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pour les peuples autochtones

A CASE STUDY APPROACH

LESSONS LEARNED IN ONTARIO - ABORIGINAL TOBACCO CESSATION

ABORIGINAL TOBACCO STRATEGY
Aboriginal Cancer Care Unit
Cancer Care Ontario

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ABORIGINAL TOBACCO STRATEGY

The Aboriginal Cancer Care Unit, Aboriginal Cancer Strategy

The Aboriginal Cancer Care Unit (ACCU) is responsible for developing the Aboriginal Cancer Strategy (ACS) and is based on a wholistic approach to cancer prevention, screening and research.

The Aboriginal Tobacco Strategy (ATS) supports Aboriginal peoples on their path to developing tobacco-wise communities. It honors the Aboriginal path of wellness and adheres to the principles of the ACS within Cancer Care Ontario.

Guiding Principles

- We will take a wholistic, Aboriginal approach to healthy physical, mental, emotional, spiritual and cultural needs of the individual, family and community.
- We will make a difference at the community level and be inclusive of Aboriginal people's voices.
- We will work in conjunction with natural, informal support networks within Aboriginal communities, understanding the Aboriginal worldview and recognizing community knowledge and assets.
- We will be process-oriented and respectful of people first.

About the Aboriginal Tobacco Strategy

The ATS's primary goal is the delivery of programming under the Aboriginal Programs component of the Smoke-Free Ontario (SFO) Strategy, Ministry of Health Promotion (MHP) based on the three pillars of prevention, protection and cessation. Our program develops and implements a strategy that reduces the use of commercial tobacco among Ontario's Aboriginal communities and populations, including on-reserve and urban/rural communities, and thereby mitigates associated health risks.

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EXECUTIVE SUMMARY

Objectives of the Study:

The intention of this report initially was to identify promising practices in Aboriginal tobacco cessation but due to various limitations, this report did not allow for the authors to do this. Instead, the focus of the study examined two existing Aboriginal tobacco cessation models in Ontario in order to identify lessons learned and potential emerging practices for consideration by others.

The identification of emerging practices from the two case studies was based on the following criteria:

- Minimization of barriers for implementation in Aboriginal communities.
- Optimization of replication for the Aboriginal population.
- Strength of evidence found within the literature to support case study findings.

Problem Identification:

Sixty percent of Aboriginal people in Canada are smokers: 72% of Inuit, 57% of Métis, and 56% of First Nations (Health Canada, 2002). Recent statistics for off-reserve Aboriginal peoples indicates that 39% of Aboriginal males and 37% of Aboriginal females smoke.¹ These rates are significantly higher when compared to non-Aboriginal populations where 25% of non-Aboriginal males and 19% of non-Aboriginal females smoke (CSQI, 2008).

When working with Aboriginal populations, tobacco control cannot be looked at in isolation from the social determinants of health. Nicotine addiction, access to tobacco, environment, tobacco cost, socio-economic status, education, and cultural norms are all risk factors in Aboriginal tobacco control.²

Methodology:

A literature review and an environmental scan were conducted on Aboriginal tobacco cessation efforts and formed the foundation of this study. Two intensive case studies were conducted with Wabano Aboriginal Health Access Centre and Anishnawbe-Mushkiki Aboriginal Health Access Centre.

Case Studies:

In-depth investigation into two Aboriginal tobacco cessation interventions in Ontario are presented along with analysis as to areas in which program design, coordination, implementation and evaluation are supported by literature findings on Aboriginal tobacco cessation. With respect to the design of the two programs, this section of the report will identify where mainstream literature about cessation is supported as well as where gaps exist within the current literature on Aboriginal tobacco cessation. Findings from the literature will be compared and contrasted with the design and findings of each program so that lessons learned can be identified.

Lessons Learned:

Of the very few Aboriginal cessation projects identified through the environmental scan, two tobacco cessation programs were chosen: Sacred Smoke, operating at Wabano Centre for Aboriginal Health, and Sema Kenjigewin Aboriginal Tobacco Misuse Program, from Anishnawbe Mushkiki. It was discovered both Aboriginal and non-Aboriginal health delivery agencies would find these cessation interventions of interest, and though they were designed to address Aboriginal tobacco risk factors and cessation intervention barriers in an urban setting, First Nations and other rural applications are possible with modifications. In fact, staff from these programs would prefer increased resources and networking opportunities between urban and First Nations communities offering tobacco cessation programs to enhance their knowledge of lessons learned from other organizations and communities in deploying tobacco cessation strategies.

In a wholistic sense, Sacred Smoke and Sema Kenjigewin Aboriginal Tobacco Misuse Program present emerging practices as they attempt to address the emotional, physical, social and mental needs of Aboriginal smokers. These projects were designed with Aboriginal cultural and social relevance in mind and as such, incorporate Aboriginal values into the curriculum, teaching strategies, counseling methodologies and paying attention to participants literacy levels, lifestyle, community behaviour, and family income levels.

Identification of Emerging Practices for Consideration in Aboriginal Program Cessation Design:

The main lessons learned in Aboriginal tobacco cessation by program managers and key staff at Wabano and Anishnawbe Mushkiki can be grouped in terms of program design, administration, support, and evaluation.

