ^2=4.44, df=1, p=.035)

Figure 7 Were Smoking-Related Resolutions Passed By Governance Bodies, To Date?



(Number of projects reporting=15, 17. Adjusted to exclude missing data.)

Consistent with the preceding findings, the number of smoking-related resolutions that were passed more than doubled over time: from 23 in 2014-2015 to 53 in 2015-2016 (Figure 8). In 2014-2015, each project reported an average of 1.35 resolutions passing, with a median of 0 (sd=4.33). In 2015-2016, the average number of resolutions passed per community was 3.53, with a median of 1.0 (sd=5.77). The number of resolutions passed ranged from a low of 0 and 1 to a high of 12, 18 and 20.

2.5.1) Types of Smoking-Related Resolutions Passed by Governance Bodies:

Respondents were provided with six types of smoking-related resolutions, plus 'other,' and were asked which were passed in their communities. In 2014-2015 the resolutions passed included (Figure 9):

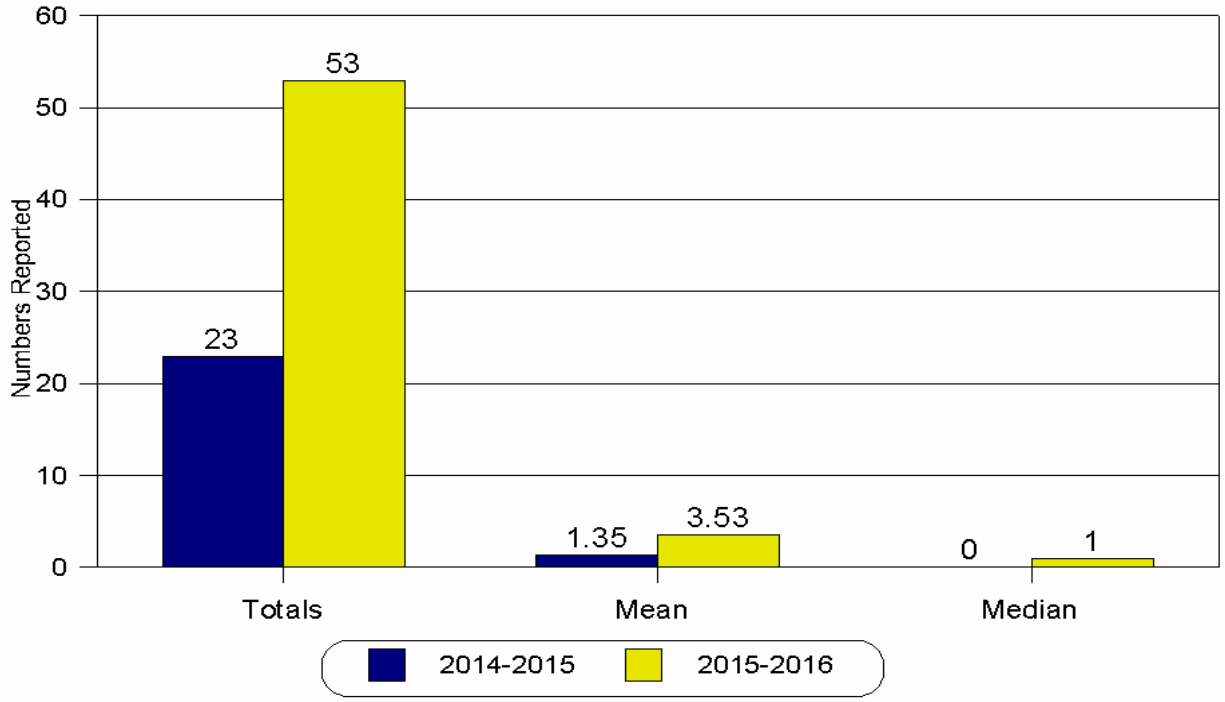
- Designating smoke-free public spaces (reported by 21.1% of all projects that year)
- Using tobacco-related revenues to fund health-promotion activities (15.8%)
- Promoting smoke-free homes (10.5%)
- Expanding smoke-free perimeters surrounding smoke-free buildings and spaces (10.5%)
- Enforcing smoke-free public spaces (5.3%)

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

The resolutions passed in 2015-2016 included:

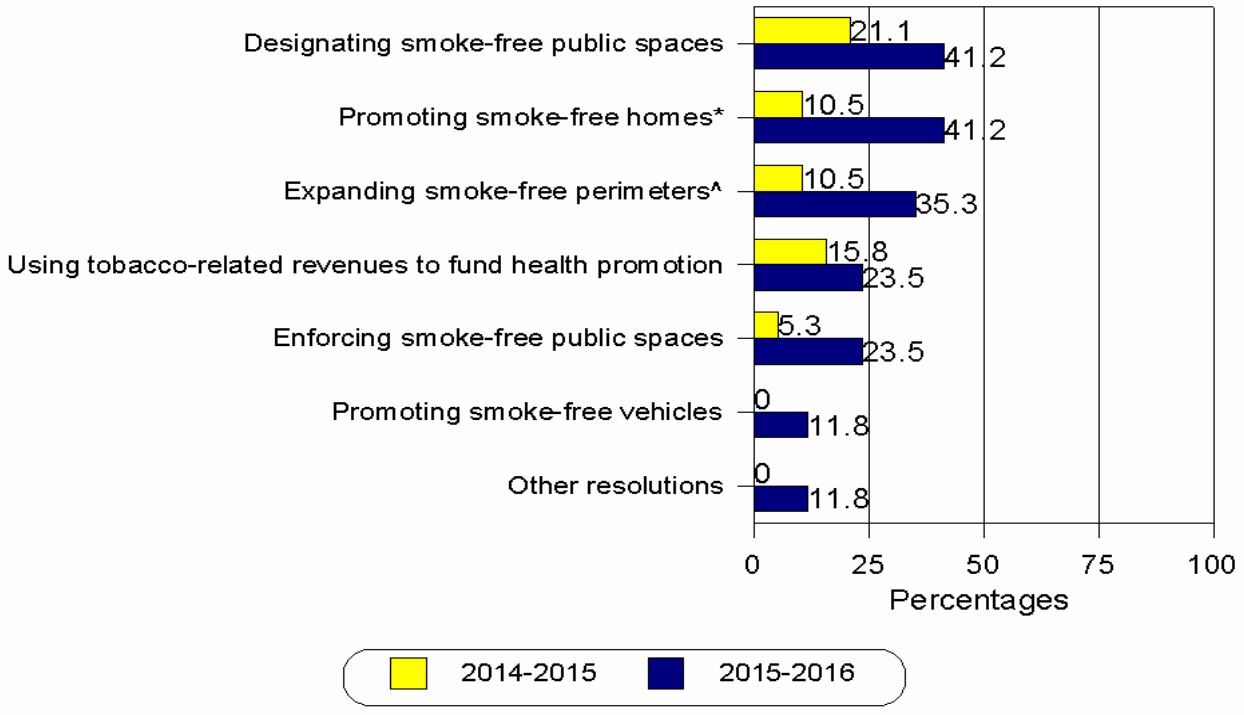
- Designating smoke-free public spaces (41.2%)
- Promoting smoke-free homes (41.2%)
- Expanding smoke-free perimeters surrounding smoke-free buildings and spaces (35.3%)
- Using tobacco-related revenues to fund health promotion activities (23.5%)
- Enforcing smoke-free public spaces (23.5%)
- Promoting smoke-free vehicles when young children are in the vehicles (11.8%)
- Other resolutions (17.6%)

Figure 8 The Number Of Smoking-Related Resolutions Passed By Governance Bodies, To Date



(Number of projects reporting=15, 17.)

Figure 9 Types Of Smoking-Related Resolutions Passed, To Date



(N=17, 17. *Statistically significant variation over time. ^Borderline significance.)

There was a statistically significant variation in the percentage of projects, over time, reporting the passing of resolutions ***promoting smoke-free homes***, (N=36, χ^2=4.50, df=1, p=.034). There was borderline significance regarding the percentage of projects passing resolutions ***expanding smoke-free perimeters*** (N=36. χ^2=3.18, df=1, p=.074). The two 'other' passed resolutions included:

- Addressing *vaping* (use of e-cigarettes) in public places.
- Restricting sales [of commercial tobacco] to minors.

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. Given that many projects began providing smoking-cessation services in 2015-2016, the data reported in this document can be considered ***baseline data*** for this service area. A matrix was developed in the survey that established nine intervention target groups and posed four questions regarding each of these:

- People who were participants at the start of the smoking-cessation program or intervention
- Of these, the people who completed these smoking-cessation programs or interventions
- People who reduced their daily smoking rates (harm reduction)
- People who quit smoking during or at the end of their smoking-cessation programs or interventions

In 2014-2015 the program was too new to operate viable smoking-cessation programs. In 2015-2016 seven projects provided some smoking-cessation services or activities to at least one or more of the target groups. Considering the aggregate figures across all projects and target groups, it was reported that 3,197 community members started a smoking-cessation program or intervention in 2015-2016 (Table 1) and that 1,141 of these individuals completed that program or intervention. This represents a completion rate of 35.7%, which is a moderately successful outcome, given the addictive nature of nicotine.[16]

Of those community members who started a program, 163 reduced their levels of commercial tobacco use. This represents 5.1% of those who started a smoking-cessation program or intervention, and 14.3% of those who completed a program. Fifty-two community members reportedly quit smoking during or at the end of the cessation program or intervention. This represents 1.6% of the people who started a program or activity, and 4.6% of those who completed a program or activity.

2.7) Smoking-Cessation 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 projects, 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 was 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.

[16] This figure would likely be higher if a larger number of participants in the 24 hour stop-smoking challenge completed their follow-up survey forms.

Table 1) FTCS Smoking Cessation Data From The Participating Projects

Intervention Target Groups	Numbers starting program/ intervention	Numbers completing program/ intervention	Numbers reducing smoking	Numbers quitting smoking
Pregnant women	61	48	4	6
Caregivers of infants/young children (less than 3 years of age)	17	4	1	3
Program participants in community-based smoking cessation programs*	1,521*	621	113	28
School-aged children and youth	372	359	10	0
Caregivers participating in community-based programs	0	0	0	0
Health care workers in specific settings (e.g. community health centres)	201	47	4	5
Elders/Other seniors	7	7	0	0
Clients in addictions treatment/rehab	0	0	12	0
Adults in the general population	0	0	0	0
Others**	1,018**	28	19	10
Totals	3,197*	1,141	163	52

*This figure includes 759 community members who responded to a '24 hour stop-smoking' challenge. No formal follow-up was undertaken with all participants. Instead, about 35 voluntarily completed a follow-up form, with 85% of these (N=26) reporting that they met the challenge. **An additional 3,081 clients reportedly received "tobacco cessation aids through provincial health benefits." As these clients were not necessarily participants in formal smoking cessation programs sponsored by an FTCS project, they are excluded from this analysis.

2.7.1) Projects Collecting Smoking-Cessation Data:

In 2014-2015 just over half of the projects (53.3%) were collecting cessation information using a population or community-level survey (Figure 10). In 2015-2016 this number rose to 73.3%. This is a notable increase in the number of projects reporting for this fiscal year.

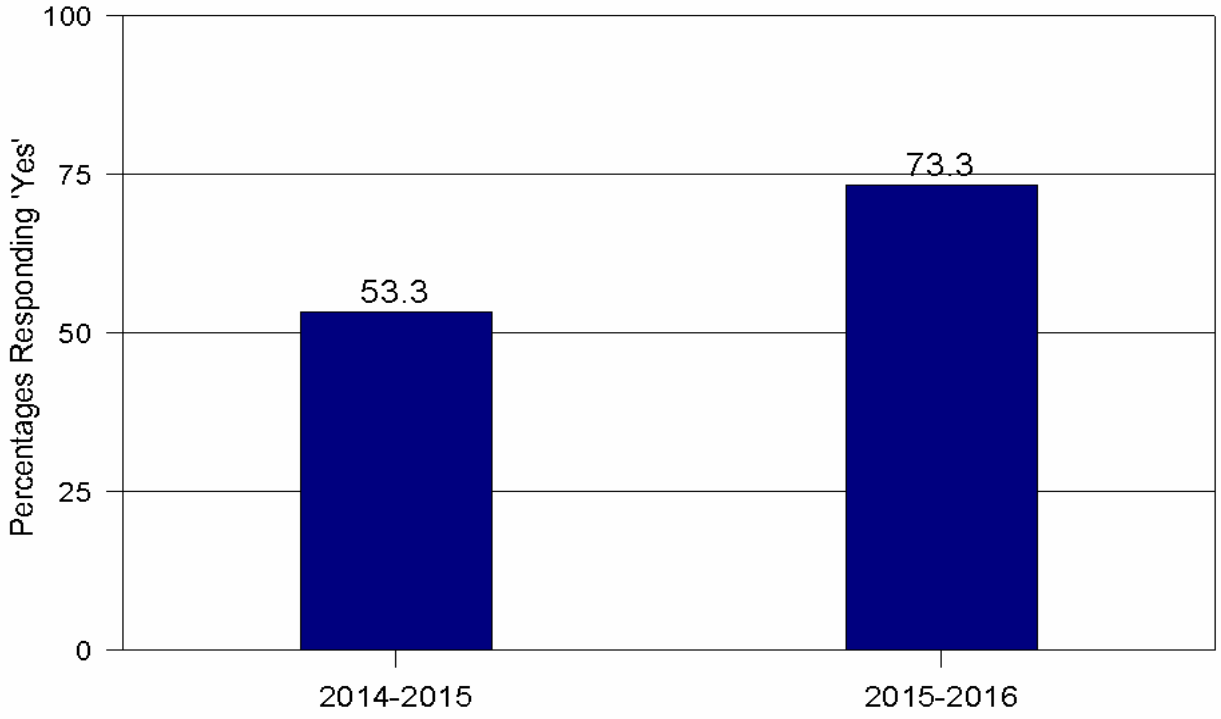
2.7.2) The Current Status of Their Studies:

Of the eight projects that responded in 2014-2015, one indicated that the related study was completed (12.5%), two (25.0%) that their studies are in process, and the remainder (62.5%) that they had not yet started to collect related data (Figure 11). In 2015-2016 there was a notable increase in the percentage of projects reporting completed studies (58.3%), or having studies underway (41.7% compared with 25.0%). The statistical significance of this variation over time cannot be determined, as the question in 2014-2015 was set up as a single response question, while the question in 2015-2016 was a multiple-response question.