Program Design

- Observe the diversity of participants and recognize their different interests: First Nations, Métis and Inuit.
- Be cognizant of the various client supports needed respecting individual situations, income, employment level, education and other social determinants of

health.

- Incorporating various aspects of culture into programming does have an impact for some participants.
- Keep the classes informal and ensure all participants have opportunity to speak.
- Elder teachings about traditional uses of tobacco, giving thanks and respecting and caring for the body are important to those who practice traditional First Nations culture.
- Factual knowledge about addiction and the process of change is essential.
- The program must be positively framed and emphasize harm reduction.
- Linkages with other health promotional activities provide opportune “teachable moments”.
- Foster autonomy and self-efficacy among participants.
- Individual quit plans are required.
- Accessibility to pharmacotherapies improves chances of success.

Administration

- The development and implementation of a cessation program entails various substantive costs and resources such as dedicated facilitator/ staff, managerial and finance staff, administrative support, food and beverages, transportation, childcare, facility space, overhead, elder honoraria, and guest speaker fees.
- Personnel are critical to the success of the program, and they should be Aboriginal, non-smokers, trained in tobacco cessation counseling, be able to develop health promotion strategies, harm reduction approaches, be knowledgeable about tobacco addiction and be familiar with the traditional uses of tobacco.
- Wrap-around support is important. Opportunities to integrate smoking cessation programs with other chronic disease programs (youth, senior’s, healthy eating active living programs) should be explored.

Support

- Supportive infrastructure and capacity within the organization is essential. Each program supports one another via cross referrals, finance, administration and supervisory supports.
- Social support is critical for success in any tobacco cessation effort.
- Training healthcare workers in tobacco cessation techniques is necessary to ensure the success of the program.
- Programs should take a wholistic approach to behavioural change.
- Capitalize on non-smoker role models, particularly among the youth:
 - Mentoring and role modeling opportunities.

Evaluation

- Qualitative data is equally important as quantitative data in evaluating program outcomes.
- Pre and post evaluations with clients should:
 - Examine current smoking behaviours before the interventions and outcomes after the intervention.
 - Ask participants questions about program design and supports (i.e., is there anything that can be improved upon within the program design itself?).

Concluding Remarks:

Various lessons learned can be gleaned from the two tobacco cessation programs studied at Wabano and Anishnawbe Mushkiki. To begin to identify promising practices in this area, further investigation is required by other researchers. As a result of examining both programs, the following research gaps are suggested for follow up:

- Implementation of the emerging practices identified in this study to determine if the practices identified are easily replicated in other Aboriginal communities or by mainstream cessation program counselors when working with the Aboriginal population.
- Rigorous evaluation designs are recommended to analyze program results. Evaluation design needs to include qualitative as well as quantitative methods.
- As identified in the literature, the impact of tobacco taxes, smoke-free policies and environments and the denormalization of smoking cannot be overlooked in the context of any smoking cessation initiative.
- Tobacco cessation programs must be integrated within the larger tobacco control community. At this present time, the author is unaware of population-level strategies pertaining exclusively to the Aboriginal population therefore warranting further research and investigation to determine the impact provincial and federal legislation, jurisdictional issues affect the Aboriginal population.

OBJECTIVES

Initially, the purpose of this study was to focus on identifying promising practices in Aboriginal tobacco cessation, specifically to:

- Engage in an environmental scan to see what programs, services and resources currently exist in Aboriginal communities regarding tobacco cessation programming (identifying what is working well within these models and what challenges exist within these models).
- Seek input from Aboriginal front-line service providers to discuss their strategies and challenges regarding the delivery of cessation activities at the grassroots level.
- Examine two existing Aboriginal tobacco cessation programs as case studies to aid in identifying promising practices from which others can gain insight.
- Identify mainstream interventions that might be adapted to fit Aboriginal needs for cessation.

Limitations to the Study

Some considerations in producing this report must be noted. While significant research on tobacco cessation exists including culturally competent interventions for Australian Aborigines, New Zealander Maoris, and Hispanic Americans, for instance, valid research data on Canadian Aboriginal tobacco cessation services and policy is quite limited. Thus, it is difficult to qualify any intervention or practice as “best or promising” at this time.

While organizations that implement Aboriginal tobacco cessation interventions may undertake an evaluation to determine what is effective and where improvements could be made, this information is often not available in the published literature. Because there is very little published literature found on best or promising practices in Aboriginal tobacco cessation, the findings presented in this report on tobacco cessation intervention models designed specifically for Aboriginal people are based on the observations, experiences and perceptions of project managers and staff at two Aboriginal tobacco cessation projects in Ontario.

Analysis and lessons learned are based on research and discussion with a variety of practitioners and tobacco cessation experts in Ontario.

Due to time and financial constraints, the scope of the project was limited to engaging in a case study approach through the following methods:

- In-depth examination and discussion with two urban, Aboriginal community-based smoking cessation interventions in Ontario.
- The facilitation of one small focus group involving participants who were involved in one of the programs.

While it is not possible to make broad recommendations based solely on the findings in this report, the qualitative information shared as a result of the case studies is valuable and insightful. The information is presented in a case study format and will highlight some lessons learned and emerging practices that show promise in Aboriginal tobacco cessation efforts. It should be noted that further research will be required in order to examine the long-term outcomes of the identified emerging practices in other communities.

The authors acknowledge the literature clearly states in order for cessation interventions to be effective, it is important to ensure smoke-free environments are offered in combination with smoking cessation programming. Cessation services are proven to have less impact on high prevalence of tobacco unless they are combined with tax and price increases, advertising, promotion and sponsorship bans, and smoke free environments. Thus a “push and pull” strategy has more impact than either technique on its own. However, little information exists on Aboriginal communities that have developed and implemented smoking policies and by-laws which could serve as models for others.

RESEARCH METHODOLOGY

A literature review and an environmental scan were conducted on Aboriginal tobacco cessation efforts and formed the foundation of this study.

Definitions:

For the purposes of the study, tobacco related definitions remained broad in recognition of the challenges of applying these terms to an Aboriginal context for which social and cultural meanings for tobacco are implied. Several sources of information were consulted for guidance. For instance, the Ontario government defines *cessation* as the following:

- Cessation (helping Ontarians quit smoking)

Despite the fact that Inuit do not share First Nations' history in traditional tobacco usage, the Pauktuutit Inuit Women's Association of Canada defines cessation as follows:

- Cessation (encouraging and helping those who want to learn to live without tobacco)³

Promising Practice

In 2005, the Aboriginal Tobacco Strategy (Aboriginal Cancer Care Unit) developed a working definition for identifying promising or emerging practices for which emphasis is placed on the autonomy of community to evaluate success:

- Community-based promising practices are ideas or actions that worked as defined by the community and are supported by evaluation outcomes.

Emerging Practice

As stated previously, the intention of this report initially was to identify promising practices in Aboriginal tobacco cessation but unfortunately the limitations of this study did not allow for the authors to do this. Instead the focus of the study examined two existing Aboriginal tobacco cessation models in Ontario in order to identify some potential emerging practices for consideration.

The identification of emerging practices from the two case studies was based on the following criteria:

- Minimization of barriers for implementation in Aboriginal communities
- Optimization of replication for the Aboriginal population

- Strength of evidence found within the literature search to support each program design

Sources of Literature

Literature searches included web-based information from government health sites, academic centres specializing in health promotion, addictions and tobacco control, and Aboriginal organizations and communities associated with tobacco control. Information sources included “grey” literature as well as published and unpublished reports, documents and studies.

More emphasis was placed on researching local Ontario and Canadian-based sources rather than international documents and materials, however, use of search terms such as “indigenous,” “Aboriginal,” and “Native,” were included, leading to valuable information from the U.S., Australia, and New Zealand.

Environmental Scan

The scope of the environmental scan included cessation interventions implemented by primary health care providers and smoking cessation specialists in a wide range of health settings including general practice, hospitals, Aboriginal community health centres, and Indian Friendship Centres.

The types of cessation interventions included in the search were behavioural, pharmacological and alternative. Aboriginal priority groups for intervention considered separately from the general population include youth and pregnant women.

Interviews

For the purposes of discussing and confirming research findings, the Aboriginal Cancer Care Unit recommended interviews with staff and management from various organizations involved in health and social services related to tobacco control including tobacco cessation counselor training, youth tobacco control, smoke-free legislation, substance abuse treatment, and Aboriginal tobacco cessation interventions. The following organizations were contacted:

- Anishnawbe Mushkiki – Aboriginal Health Access Centre
- Training Enhancement in Applied Cessation Counselling and Health (TEACH) Project, and Stop Smoking Therapy for Ontario Patients (STOP) Study, Centre for Addictions and Mental Health
- De dwa dehs nye>s Aboriginal Health Centre
- MAKWA Youth Action Alliance, Thunder Bay District Health Unit
- Smoke-Free Ontario, Ministry of Health Promotion
- National Native Addictions Partnership Foundation
- Regional Cancer Program, Sudbury Regional Hospital

- Union of Ontario Indians
- Wabano Centre for Aboriginal Health
- Youth Action Alliance of Manitoulin Island

Key informants from these organizations were interviewed over the telephone concerning the existence of Aboriginal specific cessation interventions, the potential for adapting mainstream intervention models for Aboriginal communities and organizations, and teaching resources, cessation counselor training, etc.

Interview Guides and Research Participation Consent correspondence are presented in the appendices at the end of this report.

Aboriginal Tobacco Cessation Project Site Visits and Focus Group

Due to the lack of literature focused on Aboriginal smoking cessation programming within the Canadian context, evidence for this report came from two intensive case studies: Wabano and Anishnawbe Mushkiki's tobacco cessation programs for the urban Aboriginal population.

The Sacred Smoke Program at Wabano Centre for Aboriginal Health in Ottawa was launched in 2004. Sacred Smoke is an 8-week 8-module intervention adapted from the City of Ottawa's "Accessible Chances for Everyone to Stop Smoking Program (ACCESS)." The Sacred Smoke Program was piloted at three Aboriginal Health Access Centre sites in Ontario and received funding from the Aboriginal Cancer Care Unit to conduct an evaluation in 2005; Wabano was invited to participate in the research.