2.7.3) The Studies' Projected or Actual Sample Sizes:

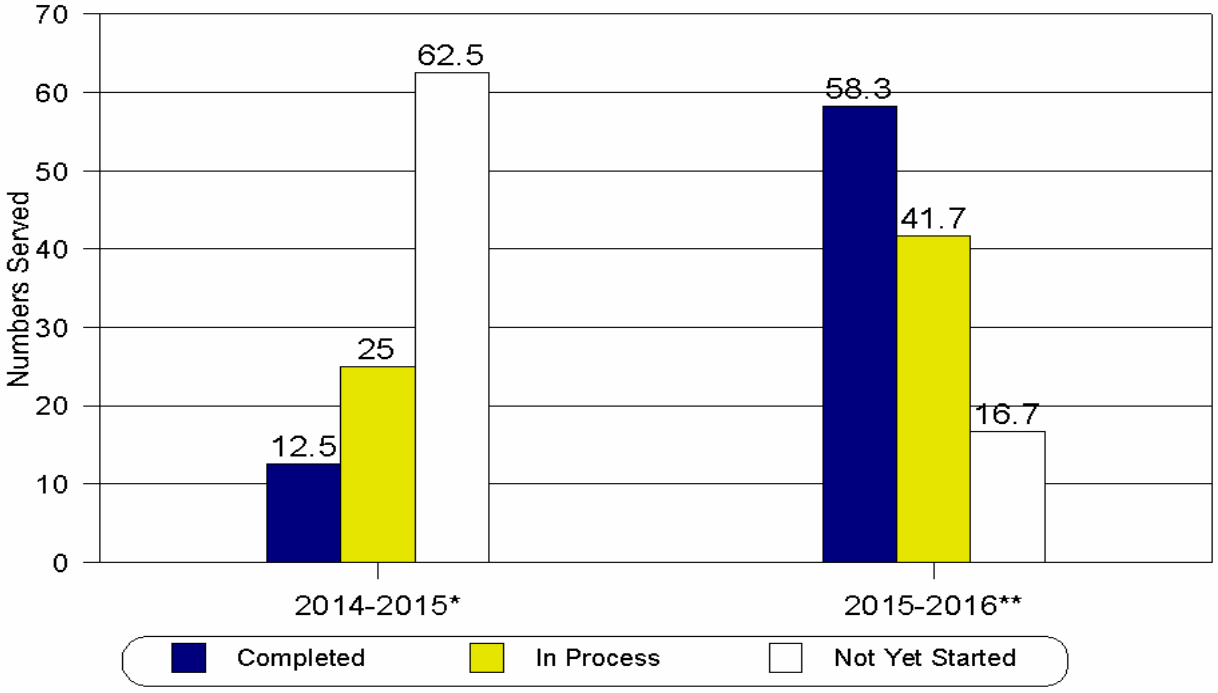
In 2014-2015, seven projects provided their actual or planned sample sizes. They ranged from 20 to 5,700, with a mean of 1,145 and a median of 200 (sd=2040.12) (Figure 12). The total number of actual or planned respondents for that year was 8,017. In 2015-2016, nine projects provided their actual or planned sample sizes. These ranged from 197 to 5,700. The mean number of projected respondents for this year was 1,584, with a median of 750 (sd=1957.64). There was no statistically significant variation in the mean sample sizes, by year (N=16, t=0.44, p=.67).

Figure 10 Projects Collecting Smoking Cessation Information Using A Population/Community Survey, To Date



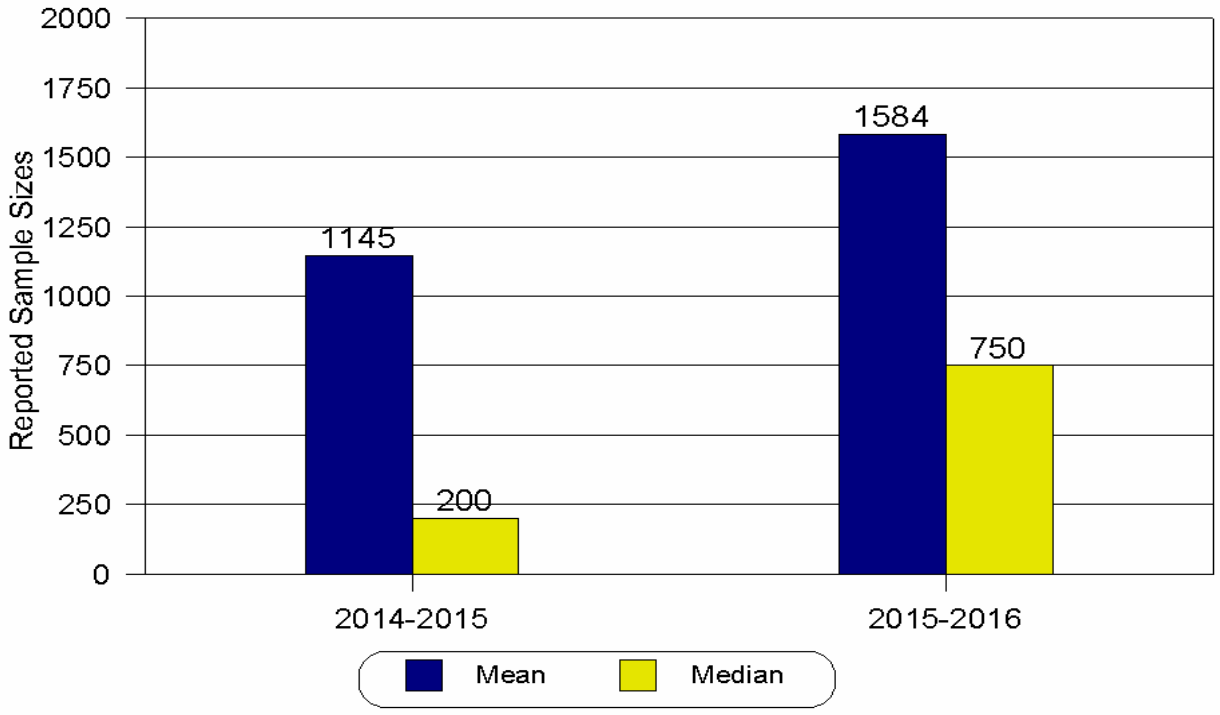
(Number of projects reporting=15, 17. Adjusted to exclude missing data.)

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



(Number of projects reporting=8, 12. *Single response question. **Multiple responses were allowed in 2015 2016. Adjusted to exclude missing data.)

Figure 12 Of Projects Are Collecting Information, What Are Are Their Actual/Planned Sample Sizes? To Date



(Number of projects reporting=7, 9.)

2.7.4) The Study Populations:

In 2014-2015 respondents identified ten study populations:

- Four were planning to survey school-aged youth
- Three were planning to survey pregnant mothers
- Three were planning to survey adults in the general population
- One was planning to survey post-natal mothers
- One was planning to survey clients with chronic illnesses
- One was planning a household survey
- One was planning to survey Elders in the community
- One was planning a survey of healthcare workers
- One was planning a staff survey
- One was 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 community members. Another survey was planned for September 2015, which was to focus specifically on students' smoking patterns. This project has not determined if it will also do a community-wide survey.

In 2015-2016 ten projects described a range of research populations:

- Nine are planning to survey adults in the general population
- Eight are planning to survey school-aged youth
- Two are planning a survey of healthcare workers
- One is planning to survey pregnant mothers
- One is planning to survey post-natal mothers
- One is planning to survey clients with chronic illnesses

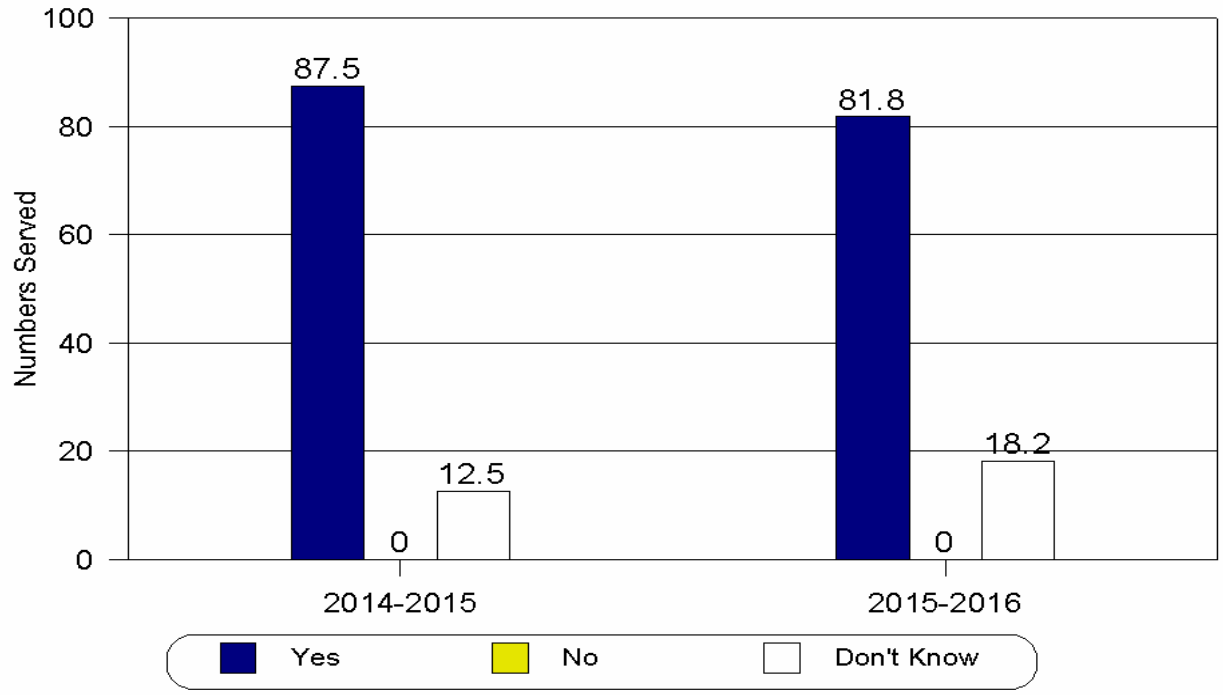
- One is planning a household survey
- One is planning to survey Elders in the community
- One is planning a staff survey
- One is planning to survey program participants

One respondent in 2015-2016 noted that her project "did two separate surveys… Both are planned again in the fall of 2016. School planned sample size is all grade 5 to 12 unless [students'] parents 'opt out.' [The] community planned sample size is 350 next time. Current sample is 250."

2.7.5) Projects Replicating Their Initial Surveys:

In 2014-2015 87.5% of the respondents who answered this question planned to replicate their studies over time. Another 12.5% were unsure about this (Figure 13). In 2015-2016 81.8% of those who answered this question indicated that their studies would be replicated, with 18.2% being unsure about this (N=21, χ^2=0.01, df=1, p=.92).

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



(Number of projects reporting=8, 11. Adjusted to exclude missing data.)

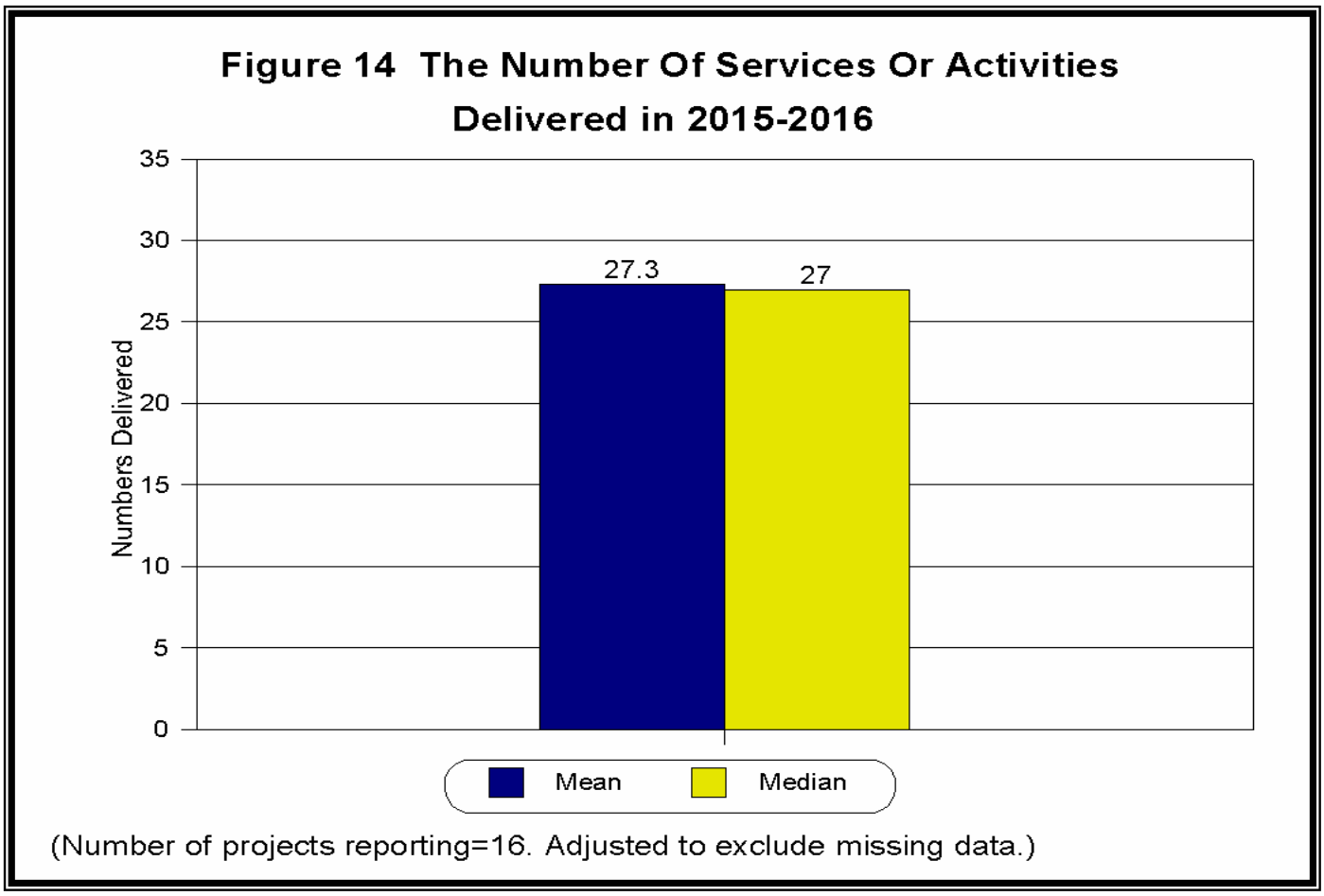
2.7.6) When Replicated Studies Will Be Undertaken:

In 2014-2015 four respondents reported that study replication 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.