The Sema Kenjigewin Aboriginal Tobacco Misuse Program at Anishnawbe Mushkiki Aboriginal Community Health Centre in Thunder Bay was launched in 2007. Sema Kenjigewin, a 12-week facilitated group counseling program, was invited to participate. Site visits were conducted in March 2008 at Wabano and at Anishnawbe Mushkiki. At both sites, personal interviews with staff took place. A focus group was held with those clients that succeeded in tobacco cessation at Anishnawbe Mushkiki.

Outcomes from the case studies indicate some strong common themes between the two models for consideration by others. Further research should be explored to evaluate the emerging practices identified as a result of this study.

PROBLEM IDENTIFICATION

Aboriginal Smoking Rates

Sixty percent of Aboriginal people in Canada are smokers: 72% of Inuit; 57% of Métis; and 56% of First Nations (Health Canada, 2002).

The Cancer Quality Council of Ontario recently released the 2008 Cancer System Quality Index results in regards to off-reserve Aboriginal Cancer Risk Factors. Data reported by off-reserve Aboriginal peoples show higher rates of smoking and alcohol consumption suggesting off-reserve Aboriginal peoples may be at greater risk for cancer than non-Aboriginal peoples. These results indicate that Aboriginal men and women have greater smoking rates than compared to non-Aboriginal populations.⁴ Recent statistics for off-reserve Aboriginal peoples indicates that 39% of Aboriginal males and 37% of Aboriginal females smoke.⁵ These rates are significantly higher when compared to the non-Aboriginal populations where 25% of non-Aboriginal males and 19% of non-Aboriginal females smoke.

In addition, data from the Canadian Tobacco Use Monitoring Survey (2004) (CTUMS) reported that an estimated 5.1 million people, representing roughly 20% of the Canadian population aged 15 years or older were current smokers. Smoking rates for Aboriginal youth were especially high, with 54% of teens and 65% of 20 – 24 year olds reporting smoking cigarettes (Health Canada, 2000). While smoking rates in Ontario have declined over the past 20 years, they are on the rise in Aboriginal population.⁶ The Environics Research Group (2004) reported that 60% of First Nations people who live on reserve smoke.

The First Nations Centre of the National Aboriginal Health Organization (NAHO) reports that of the First Nations people surveyed in the *First Nations Regional Longitudinal Health Survey (2002/2003)*:

- Just over half of First Nations pregnant women were smokers at the time of the survey and a large proportion were former smokers.
- Nearly half (43%) started between 15 and 19 years of age with 38% of the adult smokers started smoking between the ages of 10 and 14.
- Half of the adult non-smokers were former smokers.
- Among current youth smokers, over 70% had tried to quit smoking at least once in the past year; nearly half of these youth tried over three times.
- Nearly half of First Nations youth (44.2%) were exposed to cigarette smoke in their homes.

Social Determinants of Health - Risk Factors

When working with Aboriginal populations, tobacco control cannot be looked at in isolation from the social determinants of health. Nicotine addiction, access to tobacco, environment, tobacco cost, socio-economic status, education, and cultural norms are all risk factors in Aboriginal tobacco control.⁷ Tobacco control has a significant impact on cessation in two ways. When the cost of tobacco is high, it creates an incentive for people to quit smoking and thus, has an important impact on cessation (de Guia et al, 2000; Marriot and Mable, 2002). Relapses can be triggered in a social environment; therefore, policies on smoking in public places are very important (de Guia et al, 2000). The World Health Organization (2008) states that:

Treatment of tobacco dependence might be inefficient without strong incentives for tobacco users to quit. For these reasons, cessation services will not decrease tobacco use prevalence unless they are combined with tax and price increases, advertising, promotion and sponsorship bans, anti-tobacco advertising and establishment of smoke-free places. (p. 32)

This is particularly relevant in Aboriginal communities where tobacco "...is easy to access and cheaper on reserves." (Marriot and Mable, 2002, p.13) In the report *Toward Effective Tobacco Control in First Nations and Inuit Communities*, Physicians for a Smoke-free Canada (2007) state that "education and cessation programs offered in a pro-tobacco environment and in the absence of other tobacco control measures are generally ineffective." (p. 40)

Young people have stated, in a consultation conducted by Valentine et al (2003), that there should be local policies that restrict access to tobacco products. This supports the claim by the National Advisory Committee on Health and Disability in New Zealand (2002) that, "no cessation program for teen smokers has been shown to work, so prevention [via limiting access to tobacco products] is the key (e.g., repeated positive reinforcement of abstinence)."

Highlighted below is a summary list of some of the tobacco risks found in the literature pertaining to the Aboriginal population:

- Smoking and the use of smokeless tobacco can begin in Aboriginal children as early as seven or eight years of age, with even younger children initiating the habits of adults around them.
- Studies have shown that easy access to cigarettes is one of the best predictors of a child becoming a regular smoker at a young age.⁸
- This is compounded by the fact that there is no consistent smoking age across Canada and many First Nations have an illicit tobacco trade that provides easy access to low-cost contraband cigarettes.⁹
- The sale and distribution of tax-free tobacco accounts for a big proportion of First Nations income so there is little incentive to discontinue the practice.¹⁰
- Social acceptance and tolerance of smoking allow it to continue.¹¹

- Provincial regulations for smoking do not apply on reserves and few First Nations have instituted smoking regulations and by-laws.
- Studies have shown a correlation among poverty, high unemployment, low income and high rates of smoking. Low income levels and high unemployment rates are problems on most reserves in Canada and affect many off-reserve Aboriginal people as well.¹²
- Data confirms that Aboriginal women's smoking patterns are intimately linked to their life situation of isolation, poverty, abuse, and care giving.¹³
- When First Nations youth report they like school they are more likely to report never smoking cannabis or tobacco, and not drinking over the past 12 months.¹⁴
- Unfortunately educational attainment among First Nations people in Canada is much lower than that of the general population. Research from 1996 reports on First Nations education found that only 63% of First Nations people have completed high school whereas the Canadian figure was 79%.¹⁵

It is challenging to raise tobacco issues to the forefront of the Aboriginal agenda when there are numerous basic needs that require immediate action and attention. For example, inadequate housing, suicide, water quality, alcohol and family violence take precedence over tackling high prevalence of commercial tobacco in the community. A recent study of 20 Saskatchewan First Nations revealed that smoking is a less important community priority than alcohol, illegal drugs, bingo and gambling. In addition to the Saskatchewan report, the First Nations and Inuit Tobacco Control Strategy identified the following barriers First Nations communities face in regards to tobacco control:

- Other addictions in the community have a higher priority (42%)
- The community's attitude to smoking is permissive (36%)
- Staff, financial and material resources is lacking (34%)
- Knowledge about tobacco's effects in the general population is lacking (31%)
- Community leadership is not supportive of tobacco control activities (25%)
- There are no non-smoking role models in the community (21%)¹⁶

Outsiders cannot argue that the above concerns require immediate action and are a cause for concern. The communities are also limited by their capacity to respond to smoking concerns when funds and resources are lacking.

Cigarette smoking is often utilized as a coping strategy and is an outcome of a series of social challenges. Addressing tobacco usage cannot be looked at in isolation, rather, it must incorporate a wholistic approach encompassing physical, spiritual, mental and emotional needs in order to be most effective. There are numerous issues surrounding tobacco use in Aboriginal communities requiring interventions to address the root challenges in order to effectively address the problem.

Community support is clearly recognized as essential for success in any cessation initiative, but particularly so for Aboriginal people. Using positive role models (parents, teachers, and community leaders), combined with other community resources,

enhances the sense of connectedness and unity in the cause while minimizing costs.¹⁷ The Tobacco Reduction Strategy Study conducted by the Aboriginal Health Association of British Columbia (1998) discovered some interesting findings regarding adult and youth smokers:

- Peer and family influences have the greatest influence in their decision to use tobacco.
- They smoke most when socializing during recreational events such as Bingo as well as ceremonial occasions such as funeral feasts where cigarettes are often put in a bowl and served along with the food.
- Easy access to tobacco and its low cost on reserve supports smoking.
- Tighter controls on tobacco and smoke-free zones would support efforts to quit, but these initiatives would have to be approached collectively, since individualistic “crusades” conflict with Aboriginal values.
- Social acceptance and tolerance of smoking allows it to continue.¹⁸

The lack of tobacco regulations and controls within the reserve communities presents a difficult barrier to tobacco cessation efforts. It can be argued that high unemployment, low income and poverty allow for the perfect opportunity to create an environment where the production and sales of tobacco is supported within the communities. The supply and distribution of cigarettes create economic ventures for those who might otherwise be unemployed or would have to leave their home communities for employment opportunities. It can also be argued that communities require more unique approaches to address smoking cessation due to the complexity of issues that interplay with one another: federal/provincial jurisdictions in regards to tobacco control, Aboriginal governance structures and competing health priorities. The impact of lower costs and accessibility to cigarettes requires further research and investigation to determine true impacts on smoking uptake in Aboriginal communities in turn these findings can be utilized to create wholistic approaches to cessation, protection and prevention intervention efforts in tobacco control.

Tobacco and Aboriginal Culture

The unique relationship that First Nations people have with tobacco cannot be ignored in this discussion on risk factors. Tobacco has been used ceremonially among most Indigenous Peoples in the Americas for thousands of years under prescribed traditional practices in ceremonies. Traditional tobacco practices continue today by those knowledgeable in Aboriginal culture, however, many Aboriginal people lack knowledge as to the proper use of traditional tobacco so in smoking commercial tobacco “recreationally” they misuse the sacred plant.¹⁹ Compounding this problem is the fact that mainstream tobacco cessation interventions typically identify any tobacco as an ‘evil’ substance that has no place in society - without exception. Alternatively, the Aboriginal Tobacco Strategy has been educating communities about the traditional uses of tobacco in order to help combat the high prevalence of cigarette smoking. ATS utilizes strategies such as mass media campaigns, small-scale community tobacco projects, creative arts projects and forums in order to transfer knowledge to the communities about tobacco misuse and traditional tobacco use.

ABORIGINAL TOBACCO CESSATION INTERVENTION MODELS

A Case Study Approach

In-depth investigation into two Aboriginal tobacco cessation interventions in Ontario are presented along with analysis as to areas in which program design, coordination, implementation and evaluation are supported by literature findings on Aboriginal tobacco cessation. With respect to the design of the two programs, this section of the report will identify where mainstream literature about cessation is supported as well as identify where gaps exist within the current literature on Aboriginal tobacco cessation. (Please refer to the chart at the end of each Case Study for a summary of the program) Findings from the literature will be compared and contrasted with the design and findings of each program so that lessons learned can be identified.