In 2015-2016, one respondent reported that the replicated study would be completed in October 2016; two in December 2016; one in January 2017; two in February 2017; one in March 2017; and one in June 2017.

2.8) FTCS Projects' Services and Activities:

During the last FTCS conference held in Winnipeg, the decision was made to include an analysis of the services and activities undertaken by each project during the 2015-2016 fiscal year. Thirty-six services and activities were identified at that time. On average each project delivered 27.3 different services or activities, with a median of 27.0 (sd=6.74) (Figure 14). The number of services or activities delivered by individual projects ranged from a relative low of 14 to a high of 35.

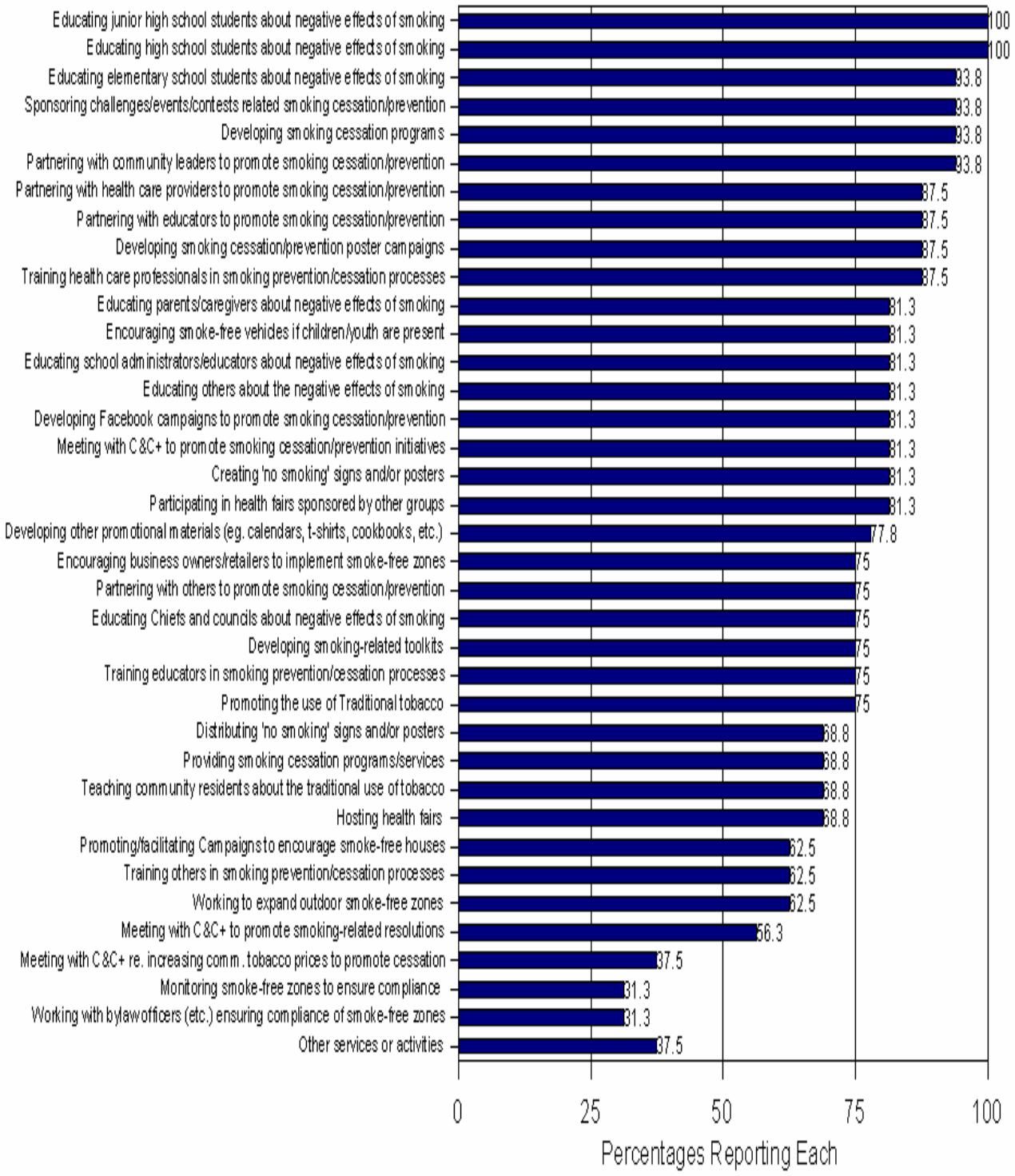


The most frequently identified services and activities included: educating students in all grades about the harmful effects of smoking commercial cigarettes; developing partnerships across sectors; and training and educating different sectors about smoking-cessation (Figure 14):

- Educating junior high school students about the negative effects of smoking (100% of all projects)
- Educating high school students about the negative effects of smoking (100%)
- Educating elementary school students about the negative effects of smoking (93.8%)
- Developing partnerships with community leaders to promote smoking cessation/prevention (93.8%)
- Developing partnerships with health care providers to promote smoking cessation/prevention (87.5%)
- Developing partnerships with educators to promote smoking cessation/prevention (87.5%)
- Training health care professionals in smoking prevention/cessation processes (87.5%)
- Educating parents/caregivers about the negative effects of smoking (81.3%)
- Educating others about the negative effects of smoking (81.3%)

Other frequently identified services and activities included: developing events, fairs, promotional materials and signage; developing Facebook campaigns related to smoking cessation; developing smoking-cessation programs; encouraging smoke-free vehicles; and meeting with Chiefs and Band Councils to promote smoking-cessation and prevention activities in their communities:

Figure 15 What Services Or Activities Have Projects Delivered In 2015-2016?



(Number of projects reporting=16. Multiple responses are allowed. +'C&C'= "Chiefs and Councils".)

- Sponsoring challenges/events/contests related smoking cessation/prevention (93.8%)
- Developing smoking-cessation programs (93.8%)
- Developing smoking cessation/prevention poster campaigns (87.5%)
- Encouraging smoke-free vehicles if children/youth are present (81.3%)
- Meeting with Chiefs and Band Councils to promote smoking cessation/prevention initiatives in their communities (81.3%)
- Developing Facebook campaigns to promote smoking-cessation/prevention (81.3%)
- Creating 'no smoking' signs and/or posters (81.3%)
- Participating in health fairs sponsored by other groups (81.3%)
- Educating school administrators and educators about the negative effects of smoking (81.3%)

A moderately high percentage of the projects (from about two-thirds to three-quarters) developed promotional materials; educated their Chiefs and Band Councils about the negative effects of smoking; encouraged business owners to implement smoke-free spaces; trained educators in smoking-prevention and cessation processes; taught community members about the traditional uses of tobacco and how to use it; promoted Blue Light and Green Light campaigns to encourage smoke-free houses; worked to expand smoke-free spaces; and provided smoking-cessation programs and services:

- Developing other promotional materials (e.g. calendars, t-shirts, cookbooks, etc.) (77.8%)
- Educating Chiefs and Band Councils about the negative effects of smoking (75.0%)
- Encouraging business owners/retailers to implement smoke-free zones (75.0%)
- Developing other partnerships to promote smoking cessation/prevention (75.0%)
- Developing smoking-related toolkits (75.0%)
- Training educators in smoking-prevention/cessation processes (75.0%)
- Promoting the uses of Traditional tobacco (75.0%)
- Distributing 'no smoking' signs and/or posters (68.8%)
- Providing smoking-cessation programs/services (68.8%)
- Teaching community residents about the traditional use of tobacco (68.8%)
- Hosting health fairs (68.8%)
- Promoting and/or facilitating Blue/Green Light Campaigns to encourage smoke-free houses (62.5%)
- Training others in smoking-prevention/cessation processes (62.5%)
- Working to expand outdoor smoke-free zones (e.g. increase distances from entrances) (62.5%)

The least frequently reported activities of the FTCS projects included meeting with Chiefs and Band Councils to promote smoking-related resolutions and exploring increases in commercial tobacco prices to help fund smoking-cessation programs; monitoring smoke-free zones: and working with bylaw officers and others to ensure compliance in this regard.

- Meeting with Chiefs and Band Councils to promote smoking-related resolutions (56.3%)
- Meeting with Chiefs and Band Councils to explore increasing commercial tobacco prices to promote smoking-cessation (37.5%)
- Monitoring smoke-free zones to ensure compliance (31.3%)
- Working with bylaw officers and other officials to ensure compliance of smoke-free zones (31.3%)

Just over one-third of the respondents (37.5%) indicated ‘other’ services or activities with which their projects were involved in 2015-2016. These included:

- Implementing a workplace Quit Challenge
- Growing [traditional] tobacco plants
- Including the topic of commercial tobacco to related programming areas/staff (ADI, NADAP, BF, BHC etc.)
- Hosting radio shows to educate listeners about the dangers of commercial tobacco

III) PROMISING PRACTICES FOR 2015-2016:[17]

As part of the 2015-2016 annual outcome reporting process for the First Nations Inuit Component of the Federal Tobacco Cessation Strategy, project managers were asked to identify their ***promising practices*** related to Leadership; Health Promotion, including prevention and education; and Smoking Cessation.[18]

3.1) Promising Practices Related To Leadership:

Fifteen projects provided examples of promising practices for this past year related to ***leadership,*** as it is associated with designating smoke-free spaces and/or smoking-related resolutions and policies. Several of the entries related to revising and promoting smoking-related policies regarding commercial tobacco; designating smoke-free spaces in local businesses, in a health centre and across the larger communities; sponsoring related educational events; and educating health service providers about the health implications of smoking commercial cigarettes. Several projects have support from their community leaders that has resulted in passing smoking-related resolutions and promoting activities to reduce smoking levels or encouraging residents to stop using commercial tobacco. Some projects are developing relationships with bylaw officers and business owners. Several projects provided very detailed descriptions of successful initiative they undertook, and the processes they used to achieve their objectives.

[We] revised 'smoking policy' to include all forms of commercial tobacco.[19]

All [smoking-related] designations are in place at all businesses of practice.

Leadership is interested in making policies based on the same [commercial tobacco-related] guidelines that the New Brunswick Provincial Government uses.

[We provided a] Distance Education Program for frontline health workers.

Community centre and administration office [are now] designated smoke-free. School and recreation centres are [also] smoke-free.

Designated smoke-free spaces at the health facility, wellness facility and four other local businesses, posting designated smoke-free signs at the Elementary and High School.

Awareness week Tobacco-Free Day at BFN Culture Camp. All activities received support from Chief and Council.

Surveyed need for NG Smoking Policy. Support is wide-spread buy in. Sharing of TCS video with elected officials and other members of Nunatsiavut Government to promote widespread commitment to strategy.

The Tobacco Reduction Program has been working with key stakeholders at the Qikiqtani General Hospital in Iqaluit on a Tobacco and Smoke-Free Grounds Program. The work has been proceeding as planned, with an implementation date of June 30th, 2016.

Collaboration and partnership with the band council to implement the Blue Light campaign. The Council Chief will be asking these establishments (bars, restaurants and social clubs) to participate in the Kahnawake Blue Light Project to further the Chief's initiative to create more smoke-free environments throughout the community. Establishment of a working committee to develop a tobacco control policy. Development of resolutions for smoke-free environments.

We already have strong leadership in designating smoke-free spaces and did not need to ask for further spaces or resolutions this year. We have learned that we need to work more closely with the bylaw officer in having him report complaints and violations of smoke-free public place areas. Community leadership offered support for staff to attend

[17] The promising practices from 2014-2015 are included in **Appendix Two** of this report.
[18] The comments highlighted in this section include those from File Hills Qu'Appelle Tribal Council Health Services.
[19] Verbatim comments provided by the FNIC-FTCS projects.

the 'Quitting Works' Workplace Cessation Program provided by MANTRA during the workday.

Ekaya Pihtwaw has developed a business owners' network with more than 20 business owners in the five Nations involved in the project. Through our collaborative involvement in a fun activity they are now engaged in obtaining information on both federal and provincial tobacco control legislation. Signage is up in stores. Records indicated 52 interactions this fiscal year with business owners. Through data collection on 131 band owned buildings in the Five Nations, project staff visited each building in person and promoted smoking related policies, such as smoke-free buildings and buffer zones outside buildings. Samson Cree Nation is ready to pass their Smoke-Free bylaw.

In the 2015/16 year the project developed a tobacco policy template to propose to the 6 FN communities titled 'Respecting Traditional Tobacco' No Smoking Policy. The policy was guided by an existing policy used by a neighboring FN community. It speaks on respecting tobacco by utilizing it only for cultural reasons. With the increasing trend of e-cigarettes it also addressed vaping. Sales to minors, second and third hand smoke were also addressed. Only 5 of the 6 communities were able to meet with the project to initiate talks at some level.

One community [in our project] adopted the policy and another adopted a policy being used by the casino on Treaty land. The others will be followed up in the 2016/17 year. Lessons learned: There is need to engage with different levels of leadership and stakeholders in the communities such as Health Councillors, Elders' Council, Health Committee and Chief and Council. Working one's way up the leadership ladder is necessary to get buy in. Having a proponent in leadership and Elder support guarantees better results. Address the policy critiques with proponents in tow.

A gentle approach has been taken with regard to the encouragement of smoke-free spaces. This tobacco strategy is cognizant of political resistance based on the passing of resolutions and policies. This approach has been a slow but effective process. The communities have been steadily increasing their capacity with regards to this file and the desire to progress towards smoke-free spaces has been encouraging. Leadership was present at our annual conference. This helped to bridge their under-standing of the concerns related to commercial tobacco use in public places. Bringing forward the proactive communities who have demonstrated their dedication to smoke-free spaces is highlighted in hopes of encouraging others to follow their path.

In partnership with BC Lung Association, we developed and launched a second-hand smoke awareness campaign called 'Inside Out.' From April to early June, we worked with the BC Lung Association to develop the campaign materials and resources. We started with a small pilot launch of the initiative in one region of BC, the Fraser Salish Region, because of a strong existing partnership between QuitNow BC, the FNHA, and Fraser Health Authority. Inside Out is an information campaign targeted towards parents and caregivers that have children present in their home to raise awareness of the harmful effects of second-hand smoke. It is designed to be set up as an information table for health fair and community gatherings. A interactive magnetic game board was created as an interactive way for children to be drawn to the table, while the health promoters talk to the parents or caregivers about second-hand smoke harms and their potential behaviors of smoking when children are present. The slogan for the campaign is 'When children are inside, smoking goes out.' Between June 2015 and August 2015, the Inside Out campaign set up at 10 events in the Fraser Salish Region. In December 2015, we renewed our agreement with BC Lung Association and confirmed participation for two additional regions, Northern and Interior. One additional Inside Out event took place at the All Native Basketball Tournament in Prince Rupert in March 2016. There are 30 planned events that will take place in the 2016-2017 fiscal year.

3.2) Promising Practices Related Health Promotion (prevention and education):

Promising practices for health promotion provided by 11 projects fell in 12 categories They included promotions such as poster campaigns, contests and signage; Sponsoring community challenges and physical activity sessions; School-based activities; Using local media and social media; Initiatives to reach and incorporate youth participation; Developing materials, reviewing policies and providing staff training; Focusing on traditional tobacco; Participating in health fairs; Developing partnerships; Educating local businesses; Using role-models; and increasing awareness of the harms of commercial cigarettes. Multiple responses were allowed. Details are provided below.

Themes	Relate Prevention and Educational Initiatives (verbatim comments)
Promotions, Contests, Posters, Signs, Videos (N=16)	➢ Items produced by the project include water bottles, manicure set, lunch bags, key ring-earphones, journal, folders, pens and pencils ➢ Cultural themed magnets sent to the New Brunswick Project Coordinator ➢ Distributed posters ➢ Locally developed posters ➢ Poster campaign ➢ Our poster contest ➢ Pamphlets in English, Cree and Dene ➢ Posted about 50 anti-tobacco messages ➢ Posters created by the Youth Coalition Against Smoking ➢ Cree-English non-smoking signs ➢ Developed e-cigarette brochure ➢ Sent 982 bookmarks promoting services to quit smoking at health centre ➢ Art and slogan contest. The winners from each school given gift card prize ➢ Four videos addressed sacred tobacco use, harms of smoking, what youth think about smoking and a drama skit ➢ [Created] videos: “Pick berries not butts”; “Smoke fish, not cigarettes” ➢ Educational posters in place in businesses
Community challenges and Physical Activities (N=8)	➢Programs include or are focused on physical activity ➢Community challenges ➢Workplace quit challenge ➢Implemented 'Run to Quit' ➢Addictions Week Tobacco-Free Day ➢A contest on the effects of smoking was also launched among elementary school clientele; Winners’ drawings will be used for other projects next year ➢Facilitated 84 program based activities reached 2,597 participants ➢Blue Light Community Challenge
School-based Activities (N=7)	➢ Youth Involvement going into the six communities’ schools ➢ Develop and implement school-based smoking prevention program ➢ School-based preventive workshops on smoking ➢ Developed educational guidelines on all the problems caused by smoking ➢ School based prevention program was awareness of the harmful effects ➢ Pilot program of new resources for students Grades 1 to 8 ➢ “National Non Smoking Week 2016“ in which 172 students and 17 teachers participated
Local Media, YouTube (N=7)	➢Radio shows ➢Radio spots ➢Every Thursday morning from 9:30 to 10:00 a.m. on Hawk radio. It is listened to by 10,000 people in the Four Nations ➢Short public service announcements, two 30 second commercials ➢60 second health promotion messages were run on the radio for the month of January 2016 for Tobacco Awareness Month. ➢YouTube Videos ➢Maintained Facebook page

Themes	Relate Prevention and Educational Initiatives
Reaching Youth (N=6)	➢Training of leadership youth ➢Developed no-smoking program and associated toolkits and awareness programs for youth ➢Young people as ambassadors for tobacco control ➢Youth Capacity Building Workshop ➢Participated in their youth conference ➢Youth Ambassadors "KISS Squad"
Developed Materials, Reviewed Policies, Staff Training (N=4)	➢Reviewed the Community Health Nursing Manual ➢Revised the maternal tobacco-cessation module ➢Healthy alternatives to smoking ➢Trained frontline workers
Focusing on Traditional Tobacco (N=2)	➢Ensure that there is a distinction between traditional and commercial tobacco uses. ➢Growing tobacco and tobacco ties. The tobacco seeds were ordered and planted in the North Battleford greenhouse. Use as teachings in the schools and communities to promote sacred use of tobacco and stop the use of commercial tobacco.
Health Fairs (N=2)	➢Health Fairs ➢Talking with kids at health fairs
Developing Partnerships (N=1)	➢Working in partnership with Siksika pre/post-natal program
Educating Local Businesses (N=1)	➢Mailing of a letter to stores to heighten their awareness of the ban on selling cigarettes to minors
Using Role-Models (N=1)	➢Role-models from the communities are utilized
Increasing awareness of harm of commercial tobacco use (N=1)	➢Using the CO monitor (Smokerlyzer) The Simulated Smokers' Lungs (pigs lungs) and "The Smokey Sue Smokes for Two" as health-promotion tools in all communities in Nunavut*.*

Projects' verbatim comments are included below:[20]

> ***'No Butts To It' community challenges and Smoking Sucks workshops visitation to high school students to give prevention and education on health effects, distributed posters, contests and radio shows about the program that will be the on-going events***.
>
> ***Working in partnership with Siksika pre/post-natal program, as well as Maternal Child Program to reduce smoking rates during pregnancy, reduce low birth weights and newborn health complications due to maternal smoking. Building relationships with school administrators to develop and implement smoking prevention and awareness programs for youth. Establishing ongoing presence within the community through community-based education.***
>
> ***Training of leadership youth groups within the schools have been conducted. These youth will educate their peers and this has been very successful so far. Six youth were trained from each of the three schools, 18 in total. They are part of the Teens Against Tobacco Use (TATU) Group. Youth and Elders have been working together in messaging of prevention. Incorporation of culture in all aspects of project activities.***

[20] Some of the information provided by the projects is very detailed. While verbatim text is often edited for brevity, it is the view of the author that the richness of the information provided, and the potential for the projects to learn from each other, warranted including the full verbatim comments. Some minor reformatting has taken place.

Locally developed posters, slogans, and video ideas/materials. For example 'pick berries not butts'; 'smoke fish not cigarettes.' Local youth/elder role models on posters. The use of traditional knowledge keepers has been a strong asset in the area of health promotion. The key individuals ensure a holistic approach is taken and that the programming is respectful. Since tobacco is a sacred medicine, we must ensure that there is a distinction between traditional and commercial tobacco uses. Role-models from the communities are utilized whenever possible to help to encourage others to lead an addictive free lifestyle. Working with the project evaluator, Samson Community Wellness has set up its program in detail by the six elements. Each element has associated toolkits and participant and client data is tracked daily in PathDMS.

We have been using the CO monitor (Smokerlyzer) as a health-promotion tool in all communities in Nunavut. This device has increased awareness about the harms of tobacco smoke and has engaged Nunavummiut. Change in staff in the communities, headquarters and Health & Wellness committees led to communication issues and slow down of the process of coming up with community quit plans. The constant change of staff also means that training or presentations need to be repeated regularly. Weather and travel to the communities was a challenge during the consultation phase of the project. We couldn't get into all the communities that we needed to for consultation with community members. Missing or malfunctioning resources in the communities meant that not all communities have access to a consistent level of service. Poor Internet connectivity and bandwidth, even in Iqaluit, means that we can't take for granted that once we create a resource that it can be delivered by internet. Competing priorities for health care providers in community health centres is always a challenge when implementing brief tobacco interventions. The Simulated Smokers' Lungs (pigs lungs) are a very popular resource with the youth population. They are so interested that they will approach the health care provider and ask questions. The Smokey Sue Smokes for Two, remarkably, is a popular resource with the prenatal population. They really like to be able to visualize the harm that happens to the fetus related to tobacco use.

- ***The Tobacco Coordinator recorded 214 meetings to support training and education. In this fiscal [year], a total of 84 program based activities reached 2,597 participants.***
- ***The focus of the school-based prevention program was awareness of the harmful effects.***
- ***The program started with the younger grades and used a colouring book campaign***
- ***20 educational workshops were held in the schools educating youth on the harmful effects of smoking with a total of 567 participants***
- ***The project maintains a Facebook page. There are posters for many events***.
- ***Media Campaign:***
  - ***Tobacco education and cessation topics are shared every Thursday morning from 9:30 to 10:00 a.m. on Hawk Radio. It is listened to by 10,000 people in the Four Nations and is in the background playing in every office and home.***
  - ***Hawk Radio also attends many events hosted by the project. They are a sponsor to many events.***

Collaboration with health promotion program to teach community residents and youth about health topics as well as provide smoking-cessation information and teaching programs as healthy alternatives to smoking. Providing health fairs with public health to community residents. Tobacco reduction and elimination have been addressed at the majority of community activities. Addictions week tobacco- free day at BFN Culture Camp. Developed [an] E-cigarette brochure. Implemented 'Run to Quit' in some of our communities. Planned and implemented workplace quit challenge. Designed and produced community specific posters and community non-specific pamphlets in English, Cree and Dene. Posted about 50 anti-tobacco messages centered on health effects/consequences of tobacco; tobacco industry deceptive practices; second-hand smoke and its potential harm on NSBE social media accounts. Radio spots: anti-tobacco messages are broadcasted through local community radios stations and MBC Radio in English, Dene and Cree bi-

monthly. We have had 84 radios spots to date. Revised the maternal tobacco cessation module and trained frontline workers. Reviewed the Community Health Nursing Manual and made some recommendations.

There is great openness among school principals to offer school-based preventive workshops on smoking for the upper elementary level of education. The objectives are clear: to use our young people as ambassadors for tobacco control. We have held preventive workshops on smoking among elementary and high school clientele. Our high school is an ambassador of the 'DE FACTO Program,' something of which we are very proud! A contest on the effects of smoking was also launched among elementary school clientele. Winners' drawings will be used for other projects next year. Moreover, we are pleased to have developed educational guidelines on all the problems caused by smoking. The guidelines are used during the first prenatal meeting to inform expectant mothers of the dangers of smoking during pregnancy and to offer instruction on how to quit smoking. A reference is provided to the addictions counsellor if the desire to quit smoking is raised. Posters created by the Youth Coalition Against Smoking; sending of 982 bookmarks to promote services to quit smoking at the health centre; recording of radio spots on the damaging effects of tobacco during the tobacco-free week; mailing of a letter to stores to heighten their awareness of the ban on selling cigarettes to minors. In March of 2015 at the 'Gathering Our Voices' youth conference, FNHA hosted a workshop called 'Pitch Us A Commercial' and we'll make it. Youth were invited to develop ideas for messages that would resonate well with their peers. Following the workshop, two of the ideas were chosen to be made into short public service announcements. We then worked with a consultant and film crew to develop two 30-second commercials with two different themes. Zombies and Split Screen. The youth who created the idea pitch were invited to be involved in the filming of the commercials, and the film crew went to their community. The commercials were completed in early 2015 and now FNHA is working with a social marketing firm to develop a marketing campaign for them. Going to the schools, talking with kids in health fairs. Partnering with B.C. Heart and Stroke Foundation – participated in pilot program of new resources for students in Grades 1 to 8. These resources presented smoking within the context of healthy living. They were colourful and user-friendly and teachers report that they used these as part of their curriculum and it was well received by all. These resources represent a significant investment in our community. We achieved this by reaching out to this organization and offering to participate in an evaluation of the resources in exchange for the resources and support. This is an example of seeking a new opportunity that was successful. Many of our programs include or are focused on physical activity. We offer smoking related information but within the broader context of fun and physical activity – the kids are learning and being active at the same time! We also found that the music program, which might not have specifically talked about smoking each class, leads to improved self-esteem among students and an opportunity to be creative and not smoke. Through funding of this program, we have learned that at least one youth who was struggling with contemplating suicide, felt inspired and experienced improved mental health. The reach has been far beyond just tobacco which is inspiring. The better people feel about themselves, the more they are likely to want to live a healthy smoke-free lifestyle. Our poster contest and investment in the printing of the posters in a spectacular format (lenticular printing)[21] has caught the attention of many people in the community and added a sense of pride as well as educating about smoking.

1) <u>YOUTH INVOLVEMENT</u>:[22] The project started off in 2015 going into the six community schools to get youth involved. There was an Art and Slogan Contest. The winners from each school were given a gift card prize. The winning slogan was 'KISS Tobacco: Keep It

[21] Author's note: ***Lenticular*** **printing** is a technology in which **lenticular** lenses (a technology that is also used for 3D displays) are used to produce printed images with an illusion of depth, or the ability to change or move as the image is viewed from different angles. cf. https://en.wikipedia.org/wiki/**Lenticular**_printing

[22] The following six sections were submitted by one project.

Strictly Sacred.' The catchy slogan was used in the development of presentations, promo items and other things related to the project that the youth would appreciate.