Case Study #1

Wabano Centre for Aboriginal Health – “Sacred Smoke”

The Wabano Centre for Aboriginal Health is an urban, non-profit, community-based healthcare centre that provides programs and services for First Nations, Inuit and Métis. Established in 1998, it provides primary health-care services as well as a wide array of illness prevention, health promotion, education, and outreach activities in a culturally sensitive manner. With a client caseload of 6,000 annually and numerous awards, the Wabano Centre for Aboriginal Health is recognized as an innovator and centre of excellence in the area of urban Aboriginal health.

Current data tracked by Wabano indicates that smoking is one of the top three presenting concerns of clients of the centre after diabetes and heart disease. Of their 616 clients who are smokers, 386 are females and 230 are males.

To address these high rates, Wabano has actively initiated projects aimed at reducing smoking among their clients such as their current participation in a provincially piloted nicotine replacement therapy project (i.e., the STOP study). Pharmacotherapies (NRT) have been found to be very effective in supporting tobacco cessation by mitigating cravings and nicotine withdrawal symptoms and are particularly effective when combined with counselling (Anderson et al, 2002; CDC, 2007). Pharmacotherapies include: nicotine gum, patch, nasal spray or inhaler, bupropion sustained release (an anti-depressant prescription medication also known as Zyban) and varenicline tartrate (or Champix). NRTs do not contain any of the harmful chemicals in cigarettes and most people can take them to satisfy their oral cravings and the handling aspects of smoking.²⁰ Guidelines for Smoking Cessation produced by the National Advisory Committee on Health and Disability in New Zealand recommends that NRT be prescribed when the smoker:

- Is motivated to quit.
- Agrees to 100% cessation, quit date and follow up.
- Smokes more than 10 cigarettes (half a pack) per day.
- Understands the benefits and risks and agrees to use NRT.²¹

Started in 2005, the Stop Smoking Therapy for Ontario Patients (STOP) Study led by the Centre for Addictions and Mental Health (CAMH), in partnership with the Ontario Ministry of Health Promotion, is a study of the effectiveness of nicotine replacement therapy in Ontario smokers. Nicotine patches, gum and other forms of NRT are distributed in order to make NRTs more accessible to smokers. The STOP Study is being implemented in several Aboriginal communities across Ontario. Two distribution models are being tested.

One model involves having health centres administer the program by identifying and recruiting participants and having their health practitioners, including nurse practitioners and physicians, provide brief counseling sessions as they are dispensing the NRT. Participants receive two or three brief counseling interventions at varied stages of the study. A counseling protocol including tips and pointers is provided by the STOP study team. Health centres involved in this method have generally provided training to their practitioners such as the Training Enhancement in Applied Cessation Counselling and Health (TEACH) program at CAMH. Participants are followed up six months after the completion of their 10 week course with their NRT.

The other model is entitled “Stop on the Road” and differs in that participants are recruited by the Aboriginal health centre staff but the health centre does not dispense the NRT nor provide any associated counseling. Participants attend a 30 minute information presentation conducted by the STOP study team at the initiation of the program. They are also followed at varying intervals over the 10 week period and again after six months. Although other distribution models are being tested as well, these two are the primary ones targeted for evaluation amongst the Aboriginal population.

Wabano Centre for Aboriginal Health and the Mohawk Council of Akwesasne are implementing the STOP study in the first format described above which entails providing counseling. Other communities and health centres such as De dwa da dehs nye>s in Hamilton, the Noojmowin Teg Health Centre on Manitoulin Island and Mniyeya North Shore Tribal Council are making NRTs available to their client populations in the Stop on the Road format.

In addition to offering NRT, Wabano also implemented cultural-based group counseling and support program entitled “Sacred Smoke”. A detailed program description, evaluation findings and lessons learned from Sacred Smoke are provided.

Program Description

Sacred Smoke is an eight-week, eight-module facilitated group education and counseling program aimed at providing prospective quitters with knowledge, information, skills and peer support to assist their effort at smoking cessation. A program manual comprised of a facilitator's guide, teaching objectives, presentation materials, handouts and worksheets is followed when administering the program. The manual is a key resource for implementing this program.

This eight-week group smoking cessation harm reduction program was adapted by Wabano in 2003/2004 from an eight-week smoking cessation program currently offered by Ottawa Public Health called, Accessible Chances for Everyone to Stop Smoking Program (ACCESS). Wabano adapted the program based on input and advice from local community elders. In 2004/2005 and 2005/2006, Cancer Care Ontario provided financial support to Wabano to evaluate the effectiveness of the program. Program results, recommendations for improving the program and suggested promising practices were identified in the May 2005 evaluation report.

Although funding support was no longer provided at the end of the pilot phase of the project, the program continues to be offered to clients in fall and winter sessions at Wabano. The task of organizing and facilitating the program has typically been given to existing staff within the centre such as the Fetal Alcohol Spectrum Disorder Coordinator or the Health Promoter.