- ***<u>Youth Ambassadors' KISS Squad</u>: was also initiated in each school. These are a group of youth the project works with while in the schools. They assist with presentations and other youth-related support required by the project.***
- ***<u>YouTube Videos</u>: Youth ambassadors from four schools were able to develop different scripts on smoking education. They were recorded on smartphones and uploaded on YouTube. The four videos addressed sacred tobacco use, harms of smoking, what youth think about smoking and a drama skit.***
- ***<u>Youth Capacity Building Workshop</u>: In December 2015, 23 youth ambassadors and seven teachers were hosted to a workshop titled 'Recipes for Success with James Anderson.' James Anderson is a Native American motivational speaker who challenged the youth to be more deliberate about success in their studies and their future. He also addressed the use of tobacco, drugs and alcohol.***

2) <u>STRONG COMMUNITY PARTNERSHIPS AND SUPPORT FOR THE PROJECT</u>: The Project has connected and partnered with many community organizations. Kanaweyimik Child and Family Services is one of such. In May 2015, we were invited to participate in their youth conference. A presentation 'Youth Tobacco Conversation' was made to approximately 300 youth in attendance. The conversation highlighted Traditional Use of Tobacco vs Commercial Tobacco, addressed smokeless tobacco, vaping and other youth alluring tobacco products, among other things. Other partnerships included the North Battleford Youth Centre, the Lung Association of Saskatchewan, on-reserve schools, Aboriginal Friendship Centres, community based organizations and community events. Strong linkages and partners increases the project reach.

3) <u>BLUE LIGHT COMMUNITY CHALLENGE</u>: Having learned from the Blue Light Campaign in January 2015, the project decided to partner with the Lung Association of Saskatchewan to host a Blue Light Community Challenge in October 2015. The six First Nations communities challenged one another to see which community will have the highest percentage of homes register and place a blue bulb to signify they are smoke-free. It was advertised on Facebook, radio and through a brochure that was produced and distributed in the communities to provide information about second hand smoke and the Blue Light Community Challenge. Community staff, such as Family Health Workers, Head Start and nurses were encouraged to mention it to their clients. The First Nations community that emerged winner had 52% of its homes register. The Lung Association provided the winning community with a congratulatory sign to put up in their community and plaques of participation to the others. The winner was also congratulated on Facebook and radio.

4) <u>NATIONAL NON-SMOKING WEEK 2016:</u> 172 students and 17 teachers participated in the Youth Tobacco Conversation Presentation. A community member/elder from each community who had quit smoking was part of the conversation as they shared their stories to encourage the students and staff. The Blue Light Community Challenge also ended during the National Non-Smoking Week and the winner announced. Sixty-second health promotion messages were run on the radio in January 2016 for Tobacco Awareness Month. Scripts were on youth and tobacco use; smokeless tobacco and flavored tobacco; second hand smoke and infants; and prenatal smoking. It also promoted the slogan KISS Tobacco 'Keep It Strictly Sacred.'

5) <u>RESOURCES PRODUCTION and SHARING</u>: 'I Can Quit' Cessation Manual produced in 2010 was revised in the 2015-16 year. The project decided to share the 2010 version with Manitoba Tobacco Reduction Alliance MANTRA and Women Warrior, a group based out of Lloydminster Alberta, to support their quit smoking program, while working on the revision. In the revised version new stories were compiled from community members who had quit smoking. They were interviewed and their stories transcribed. Some art works from the Art and Slogan competition done in the schools were also featured in the manual.

Stats from the Regional Health Survey were updated from 2002-2003 to 2008-2010. Cree-English non-smoking signs were produced and distributed in the communities. They were of three categories: for general public buildings, for homes, and for prenatal. Cultural themed magnets were also made and samples sent as requested to the New Brunswick Project Coordinator. Cree-English signs addressing smoking in vehicles with minors, stipulating the fines were also produced and distributed. 'Respect Tobacco' brochure was produced to be used for staff orientation at Battle River Treaty 6 Health Centre. Two pop-up display banners were produced to be used during public education in schools and other venues, community events and outreach. One had an elder teaching two young ladies about the cultural use of tobacco, and also addressed traditional vs commercial tobacco. It is Cree-English material. The other featured two youth ambassadors promoting KISS Tobacco 'Keep It Strictly Sacred.' Other promotional items produced by the project include: water bottles, manicure set, lunch bags, Key ring-earphones, journal, folders, pens and pencils. These trendy youth-friendly items had slogans in line with the winning slogan 'KISS Tobacco: Keep It Strictly Sacred.' Wordings which promote sacred tobacco use were put on all items.

6. <u>GROWING TRADITIONAL TOBACCO AND TOBACCO TIES</u>: The project initiated plans of growing tobacco that would be used for traditional purposes. At the end of 2015/16 year the tobacco seeds were ordered and planted in the North Battleford Greenhouse which partnered with us to grow the seedlings. They are awaiting transplant to the various community sites and the community garden. Currently traditional tobacco is ordered from a company in Manitoba and a pipe full is tied up in cloth that represent our four directions, colours and a grandmother cloth. These ties are made following traditional protocol. They are offered to elders and used for ceremonies to promote the use of tobacco ties and not offering a stick or pack of cigarettes. These ties are used as teachings in the schools and communities to promote sacred use of tobacco and desist in the use of commercial tobacco.

3.3) Promising Practices in Smoking Cessation:

Sixteen projects completed this question. Seven projects focused their comments on smoking prevention initiatives, or discussing their preparations to develop this service:

'***No Butts To It' community challenges and 'Smoking Sucks' workshops.***

Blue Light Program was implemented in both communities. Display boards and posters at all community functions. Development of student lounge in Rocky Lane School and smoke-free recreation functions.

Providing smokers and non-smokers with cessation information using pamphlets and other hard copy material as well as providing diagram display models of the effects of smoking.

Developing information and fitness Smoking-Cessation Mobile Apps (SCMA). This will be developed on two platforms: Apple iOS 8.0+ smartphones and Android 4.1+ smart-phones. App development is at [an] advanced stage. Planned and implemented mobile app contest in school within partner communities. The goal of the contest was to identify name and icon for the mobile app. Two students won the contest. Shared message on plain packaging on May 31/2016 with the communities to commemorate World No Tobacco Day. Tobacco-Cessation Workshops in all pilot communities. Several presentations on the harmful effects of tobacco and quick cessation tips to students and interested community members.

We have learned that we must identify better ways of engaging community members in smoking-cessation programs. We are currently advertising for community leaders and members to share their smoking-cessation journeys on Facebook. We are asking for

written stories about the challenges and successes of quitting smoking. We also want to do filmed interviews about their experiences and share these on Facebook and our monitors in the health and youth centres. People are shy to share their stories but we know that they will have an impact and continue to advertise for participants.

We are developing a collaborative, multidisciplinary approach among frontline healthcare staff at our hospital that will increase identification and cessation support for patients who use commercial tobacco. A very large hospital entry poster was created to introduce the concept and showcase some departments and people who will participate: nurses, doctors, nutrition, outpatient, dentist, pharmacy, traditional medicine unit has been created. Some of the lessons learned were:

1) ***We learned to value and understand the challenges healthcare staff face with the many responsibilities and demands on their time and how that relates to implementation of our project***
2) ***We learned that speaking directly to stakeholders helps to increase their engagement with the project. Two nurses attended the 2016 Ottawa Summit for Smoking Cessation. Two additional nurses attended smoking-cessation training.***

[As a result]…in collaboration with the health professionals a promotional campaign and cessation support awareness strategy for individuals who use commercial tobacco. [The]…poster highlights the broad range of individuals who promote prevention awareness and cessation support activities within the hospital centre… 'Point of interest' prompts were designed in collaboration with these health care professionals to encourage cessation at all points of entry with congruent messaging, based on relevant research from the 2016 Ottawa Summit on Smoking Cessation. We created a toolkit to challenge individuals to quit smoking. Youth and adults were very interested. A smoking support group is offered twice a week. The group provides an opportunity for community members to receive helpful information and skills to reduce their use or to quit smoking.

Upcoming training with partners, healthcare workers, schools and other persons interested to become smoking counselors.

Renewing staff knowledge on available aids through NIHB; promotion of harm reduction strategies for smokers.

From April 2015-November 2015, we worked in partnership with the BC Lung Association and a journalism team at UBC to develop a three part podcast series that follows a BC First Nations leader through her quit journey [with] Sandra Teegee, Deputy Chief of Takl.

Two projects noted initiating the smoking-cessation component in 2016-2017:

Will implement this in coming days.

Smoking-cessation has been a secondary focus this past fiscal year due to other programming. The third-year (2016-17) will have a heavy focus on smoking-cessation groups and opportunities. Pharmacists have been engaged with regards to NIHB and pharmacotherapies. A prescription is not required for NRT and other medications as long as the patient has a one-on-one session with their pharmacist. Front-line health workers (120 in total) have been trained on smoking-cessation and brief intervention strategies.

One project noted the processes and strategies they developed to encourage smokers to participate in their smoking-cessation program, or to at least attempt to reduce their smoking rates:

We have found that demonstrating the use of the NRT gum and allowing people to try it out has broken down some of the preconceived ideas that people have about using medication with their quit attempts. Using spirit of motivational interviewing and having a client-

centred approach really resonates with the health care providers and the Inuit population in Nunavut. Creating a partnership with our clients gives them the control to move along through behaviour change at their own pace. We have found that community radio is a fabulous medium to allow Elders to tell their quit stories which then inspire others to try to quit. We have even linked in our Quitline Coach in order to provide expert information when it is required. Many of the health care providers and the community health representatives use tobacco. It takes time to build trust and partnerships with the health care providers before we can start working with the community population. Tobacco prevalence is so high that tobacco use is the normative culture. There is no shame in using tobacco even when pregnant. The program has been conducting ongoing telehealth sessions to upgrade the knowledge and skills on best practices in effective, tailored and culturally appropriate tobacco cessation interventions for different demographic and high risk populations including youth, pregnant women and young adults.

Comments from the remaining projects described their experiences implementing smoking cessations activities in 2015-2016, with various levels of success. However, even somewhat unsuccessful attempts to bring about smoking-cessation provided the projects with useful insights.

The project had initially proposed only hosting cessation groups in the communities, however the group meetings did not go as anticipated. From lessons learned a different approach would be used for 2016/17 year. For the 2015/16 year we had seven people attempt to quit smoking either through group participation, referral or self-referral; four of these were able to quit. Lessons Learned: Be adaptable. Tailor programming to suit clients' needs and challenges. Explore more one-on-one support. There is a need to partner with chronic conditions and home care workers to get client referrals.

Increasing the success rate of smoking-cessation during the prenatal period and improving maternal and newborn health outcomes. Working towards the development of smoking-cessation support groups offered within the community.

Smoking-cessation program has been offered in one community and has proven to be very successful which included a variety of guest speakers, tools, etc. being offered. In all communities there is a variety of people and resources as well as cessation specialists that work with people trying to quit or reduce their intake. Communities use a variety of educational resources, websites, tools and tips to help the individual who is trying to quit or reduce smoking. Social media are used as a way that is used to offer support to those that are unable to attend sessions, events (etc.) in person.

Client-based cessation activities reached more than 120 individuals. Weekly Support Group is available every Wednesday. Ekaya Pihtwaw held a 'Commit to Quit' contest for six weeks. Working with eight clients enrolled in the Matrix Outpatient Treatment Program on a weekly basis. Working with clients at the Young Spirit Winds Treatment Centre: A highly successful smoking-cessation initiative has been the Amazing Race activity which we held on January 20, 2016 (Weedless Wednesday) and again on March 17, 2016 St. Patrick's Day. For this event, participants only have to commit to stop smoking for four hours while they embark on an Amazing Race styled event. The Tobacco Cessation activity started with eight participants and has grown 45 participants. One on One Cessation Talks during this fiscal period: Number of clients: 106; Number of client visits: 111.

IV) BARRIERS AND CHALLENGES EXPERIENCED BY THE PROJECTS:

As a corollary to the preceding section, project managers were asked to describe any barriers or challenges they experienced in 2015-2016 related to Leadership; Health Promotion including prevention and education; and Smoking Cessation. This is a new question.

4.1) Barriers and Challenges Related to Leadership:[23]

Twelve projects responded to this question. Two noted that they did not experience challenges or barriers related to leadership in their communities:

> ***Looks okay.***
>
> ***None really. We anticipate barriers and prepare accordingly. We incorporate any barriers we encounter as opportunities to develop new solutions. Smoke-free spaces are not easy to enforce by policing, so we do public education to get the community to provide the social approval for smoking away from public spaces. Results are mixed, but progress is being made.***

The most prevalent barrier or challenges regarding leadership, offered by six projects, is perceived ambivalence regarding the use of commercial tobacco in their communities and a related lack of enforcement of tobacco-related regulations. One project manager implied that the revenue that commercial tobacco sales bring into the community can be a disincentive to reducing smoking levels. A second theme related to the perceptions that smoking commercial cigarettes has become acceptable in some communities.

> **Tobacco taxation is revenue that each First Nation receives based on sales. We haven't directly encountered this as a problem however we are cognizant that this could factor into decision making at the local levels.**
>
> ***[There are] struggles in developing and implementing smoke-free policies due to widespread ambivalence about the issue of smoking.***
>
> ***Challenge [regarding] bylaw officer provide data on activities. We do not know what regulations are enforced, investigated or how many complaints there have been. We continue to work on this. Leadership is supportive of healthy lifestyle programs and trying to educate youth about not smoking. However, a reality in the community is that cigarette sales do fund community programs and it is a difficult situation for leadership to be in. For example, if sales decrease, revenue to community decreases, which impacts leadership and programs that can be offered.***
>
> ***Some challenges experienced are the attitudes that this is the way it has always been, that people go to these establishments with the expressed purpose to smoke and drink.***
>
> ***It is very difficult to enforce the regulation implemented. There is no one to supervise the premises and enforce the regulation. Therefore, offenders face no consequences and continue to smoke near doors and in prohibited areas.***
>
> ***Some challenges we experienced in relation to smoke-free spaces and tobacco policies include not having baseline data for the number of on-reserve smoke-free services, not having a comprehensive approach for enforcement of smoke-free spaces, and disorganized or missing information about tobacco related policies such as tobacco taxation.***

Four projects cited a lack of communication as their barrier or challenge regarding leadership, along with limited access to the leadership:

> ***Lack of communication input.***
>
> ***Working with municipality to enforce smoke-free spaces. No communication when contacted multiple times.***

[23] Some comments have been separated under different headings, indicating that multiple responses are allowed for these questions.

Chief and Council meetings are busy and there is limited time to meet.

Just day-to-day scheduling. Other than that the buy-in is great from the leadership side.

For two projects the barrier related to leadership being faced with other priorities than the need for smoking cessation.

Priority of leadership has been focused on community rebuild following flood of 2012.

It was a challenging year to meet with Chief and Council as it is election year and there are other demands the leadership faces.

One project coordinator cited changes in staffing as a barrier or challenge related to leadership:

Change in staff in the communities, headquarters and Health & Wellness Committees led to communication issues and [a] slow down of the process of coming up with community quit plans. The constant change of staff also means that training or presentations need to be repeated regularly.

4.2) Barriers and Challenges Related to Health Promotion (Prevention and Education):

Coordinators from 12 projects also provided comments related to this question. Again, two of these experienced no barriers or challenges related to health promotion:

Looks okay.

No problems in this area.

The 15 barriers variously indicated by the other ten project coordinators included:

- Poor attendance at events
- Finding suitable locations to provide service
- Difficulty finding experts in their communities
- Difficulty with staff recruitment
- Front-line staff are too busy to participate
- The need for a holistic approach to reducing or eliminating the use of commercial tobacco
- Difficulties finding culturally appropriate posters and pamphlets
- Challenges related to diverse languages in some communities
- Competing against the need to address other health concerns in some communities, given scarce resources
- Closures due to deaths in the community
- The need for more information on the implications of e-cigarette use
- One Board of Education not allowing the project to operate in their schools during school hours
- Weather and travel issues interfering with successful program implementation
- Missing or malfunctioning resources and equipment
- Limited internet connectivity and bandwidth

The related verbatim comments are provided below:

Disappointing attendance at many of our programs for youth and we are still trying to understand why they do not attend. We have been using Facebook to advertise and now with new monitors in place throughout communities, we are hoping that more people will see the programs that are offered. We have had challenges in finding locations for the activities as we waited for youth centre to be complete. A significant challenge related to health promotion is lack of availability of accommodation in the community. We want to have more experts come to the community, more people to lead music and arts and sports programs, but we have no place for people to stay. More people from outside the community would add creativity to the programming as well as expertise and leadership.

Community frontline workers are too busy to take on extra duties. Although the project is on track in some elements in terms of activity implementation, it is unlikely that all intended project objectives will be accomplished by 2017 when project funding sunsets. Given that smoking/tobacco control is complicated by a range of social, structural and individual level barriers there is a need to apply a holistic approach that is long-term, sustainable and proportionate-to-the-need. Tackling social determinants as it is related to smoking would be sufficient, predictable, and sustained funding beyond 2017. Also, partners' communities are at different stages of project implementation. Sometimes there are other competing priorities at the community level. Some communities want to implement a particular element in lieu of another. Given the diversity in language, tradition and culture of NITHA partners, translating tobacco awareness resources to local language is a challenge.

Difficulty with staff recruitment in health promotion activities.

Timing and closures due to unfortunate events like a [community] member's passing.

Health programmers want more information pertaining to e-cigarettes. We have tried our best to find the latest and most relevant research but we are still lacking information on this topic. Other topics seem of higher importance including alcohol/drug addictions and HIV prevention. It is important to state that the increase in health promotion activities is largely due to the increase of personnel during this project and that in the long term once the project is over, this level of promotional activities will not be met. Hard to find culturally sensitive posters and pamphlets for the various age groups within the community.

Given the multitude of community health-related concerns bringing smoking to the forefront has challenges. A lot of youth in communities are already smokers and changing perspectives of youth and reaching youth is very important to changing the future with regards to smoking. Also adults pave the way with regards to how youth view smoking so getting greater numbers to quit and set an example for their families is key to success. The Cree School Board decided not to allow our campaign to engage students during school hours. This was previously the cornerstone of our 'Smoking Sucks' Workshops for youth leaders. Instead we engaged youth leaders who were no longer in school, or held workshops after school hours. We had more success working during school hours in previous years. Now we focus on the Youth Councils, these include young adults instead of high school students. Results have been good.

Weather and travel to the communities was a challenge during the consultation phase of the project. We couldn't get into all the communities that we needed to for consultation with community members. Missing or malfunctioning resources in the communities meant that not all communities have access to a consistent level of service. Poor Internet connectivity and bandwidth, even in Iqaluit, means that we can't take for granted that once we create a resource that it can be delivered by internet.

4.3) Barriers and Challenges Related to Smoking Cessation:

Thirteen project coordinators responded to this question. The barriers and challenges they identified, regarding the smoking-cessation component of the project included:

- The program is still being developed
- Youth reluctant to attend smoking-cessation programs in school due to possible stigma
- Reluctance of community members to participate, in general; lack of interest
- Smoking is a "normalized" behaviour, leading to limited motivation to attend programs; there is no "shame in smoking" even for pregnant mothers
- The need for community staff to receive enhanced training and support to achieve successful outcomes; need more smoking-cessation specialists

- The need to strengthen partnerships with healthcare staff
- The inability to access e-health or telehealth services, to facilitate distance programming
- High workloads relegate smoking-cessation programs to a lesser status for overworked community staff
- Competing demands for the time of healthcare workers
- Healthcare professionals who smoke themselves
- It takes time to build trusting relationships
- Clients with concomitant mental health issues are more resistant to change
- Community-based part-time staff do not have sufficient time to participate in the program
- Even when community members show interest in the program they rarely attend it
- Difficulties successfully disseminating information to raise awareness of the program. Social media have a limited audience in some communities
- Need better access to pharmacy staff
- While the Blue Light campaign was successful, the smoking-cessations program lacked the participation to keep it going

The related verbatim comments are provided below:

One project coordinator had hopes for improved participation in the future:

> ***'No Butts To It Challenges' are becoming better understood and anticipated in the community, so we expect to see an increase in the rate of participation over time***.

Comments from other coordinators included:

> ***The Siksika FTCS is still in the early stages of data collection and health promotion, working towards the development of long-term smoking-cessation efforts. There are not a large number of cessation specialists in communities; we will be training more specialists in the new fiscal year. Lack of interest by some community members. Smoking normalized in all communities; Low participant turn-out.***
>
> ***Very challenging to have youth or community members attend smoking-cessation programs. They seem to not like the school location as worried about teachers knowing they smoke. Adults also seem reluctant to attend a program. We have repeatedly advertised and offered prizes. We have found online programs and advertised the program and link on our Facebook page with the offer of prizes for people to try the online programs and tell us what they thought. However, no one has taken the opportunity. We need further training and support for community staff to provide the programs and we need stronger linkage with the nursing station on the medical side (for example, patches or other smoking-cessation medical supports). A goal for this year is to strengthen the communication and partnership with nursing station to identify people who are ready for change and to provide the right support to these people. We also want to further explore the opportunity to use the Tele-Health system in our community and work with Regional Health Authority staff to partner in providing smoking-cessation support and education in more than one community by telehealth. In this way, we can use resources without people having to travel to community, and the participants feel they are part of a bigger group (for example, if just one person shows up, they feel uncomfortable and don't come back, but we are hoping in this way, they feel part of a bigger group and will continue). The challenge has been in accessing telehealth because of the location and people cannot get to it (private office at nursing station) and we are trying to address this and find a better location with increased accessibility.***
>
> ***In terms of the TCS project, generating enough community interest to run a quit smoking challenge in some communities is due to small community size and [there] may be less smoking numbers in that particular community. [It is] also due to the normalization of smoking.***

Due to overwhelming workload, smoking-cessation has been a secondary focus. The last fiscal year will ensure a concentration of opportunities for smoking cessation.

Competing priorities for healthcare providers in community health centres is always a challenge when implementing brief tobacco interventions. Many of the healthcare providers and the community health representatives use tobacco. It takes time to build trust and partnerships with the health care providers before we can start working with the community population. Tobacco prevalence is so high that tobacco use is the normative culture. There is no shame in using tobacco even when pregnant.

The clientele with mental health issues are harder to accompany and help quit smoking. This is a clientele more resistant to change. With increased health promotion activities there is an increase in awareness to promote smoking-cessation counselling; hence an increase of referrals. Part time positions with other duties/tasks leave insufficient time, personnel, and designated office space to counsel smoking-cessation to clients, hence delivering this service is challenging. Encouraging community members to be open to receiving information on reducing or quitting smoking. As well, having community members attend the smoking support group. Many community members have shown interest in the support group, but attendance has been limited.

In relation to our 'Tobacco Timeout' short term quits campaign, one challenge we had is disseminating information to raise awareness about the campaign itself. We found that social media was the easiest way to share information, but provided us access to a limited audience (only those who use social media) and not all current commercial tobacco users.

[Would be helpful to] have access to pharmacy staff to work with smokers that are interested in quitting.

The Blue Light Program was successful. Smoking cessation had moderate participation at the start and dropped off significantly, resulting in its cancellation.

V) PROJECTS SHARING ONE SUCCESSFUL PROCESS:

The final question in this study asked project coordinators to describe, in detail, one successful process that their projects completed in 2015-16. They were asked to include the related objectives of the process, the target populations, other community partners or champions who were involved, the related activities associated with the process, and related outcomes. A broad range of processes were described. They included, briefly:

- Two projects implemented the 'Stay Quit To Win' competition. One was largely school-based and the other was community-wide
- An 'Amazing Race' activity which involved participants only committing to stop smoking for four hours while they embark on this event
- Health classes focusing on smoking-cessation
- Displaying educational materials to facilitate smoking prevention
- A youth hockey tournament that focused on healthy living and the youth leading smoke-free lives
- Training healthcare providers to facilitate smoking cessation, using a number of media and expert presenters
- Creating a billboard campaign promoting smoking prevention
- A community-wide awareness campaign to promote increasing awareness of the harmful effects of smoking and exposure to second-hand smoke in English, Cree and Dene
- A project using "Innovative approaches to prevent tobacco use" among children and youth through "positive messaging"
- Working with community leaders to Adopt a "Respecting Traditional Tobacco - No Smoking Policy" by the First Nation community
- A project assisting participants to grow traditional tobacco and to learn about nutritional lifestyles

- Sponsoring a 'Grow a Row' campaign that offers traditional tobacco seeds to First Nations communities
- Facilitating a two-day meeting to provide an overview of the strategy, share case studies, develop branding and slogans and looking at other current anti-smoking campaigns
- Developing a 'Tobacco Newsletter' to provide role-models who stopped smoking. This project also delivered interactive educational sessions in elementary schools promoting understanding and awareness among children of our original teachings on the purpose and use of sacred tobacco vs the use of commercial tobacco.
- Launching a short-term quit contest called 'Tobacco Timeout' modeled after the 'QuitNow' contest
- Describing four activities that were integrated into a global prevention strategy: 'Smoking Sucks' Workshops; 'No Butts To It' smoke-free Challenges; and a distance-education program

The verbatim comments are provided below and on the following pages.

'Stay Quit to Win' challenge yearly since 2003 with partners of community wellness workers, school principals and teachers, and nurses in Nunavik.

'Stay Quit to Win' challenge, starting from age eight and up; smokers and non-smokers. [This is the] first time with non-smokers. The school teachers, principals and other workers were involved as well as health care workers, community wellness workers, nurses and other who are interested to be part of the events. Interviews with youth, adult men and women, pregnant women non-smokers and smokers starting from age 10 and up, as well as ex-smoking counselors. Visitations to high school students to give information on health effects to the students who are involved sports.

A highly successful smoking-cessation initiative has been the 'Amazing Race' activity which we held on January 20, 2016 (Weedless Wednesday) and again on March 17, 2016 St. Patrick's Day. For this event, participants only have to commit to stop smoking for four hours while they embark on an Amazing Race styled event. The Tobacco Cessation activity started with eight participants and has grown 45 participants. Now many businesses participate as stops on the race. Therefore, they learn more about the Commercial Tobacco-Cessation initiative. People dress up. Other community members watch and ask questions. And each time the word is spread and interest grows about tobacco cessation. The goal is to instill confidence that individuals can reduce their daily smoking initially and build a trusting relationship with program staff. From there they learn more about NRT and perhaps begin their journey to Commercial Tobacco cessation.

Health classes in the school that teach smoking-cessation awareness and deter the youth from smoking.

BFN funded a Student Lounge at Rocky Lane Public School which allowed for display of educational materials and a venue to place education materials. Presentations in partnership with CHR bimonthly recreation activities were provided.

Engaging youth and developing programs that they enjoy. One example is hockey. Our program funded youth aged 8-10 to play in a tournament in The Pas. Our program supported the travel, and our staff coached the team. Youth felt a lot of pride in playing on a team together and being able to travel for a tournament. This supported healthy living and why kids should pick sports and other activities over smoking. It also showed youth that there are strong leaders in the community who choose not to smoke and live a physically active life. If it was not for a program like this, there would be no hockey available for youth in certain age groups due to lack of resources and coaches. The program helped youth without opportunity engage in a healthy activity and our program name was strongly promoted so that the community learned more about the Smoke Signals program. A unique way of strengthening links to the community.

As part of our training for health care providers we developed a series of 30-minute Telehealth sessions on topics related to smoking-cessation (with time available for Q&A) to increase access to regularly scheduled tobacco-cessation learning opportunities for all Nunavummiut healthcare providers. They occur on the second Friday of each month using the Telehealth technology available in each health centre. Two sessions occur, one for the Baffin/QGH/ Territorial Leads and the second for the Kivalliq/Kitikmeot region. This needs to happen as the technology has limited capacity. We tap into a variety of experts from all of Canada, including Dr. Milan Khara, David Forbes, Dr. Joan Botoroff and Dr. Lorraine Greaves. The topics have Included:

- ***Pregnancy & Smoking***
- ***Motivational Interviewing***
- ***Stop Smoking Before Surgery***
- ***Vulnerable Populations & Smoking***
- ***Trauma Informed Care & Smoking***

[Continuing on…] A post-telehealth survey is sent out after each session to ensure the content and the quality of the sessions is maintained. Most people agree or strongly agree that they would recommend the sessions to others and that they will make changes in their practice to integrate tobacco cessation. From a technology perspective, we created a Powerpoint for each session and linked with the Tele-health Coordinators at each site to ensure that each session runs as smoothly as possible.

The FTCS program worked in collaboration with Chief and Council, land management and health services to develop and implement a electronic billboard on-reserve. This billboard provides health promotion and prevention messages to community members, as well as non-members travelling through the community's main highway.