Group smoking cessation activities are increasingly being integrated into existing programming through youth groups, employment programs, pregnancy outreach, and parenting programs, therefore increasing access to supplies, guest speakers, transportation, rentals, meals and snacks – all significant considerations in Aboriginal communities or organizations with limited human and financial resources.

Key Program Elements

Each module incorporates the Seven Grandfather Teachings of bravery, honesty, respect, humility, love, wisdom and truth. The teachings are used to help guide individuals through the process and challenge of quitting smoking. As identified in the literature cessation programs need to be culturally appropriate to ensure relevance. The World Health Organization states that, "treatment should be adapted to local conditions and cultures, and tailored to individual preferences and needs." (p. 29) Because the Ottawa Aboriginal community has large Inuit and Métis contingents, Medicine Wheel teachings are not included though teachings about tobacco and how traditional uses differ from commercial uses and abuses of tobacco are discussed. As First Nations, Inuit and Métis communities and organizations demonstrate diversity in culture, it is especially important to customize cessation interventions to suit the differing needs of the three Aboriginal peoples of Canada. Similarly, the culture of urban Aboriginal populations differs greatly from that of First Nations, Métis settlements, and other rural communities. Marriot and Mable (2002) during their review of *Aboriginal*

Tobacco Control: Promising Strategies and Potential for Best Practices found that, “cultural sensitivity and appropriateness in community processes for tobacco control is recognized as an important component of success...” (p. 11)

The modules covered in Sacred Smoke include such topics as:

- Health risks associated with smoking and health benefits associated with quitting.
- Self assessment and personal motivations, hopes and fears about quitting.
- Nicotine replacement therapies.
- Family, friends and environment, seeking support.
- Alternative stress-management techniques.
- Tobacco habits and triggers.
- Coping strategies, skills and behaviours to avoid smoking.
- Fagerstrom Test for nicotine dependence.
- How to cut down and cope with pressures to smoke.
- Quit plan development.
- Tobacco addiction, chemicals in cigarettes.
- How to self-manage the physical symptoms of withdrawal.
- Emotional changes involved in smoking cessation.
- Practical smoking cessation tools such as quit plans, tracking sheets for cigarettes and smoking habits, self-assessment and evaluation tools, medicine bags, peer support, and journaling.

The program incorporates a wholistic approach by:

- Blending current information about the physical aspects of smoking and cessation.
- Providing knowledge and self awareness of the emotional response to a smoking cessation effort.
- Supporting the participant mentally and spiritually through a group counselling and peer support environment involving elders and traditional teachings.

A study including 20 focus groups with non-reservation, American Indian youth in Oklahoma, concluded that social support was effective. Grandparents played an important role in anti-smoking messages and tend to focus on the long-term health effects rather than the short-term impacts (Kegler et al, 2000). This research supports the view of Dr. Dean Ornish who studied the powerful influence of love, intimacy and community connection in health (1998):

Loneliness and isolation affect our health in several ways...they increase the likelihood that we may engage in behaviours like smoking and overeating that adversely affect our health and decrease the likelihood that we will make lifestyle choices that are life-enhancing rather than self-destructive.

As was identified by the British Columbia Ministry of Health and Ministry Responsible for Seniors, Dr. Ornish's views echo those of Aboriginal elders and healers who make a strong argument for developing tobacco reduction interventions that promote community, connection and meaning. "Many Aboriginal elders and healers believe that a reconnection to culture, community and spirituality is healing for Aboriginal people....The success of (substance abuse treatment) programs using this philosophy/strategy has been phenomenal."²²

Client Eligibility/Accessibility

The program is typically promoted through posters and flyers at the Wabano Centre for Aboriginal Health and other Aboriginal partners and organizations in the Ottawa area, in addition to sending out e-mails. Practitioners and service providers within the centre also actively promote the program amongst their smoking clients and encourage their participation. Other participants learn of the program by word of mouth. Taking a community approach to cessation interventions as Wabano has done is also consistent with research findings on effective program coordination.

Each session typically involves between six and eight adult participants which is a group size they find manageable. There are no eligibility criteria other than the participants' wish to attempt a smoking cessation effort or simply cut down. The program is not aimed at any particular target groups though the program coordinators do have some youth in their program and they recognize that special cessation interventions for youth and pregnant mothers would be preferable, as indicated in the research, but this is beyond their resource capacity at present explaining, "it is a big effort to tailor the program and manual to their groups as they all have very different needs and perspectives."

Wabano staff is aware of a number of capacity issues involved in designing a special intervention, they state: "you keep doing one year programs and you lose staff, then you lose any trust and relationships you have built with the youth – they do promote by word of mouth if it is a good program that they like." They have found success in working with youth by taking the kids out on the land, to beaches, to camp, bowling, or to cybercafés, etc., and making links to healthy sexuality, drugs and alcohol, so that they will be "too busy feeling good and not want to smoke" (which is supported by literature review and Wabano's evaluation about program integration). In focus groups conducted by Valentine et al (2003), young research subjects suggested cessation strategies that include participation in recreational activities, positive role models, and a media campaign that focuses on the negative health consequences of tobacco use. Again, these youth had concerns about experiencing withdrawal symptoms and a lack of social support within families and among peers.