<u>Awareness Campaign</u>: The NSBE working group planned and implemented multi-component awareness campaign with the goal of increasing awareness of the harmful effects of smoking and exposure to second-hand smoke in northern Saskatchewan First Nations on-reserve communities. The working group identified key messages and also developed a tobacco awareness logo, and specific guidelines for our campaign activities. The components of the awareness campaign include:

1) ***NITHA Partner-specific posters with key messages and pictures of role models from each partner. A total of 50 posters were developed and translated into Cree and Dene.***
2) ***Community non-specific pamphlets with information to supplement the posters were also developed. These pamphlets were also available in Cree and Dene.***
3) ***Tobacco-awareness promotional items such as T-shirts, water bottles, bracelets, piggy banks, backpacks and notebooks bearing campaign messages were also developed. Over 1,500 items were ordered and distributed to NITHA partner communities.***
4) ***We have been involved in social media marketing. Facebook and Instagram accounts were set up as part of our tobacco-awareness campaign (both accounts are linked). Posting of anti-tobacco messages centred on health effects/consequences of tobacco; tobacco industry deceptive practices; second-hand smoke and its potential harm. On our Facebook page, we have about 180 likes, a target audience of 17,000 have been reached and 600+ people engaged by our posts. About 50 anti-tobacco messages have been posted to date. We have received messages asking about quitting support.***
5) ***Radio spots: anti-tobacco messages are aired bimonthly through local community radios stations and MBC radio in English, Dene and Cree. We have had 83 radios spots to date.***

This process relates to the project objective of prevention: Innovative approaches to prevent tobacco use. This objective relates to activities that involve child/youth messaging, community school-based programs, and prevention through partnerships. We are proud of our youth who participated in the leadership training. They are part of the 'Teens Against Tobacco Use.' The Project Navigator, Project Community Based Workers, Principals, Teachers and off-reserve schools/educators were involved in the process. Students in Grades 4-7 were involved. The youth earned and received badges in nutrition, physical activity, culture, leadership, and public speaking. These badges were sewn onto hoodies for youth to

wear proudly as team members. These youth have made plans in education, team building and messaging to peers and community for the new year.

Adopting of policy: "Respecting Traditional Tobacco - No Smoking Policy" by a First Nations Community. Objectives: To propose policy to Chief and Council of the First Nation Community; To have Chief and Council adapt/adopt the policy as they deem fit. Target Populations: First Nations Community Chief and Council; Community Partners and Champions; Community Health Committee; Band Manager; Health Councilor and some Elders. Activities: Project team met with the band manager. She suggested a meeting with the Health Committee, which comprises the health portfolio councilor and other community members. There was buy-in from this level of leadership. After some further deliberation the health committee made a recommendation to the Chief and Council. The health portfolio councilor brought it forward during the Chief and Council meeting. There was a divided house, with the majority being for the policy. The project team was invited to meet with the elders' council as there was huge resistance from these stakeholders. The project team met with this group, having an elder proponent in attendance. After discussions were held, resistance still came from some members, but Chief and Council decided to adopt the policy. Outcomes/Going forward: Policy was adopted. Enforcing is a huge challenge especially in the community hall. The project provided a 48" x 24" Cree-English sign to be mounted in the hall. Council members are encouraged to ask community members to respect the signs and policy in place.

'Grow a Row.' Traditional Tobacco access is limited in our region. Many people elect to purchase commercial tobacco products for use in traditional ways. There is traditional tobacco available for purchase but since it falls under the Tobacco Act, this product is very expensive. Our Grow a Row campaign offers traditional tobacco seeds to people along with a video tutorial on how to grow your own traditional tobacco. This tobacco originates from the Hopi Tribe in the United States and has been acclimatized to our shorter growing season. When individuals and communities grow their own row of traditional tobacco, they will have access to organic products that have not been altered by tobacco companies. The tobacco is at no-cost aside from the time and effort it takes to grow. This strategy has been very welcomed in our region. A lot of communities are interested and will be in turn growing a row.

All have completed with a great number of participants, each participant having successfully grown tobacco and has been and will be using it for traditional purposes and healing. Each participant engaged in the 12 programs delivered by our schools of wellness coordinator while also learning and grasping a nutritional lifestyle while reducing tobacco. The nutritional part of the program is provided by FHQ Health Services community dietitians.

Facilitated a two-day meeting in Happy Valley-Goose Bay re: Tobacco Control (February 4-5). Day 1 focused on providing a brief overview of the strategy and some of the projects also had a group discussion about smoking in Nunatsiavut communities and worked on some case studies. Day 2 focused on branding and slogan development, credible messaging for all target groups, looking at current anti-smoking campaigns out there and discussion about anti-smoking videos to be developed. Representatives from communities included: Elders, youth council members, mental health/addictions workers, public health, community health workers and the core management team. This engagement led to the development of culturally appropriate branding/messaging for the campaign and to ideas for development of video vignettes, and to get workers thinking about how to implement anti-smoking/harm reduction TCS activities into current program delivery.

The development of the first tobacco newsletter has been a successful process that will be followed up, since a second newsletter is presently in the making. It is essential to inform the adult population, young people and pregnant women by providing role models through the accounts of two people who stopped smoking. It is important to seek people's opinions on what they want to do in the future to fight smoking. This is why a survey was offered to the population receiving the newsletter. To produce this newsletter, a first meeting was held to

determine the subjects to include and the person responsible for drafting the text associated with each subject. Thereafter, a communications advisor was tasked with implementing the concept on a computer. It is important to mention that 100% of this newsletter was translated into Innu. 'Plant the Seed Elementary School Prevention Campaign': Our objective was to create and deliver interactive educational sessions in three elementary schools that promoted understanding and awareness among children of our original teachings on the purpose and use of sacred tobacco vs the use of commercial tobacco. The materials developed were age sensitive, interactive, with a theme that explored differences in health benefits and consequences of sacred tobacco and commercial tobacco. The schools, school nurse, two prevention workers and two school health educators teamed to build, coordinate and deliver the sessions. The total number of students involved was 130 in Grades 1, 5 and 6. The addictions and wellness team has developed a partnership with the addictions workers from the local CISSS-TK (Hospital). They are currently working together to plan a Smoking/Tobacco Prevention Plan Program that will be integrated into the 2016-2017 school year at the local school where our members attend.

In September 2015, we launched a short term quit contest called 'Tobacco Timeout' (tobaccotimeout.ca). Modeled on the QuitNow contest already in place called Tobacco Free Tuesdays, FNHA worked with the BC Lung Association to develop an Aboriginal version of this contest, with the target audience being Aboriginal people living in BC over the age of 18. We worked with a BC First Nations artist to design a special contest logo, which aligns well with the FNHA brand. The contest is a 24-hour commercial tobacco quit contest that takes place the first Tuesday of every month and is on-going. To adapt the contest from the mainstream version, we worked closely with an internal working group at FNHA to inform and ensure cultural safety of the content. QuitNow is BC's smoking-cessation resources, funded by the provincial government. Each time QuitNow goes out to an event where they set up an information table for a mostly Aboriginal audience, and they bring information about Tobacco Timeout to promote it. Each month, two $250 cash prizes are awarded to randomly drawn participants. Between September 2015 and March 2016, we had 753 participants in the contest. A survey was distributed to contest participants, with a 4% response rate. Of those surveyed, 55.6% were participating in the Tobacco Timeout Challenge for the first time, 29.6% two times, 11.1% three times, and 3.7% four times or more. Of those surveyed, 83.9% had remained tobacco-free for the entire 24 hours of the contest date. Of those surveyed, 16% strongly agree that the tobacco timeout challenge had given them more confidence to quit and remain commercial tobacco-free, 44% agreed, 36% said it made no difference.

The three processes we describe are integrated with one other, and the results in one of the activities wouldn't be the same if we only implemented one activity on its own. 'No Butts To It!' (NBTI) had very encouraging results in Year Two with: 1) Smoking Sucks Workshops; 2) No Butts To It Smoke-free Challenges; 3) Distance Education Program; and 4) Resources that we developed to support our work. [As described in detail below:]

1. Smoking Sucks Workshops (SS Workshops): The Smoking Sucks Workshops train Cree youth to reduce smoking among their peers, families and community, and since 2012 we have trained about 150 youth from all nine Cree communities. During January 2016 we held our first Smoking Sucks Workshop of the year in Chisasibi with nine high school students over four days. Sessions took place during lunch hour, after school and evenings. Participants used the book Y 'Smoking Sux' and other materials to develop critical awareness about the immediate and underlying problems of smoking. They practiced sharing what they learned with each other, and ended with a presentation to members of the community, a supper and prizes. Our second Smoking Sucks Workshop was in Mistissini with 11 members of the Mistissini Youth Council plus high school students. This time we combined the Smoking Sucks Workshop with the NBTI Challenge as an integrated intervention in which the workshop team launched the Challenge as their community project. It was a great success, so we'll try to do the same in all communities, while being open to adapting to the local circumstances that ultimately determine what is possible at that time.

2. 'No Butts To It' Smoke-Free Challenges (NBTI Challenges): The first NBTI Smoke-Free Challenges were in Chisasibi and Mistissini, co-sponsored by the youth councils of each community and the Health Board. The challenges engaged children, youth, adults, and Elders smokers and non-smokers within and between the two communities, to be smoke-free for 5 days. The NBTI Challenges comprised 3 stages: 1) the launch: to promote the challenge, and encourage people to sign up; 2) activities to keep the challenge on the public agenda and to help smokers stay smoke-free (radio shows, meetings with individuals and organizations, etc.); 3) individual follow-up phone calls with all smokers who entered to see if they stayed quit, and to encourage them to keep trying if they did not. This last intensive phase of individual contact by phone, with counselling, is a new development in our experience of 'Quit-and-Win' challenges, and we hope to extend this approach by adding new resources and capacity during the Distance Education Program (see next Update). We gave away 12 iPads in each community, eight in draws for smokers who stayed smoke-free, and four for the non-smokers who supported the challenge. We asked smokers to do a cotinine saliva test to confirm their smoke-free status: all had their status confirmed as we expected. 2.1) Results from the NBTI Challenge between Chisasibi and Mistissini: A total of 668 people entered the two challenges, just over 11% of the total eligible population from both communities. (The StatsCan 2011 census for people aged 10 and up - the closest equivalent statistics available for Chisasibi is 3,464, and for Mistissini, 2,607 for a total of 6,071 in both communities). For our first intensive NBTI Challenge, these numbers are double what we expected, and they set the baseline to beat in subsequent challenges. 2.2) Results from the Chisasibi Challenge: 350 people participated in the Chisasibi Challenge: 103 adult smokers and 153 adult non-smokers; plus 15 student smokers and 79 student non-smokers. These results surprised us as we've never before seen such a high ratio of adult smokers to non-smokers in a Challenge, so we know that we succeeded in getting the word out about quitting. Even more encouraging was the number of smokers who stayed smoke-free for the Challenge. Of the 111 smokers we were able to contact (from 118 smokers who entered), 62% were still smoke-free by the end of the Challenge. 2.3) Results from the Mistissini Challenge: 318 people participated in the Mistissini Challenge: 88 adult smokers and 135 adult non-smokers; plus 48 student smokers and 47 student non-smokers. Mistissiniâ's participation was two percentage points higher than Chisasibi, so they were the winners on this point. Out of the 81 smokers we were able to contact (from 136 who entered), 42% were still smoke-free by the end of the Challenge. Chisasibi Challenge entrants = 10% of population. Mistissini Challenge entrants = 12% of population. 2.4) What percentage of smokers who entered the Challenge stayed smoke-free? In Chisasibi, 62% of smokers stayed smoke-free for the whole Challenge. In Mistissini, 42%. Both these results are excellent, but Chisasibi was in the lead by 20 percentage points over Mistissini. 62% of Chisasibi entrants stayed smoke-free; compared to 42% of Mistissin entrants stayed smoke-free. Finally, who actually won the NBTI Challenge: Chisasibi or Mistissini? The answer is both communities won. Mistissini had the higher percentage of community participation and the higher percentage of smoker compared to non-smoker entrants and Chisasibi had the higher percentage of smokers who stayed smoke-free.

3. Distance Education Program (DEP): The DEP began with 14 Community Health Representatives from Wemindji, Chisasibi and Mistissini participating in the orientation training held over 4 days in Val d'Or in March 2016. In the DEP, each participant has their own customized distance education program to meet their specific learning needs, taking into account their prior experience and training. The DEP has four main stages: 1) the orientation workshop, 2) preparation and learning, 3) implementing projects, and 4) providing evidence of competency and evaluation. Most participants have now drafted their individual learning plans with input from the course facilitators, and will complete their preparation using resources developed for the course, and then implement their projects in conjunction with the upcoming NBTI Challenges and Smoking Sucks Workshops. In this way, the DEP takes into account the individual learning needs and experience of participants to help them develop competencies for their practice, doing so in a structured, distance education program that allows them to combine study and work.

VI) EVALUATION SUMMARY AND CONCLUSIONS:

This report provides national outcome findings for the ***First Nations and Inuit component*** of the ***Federal Tobacco Cessation Strategy*** for 2015-2016. This is the second of four iterations of this analysis. It compares the findings from 2014-2015, (Year One) with those of 2015-2016 (Year Two). Statistical tests were undertaken to measure responses to quantitative data over time. It is apparent from the comparative data, over time, that the projects, overall, have made notable progress in achieving their deliverables and outcomes.

6.1) Number of Communities Served:

In 2014-2015 (Year One) the FTCS projects served 347 communities across Canada. In 2015-2016 (Year Two) that number increased to 388.[24] Some projects served entire provinces or regions, others served multiple communities, some of which were often spread across many kilometers, and others served one community.

6.2) Populations Served by the Projects:

There were statistically significant increases, over time, in the percentage of projects serving nine populations, with some of these increases being very significant. They included, in ranked order of significance:

- Adults in the general population
- Children and youth in non-school settings
- Other community leaders
- Healthcare managers and staff
- Elders and community seniors
- Preschool children
- Students in Grades 1 to 12
- School administrators and staff
- Pregnant mothers

6.3) Projects' Community Partners:

There were also significant increases in the percentage of projects, over time, reporting that they worked with 12 types of community partners. They included, in ranked order:

- Federal/Provincial police
- Educators
- Other health care providers
- Youth councils
- Business owners/retailers
- Schools
- Community media
- Daycares
- Bylaw officers
- Youth role models
- Recreation centres
- Aboriginal Head Start Programs

6.4) Projects Reporting Smoke-Free Spaces:

In Year One projects in that study identified a total of 676 smoke-free spaces: 466 indoors and 210 outdoors. In Year Two the total number of smoke-free spaces increased to 1,688: 1,001 indoor and 687 outdoor. This constituted a mean of 56.3 indoor and outdoor spaces per project in Year One, compared with a combined mean of 102 in Year Two. Some notable increases, over time, emerged:

6.4.1) Indoor Smoke-Free Spaces:

- The number of First Nations Band Offices with indoor smoke-free spaces, across projects, increased from 65 in Year One to 168 in Year Two
- The number of schools with indoor smoke-free spaces increased from 71 to 166
- The number of health centres with indoor smoke-free spaces increased from 80 to 127
- The number of daycare centres with indoor smoke-free spaces increased from 58 to 113
- The number of community/recreation centres with indoor smoke-free spaces increased from 31 to 64
- The number of Aboriginal Head Start sites with indoor smoke-free spaces increased from 21 to 60

[24] By including the information provided by File Hills Qu'Appelle Tribal Council, the actual number of communities served in 2015-2016 by the projects in this study increases to 399.

6.4.2) Outdoor Smoke-Free Spaces:

- The number of stores with outdoor smoke-free spaces, across projects, increased from 11 to 95
- The number of restaurants with outdoor smoke-free spaces increased from 17 to 51
- The number of schools with outdoor smoke-free spaces increased from 71 to 102
- The number of sports facilities or arenas with outdoor smoke-free spaces increased from 10 to 37

6.5) Projects Reporting Smoking-Related Resolutions:

In Year One 33.3% of the projects reported that their governance bodies passed smoking-related resolutions. This almost doubled to 64.7% in Year Two. In Year Two the three most frequently passed smoking-related resolutions included:

- Designating smoke-free public spaces (41.2%)
- Promoting smoke-free homes (41.2%)
- Expanding smoke-free perimeters surrounding smoke-free buildings and spaces (35.3%)

6.6) Decreasing the Number of Daily Smokers:

The process for developing and implementing programs to facilitate smoking-cessation for First Nations people, or to reduce commercial cigarette usage, requires adequate time for the projects to become established and visible in their communities, to acquire adequate facilities, to hire adequately trained staff, to acquire or develop treatment materials, to identify prospective clients, and to open their doors. Accordingly, in Year One very few of the projects were able to report any smoking-cessation activities or outcomes.[25] Year Two yielded different results, with 12 projects providing at least some data for this analysis. Specifically, in Year Two:

- 3,197 community residents started a smoking-cessation program or intervention through the FNIC-FTCS projects. These were primarily program participants in community-based smoking-cessation programs (1,521), school-aged children or youth (372), healthcare workers (201), or pregnant women (61)
- Of these, a total of 1,141 reportedly completed the program or intervention in which they were participating. This is a completion rate of 35.7%, which is a moderately positive outcome, particularly for addictions programs in their formative stages.
- Of those who completed their program or intervention, 163 reportedly reduced their smoking (i.e., harm reduction), and 52 quit smoking. This reflects success rates of 14.3% and 4.6%, respectively.

6.7) Projects Collecting Smoking-Cessation Data:

When project coordinators were asked whether their projects collected smoking-cessation data related to population or community-level analyses, 53.3% of the projects in Year One, reported 'Yes,' compared with 73.3% in Year Two.

In Year One 12.5% of the projects (n=1) reported that the study had been com-pleted, 25.0% that they were underway, and 62.5% that they had not yet started. In Year Two, 58.3% of these projects reported that their smoking-cessation studies had been completed, 41.7% said that they still had studies under way, and 16.7% had not yet started.[26]

The planned or actual sample sizes ranged widely: from a low of 20 to a high of 5,700. The mean sample size was 1,145, with a median of 200.

[25] For insight regarding promising practices related to the smoking cessation component of this project, along with related barriers and challenges experienced by the projects, please see Sections 3.3 and 4.3 of this report.

[26] Multiple responses were allowed for this question, given that some projects may have multiple studies at various stages of completion in 2015-2016.

In Year two the most frequently identified study populations were:

- Adults in the general population, identified by nine projects
- School-aged youth, identified by eight projects

In both years a large percentage of the FNIC-FTCS projects planned to replicate their baseline studies in the future (87.5% and 81.8% for Years One and Two, respectively).

6.8) Services Provided By the Projects:

At the FNIC-FTCS ***Community of Practice*** gathering in 2015, it was decided to add a new question to the Annual Outcome Reporting Form that would document the services or activities provided by each project. A consultation process at the gathering resulted in 36 services or activities being identified. These were added to the form, with project coordinators being asked to select all responses that applied. From the data each project identified a mean of 27.3 services or activities, with a median of 27.0 (sd=6.74). The number of activities selected ranged from 14 to 35. There were 18 services or activities that were identified by over 80% of the projects, including:

- Educating junior high school students about the negative effects of smoking (100% of all projects)
- Educating high school students about the negative effects of smoking (100%)
- Educating elementary school students about the negative effects of smoking (93.8%)
- Developing partnerships with community leaders to promote smoking-cessation/prevention (93.8%)
- Sponsoring challenges/events/contests related smoking-cessation/prevention (93.8%)
- Developing smoking-cessation programs (93.8%)
- Developing partnerships with health care providers to promote smoking-cessation/prevention (87.5%)
- Developing partnerships with educators to promote smoking-cessation/prevention (87.5%)
- Training health care professionals in smoking-prevention/cessation processes (87.5%)
- Developing smoking-cessation/prevention poster campaigns (87.5%)
- Educating parents/caregivers about the negative effects of smoking (81.3%)
- Educating others about the negative effects of smoking (81.3%)
- Encouraging smoke-free vehicles if children/youth are present (81.3%)
- Meeting with Chiefs and Band Councils to promote smoking-cessation/prevention initiatives in their communities (81.3%)
- Developing Facebook campaigns to promote smoking-cessation/prevention (81.3%)
- Creating 'no smoking' signs and/or posters (81.3%)
- Participating in health fairs sponsored by other groups (81.3%)
- Educating school administrators and educators about the negative effects of smoking (81.3%)

6.9) Projects' Promising Practices:

6.9.1) Related to Leadership:[27]

Promising practices in Year Two related to Leadership included:

- Revising and promoting smoking-related policies regarding commercial tobacco
- Designating smoke-free spaces in local businesses and across the larger communities
- Sponsoring related educational events
- Educating health service providers about the health implications of smoking commercial cigarettes
- Gaining support from community leaders that resulted in passing smoking-related resolutions and promoting activities to reduce smoking levels
- Encouraging residents to stop using commercial tobacco
- Developing relationships with bylaw officers and business owners

[27] The full report includes the related verbatim comments from the project coordinators.

6.9.2) Related to Health Promotion (prevention and education):

The comments in this section, many of which were highly detailed, yielded 12 related promising practices themes, with a range of examples for each. The themes included:

- Promotions, contests, posters, signs, videos (N=15)[28]
- Community challenges and physical activities (N=8)
- School-based activities (N=7)
- Using local media, other media, YouTube (N=7)
- Reaching youth (N=6)
- Developed materials, reviewed policies, staff training (N=4)
- Focusing on traditional tobacco (N=2)
- Health fairs (N=2)
- Developing partnerships (N=1)
- Educating local businesses (N=1)
- Using role-models (N=1)
- Increasing awareness of harm of commercial tobacco using health promotion tools (N=1)

6.9.3) Related to Smoking Cessation:

Of the project coordinators who responded to this question, seven discussed being involved in establishing their smoking-cessation programs or initiatives; two noted initiating the smoking-cessation component in 2016-2017; one identified processes and strategies developed to encourage smokers to participate in their smoking-cessation program, or to at least attempt to reduce their smoking rates; and three described experiences implementing smoking-cessation activities in 2015-2016, with varying levels of success.

6.10) Projects' Barriers Or Challenges:

6.10.1) Related to Leadership:

Two project manager had not experienced any challenges or barriers related to leadership in their communities in Year Two; six noted the leaderships' perceived ambivalence regarding the use of commercial tobacco in their communities, a related lack of enforcement of tobacco-related regulations, the inference that revenue from commercial tobacco sales bring into the community can be a disincentive to reducing smoking levels, and that smoking commercial cigarettes has become acceptable in some communities (i.e., the norm); four coordinators cited a lack of communication as their barrier or challenge regarding leadership, along with limited access to the leadership; two coordinators felt that their leadership was faced with other more pressing priorities than the need for smoking cessation; and one coordinator cited frequent changes in staffing as a barrier or challenge related to leadership.

6.10.2) Related to Health Promotion (prevention and education):

Fifteen barriers or challenges to health promotion were identified by project coordinators. They included:

- Poor attendance at events
- Finding suitable locations to provide service
- Difficulty finding experts in their communities
- Difficulty with staff recruitment
- Front-line staff are too busy to participate
- The need for a holistic approach to reducing or eliminating the use of commercial tobacco
- Difficulties finding culturally appropriate posters and pamphlets
- Challenges related to diverse languages in some communities
- Competing against the need to address other health concerns in some communities, given scarce resources
- Closures due to deaths in the community
- The need for more information on the implications of e-cigarette use

[28] Numbers in brackets indicate the number of examples given for each theme.

- One Board of Education not allowing the project to operate in their schools during school hours
- Weather and travel issues interfering with successful program implementation
- Missing or malfunctioning resources and equipment
- Limited Internet connectivity and bandwidth

6.10.3) Related to Smoking Cessation:

Project coordinators identified 17 barriers or challenges to their projects' abilities to reduce daily smoking among residents in their communities. They included:

- The program is still being developed
- Youth are reluctant to attend smoking-cessation programs in school due to possible stigma
- Reluctance of community members to participate, in general; Lack of interest
- Smoking is a "normalized" behaviour, leading to limited motivation to attend programs; There is no "shame in smoking even for pregnant mothers"
- The need for community staff to receive enhanced training and support to achieve successful outcomes; Need for more smoking-cessation specialists
- The need to strengthen partnerships with healthcare staff
- The inability to access e-health or telehealth services, to facilitate distance programming
- High workloads relegate smoking-cessation programs to a lesser status for overworked community staff
- Competing demands for the time of healthcare workers
- Healthcare professionals who smoke themselves
- It takes time to build trusting relationships
- Clients with concomitant mental health issues are more resistant to change
- Community-based part-time staff do not have sufficient time to participate in the program
- Even when community members show interest in the program they rarely attend it
- Difficulties successfully disseminating information to raise awareness of the program. Social media has a limited audience in some communities
- Need better access to pharmacy staff
- While the Blue Light campaign was successful, the smoking cessions program lacked the participation to keep it going

6.11) Project Coordinators Describing One Successful Process in 2015-2016:

The last question asked project coordinators to describe successful processes they undertook in Year Two. Many coordinators put forward their positive experience, some going into great detail; with full explanations, examples and lessons learned. It is fair to say that the shared experiences reflected in this section, in addition to the promising practices, and the barriers and challenges, experienced by each project, should be very useful across all FNIC-FNCS projects. The themes for the successful processes shared by these coordinators included:

- Two projects implemented the 'Stay Quit To Win' competition. One was largely school-based and the other was community-wide
- An 'Amazing Race' activity which involved participants only committing to stop smoking for four hours while they embark on this event
- Health classes focusing on smoking-cessation
- Displaying educational materials to facilitate smoking prevention
- A youth hockey tournament that focused on healthy living and the youth leading smoke-free lives
- Training healthcare providers to facilitate smoking cessation, using a number of media and expert presenters
- Creating a billboard campaign promoting smoking prevention
- A community-wide awareness campaign to promote increasing awareness of the harmful effects of smoking and exposure to second-hand smoke in English, Cree and Dene
- A project using "Innovative approaches to prevent tobacco use" among children and youth through "positive messaging"

- Working with community leaders to Adopt a "Respecting Traditional Tobacco - No Smoking Policy" by the First Nation Community
- A third project assisting participants to grow traditional tobacco, and to learn about nutritional lifestyles
- Sponsoring a ‘Grow a Row’ campaign that offers traditional tobacco seeds to First Nations communities
- Facilitating a two-day meeting to provide an overview of the strategy, share case studies, develop branding and slogans and looking at other current anti-smoking campaigns
- Developing a ‘Tobacco Newsletter’ to provide role-models who stopped smoking. This project also delivered interactive educational sessions in elementary schools promoting understanding and awareness among children of our original teachings on the purpose and use of sacred tobacco vs the use of commercial tobacco.
- Launching a short term quit contest called ‘Tobacco Timeout’ that is modeled after the ‘QuitNow’ contest
- Describing four activities that were integrated into a global prevention strategy: ‘Smoking Sucks’ Workshops; ‘No Butts To It’ smoke-free Challenges; and a distance education program

APPENDICES

APPENDIX ONE
ESSENTIAL ELEMENTS OF FTCS PROJECTS[1]

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.

	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 TWO:
Promising Practices and Successful Processes From 2014-2015

1) Promising Practices In Leadership:

Seven respondents commented regarding their promising practices related to ***Leadership***. Three of these 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:

> ***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 learned. This included two projects that were able to identify smoke-free spaces in their communities, and one which 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 BCR's 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 & 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.

> ***There were several successful promising practices for leadership:***
>
> ***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 (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 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 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 package [them] 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) 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 first 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 (PSA) 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. Education materials and have started ordering materials. [Their] focus is on interactive, "fun" materials which youth can relate to. A program coordinator and 2 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 as opposed to others.

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 work 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.

[Providing] 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 that health promotion, prevention and education. The communities are still putting these into practice.

One respondent shared the following four Promising Practices:

1. ***FNHA, in partnership with the First Nations Health Directors Association, organized and led six regional tobacco training session 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. <u>Lessons learned</u> included: 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. <u>Lessons learned</u>: 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. <u>Lessons learned</u>: 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.***

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 the respondents who were able to offer 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 the 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) 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 the funding starting-up 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 taken 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 up to March 31, 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 information regarding 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 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:[29]

> ***[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.

> ***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.

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

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 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.