Staff have also discovered they must be indirect in teaching the youth about the benefits tobacco cessation and advise others to use a "back-door" approach, much like that used by the Ontario Federation of Indian Friendship Centres Community Activator in the healthy lifestyle programming. Their strategy is to educate seniors about the harmful

effects of tobacco during weekly exercise classes. Seniors at Wabano's programs enjoy the classes so much they will attend even when there are snow storms.

To mitigate any barriers to participation, Wabano recognized the need for a number of supportive measures including:

- Offering childcare onsite for group participants that need it or to provide money for individuals to arrange their own childcare.
- Ensuring that food and refreshments are provided to participants.
- Providing bus tickets for those participants who do not have a vehicle for transportation.
- Offering the session in the evenings to accommodate participant schedules.

Depending on the group cohesiveness and the participants' commitment level, completion rates varied. One session saw a 90% completion rate while other sessions saw large attrition with two of eight participants completing the session. When referrals are made to other service organizations, individual client follow-up is rarely done due to caseload and workload – a not uncommon aspect of community health in Aboriginal communities.

The program length of eight weeks was identified as perhaps too long for some participants and it has thus been shortened to a more condensed version of six weeks. Nonetheless, external factors such as weather, school breaks, and holidays continue to affect participant attendance and completion. These issues are consistent with research findings on the challenges of delivering group cessation interventions.

There are other considerations to note in regards to adapting intervention strategies to suit the Aboriginal population. Attracting participants and minimizing attrition rates are challenges for group-based counseling programs but research on special populations and participation in group health programs has found the following barriers:

- Problems accessing health services
- Inconvenience
- Preference to deal with the issue on their own rather than seeking professional help
- Language barriers
- Distrust in people not from their own ethnic group
- Lack of time (U.S. Department of Health and Human Services, 1998)

Program Evaluation

To prepare for project evaluation, a one-day training and orientation session was held for pilot project staff where a work plan was reviewed along with a plan for program record keeping. A project assessment and evaluation plan was developed by project staff and executed by a consultant, however, no formal tobacco cessation training was provided to staff for this project.

In the normal course of program implementation, participants completed a questionnaire both before and after the program. Facilitators also conducted a self assessment and tracked program statistics such as attendance and results. This information was entered on the Health Screen electronic medical records systems and provided Wabano with a general sense of the number of sessions or units of service offered as well as number of participants and encounters.

In addition, at each weekly session, the facilitator lead a participant Talking Circle or “check in.” It helped the facilitators identify any issues participants were encountering and provided them with direction as to any program changes that needed to be addressed or additional supports needed for the program participants. This practice is supported by cessation intervention literature.

Interview questions were developed for evaluation purposes. Each program facilitator engaged in a reflective process of self and program assessment. The evaluation report explains that “staff observation of participant progress, program notes, ongoing participant satisfaction/progress surveys and referral/case management processes were also used to assess program impact.”

At the end of the pilot project, five, one-hour individual interviews and one, one-hour teleconference focus group were held. Feedback included recommendations for program improvement. Preliminary and final evaluation reports were prepared. Evaluation aimed at addressing the following questions:

1. Is the cultural component relevant?
2. Do our methods and approaches promote increased self-management of health and reduce risks?
3. What is the level of cooperation and collaboration among program partners?
4. What impact did this project have on participants, program staff and community members specifically with respect to knowledge levels, attitudes and behavioural changes?
5. What key lessons were learned implementing this project?

Outcomes

In answer to the questions above, the report described positive changes in participants’ knowledge, attitudes and behaviours as important outcomes in community mobilization and awareness in regards to tobacco cessation. Community mobilization enhanced

community capacity and stimulated positive reinforcement of the cessation pilot project participants. From an organizational and administrative point of view, the availability of a program resource that is built on traditional knowledge and incorporates traditional teachings was a real benefit. Project staff confirmed that the cultural component that uses a wholistic approach to learning and personal action was a significant element in the pilot project's success.

In terms of absolute cessation rates, only 10% had quit smoking by the end of the pilot project, however, Wabano used a harm reduction model in which tobacco use reduction and the seeking of other supports for their overall health were considered successes. Although harm reduction as an approach is relatively new and its full impact is not known, there is evidence that a harm reduction approach with pregnant women has the potential to benefit both the mother and the fetus.

Of the 20 individuals who participated in the Sacred Smoke program (at three participating Aboriginal Health Access Centres):

- Five have significantly reduced the amount smoked;
- Eight have plans to quit;
- Two have quit smoking; and
- Ten were referred to other supports or services including medical specialists, general practitioners, addictions services and counseling or parenting programs.²³

The evaluation report also described challenges in implementing the program, lessons learned and areas of promise. In regards to program challenges, the report noted scheduling difficulties, the amount of preparation and planning required, the relative low numbers of participants, the need for in-kind donations to supplement project funding, and the wide breadth of knowledge and skills required of program facilitators.

Wabano is a perfect example of an organization that offers tobacco cessation counseling, but lacks the means to train its staff in Aboriginal tobacco cessation.

Although not clearly elaborated or described in great detail, the most emerging practices identified in the pilot phase of the study included:

- Individual quit plans.
- Elder teachings about traditional uses of tobacco, giving thanks and respecting and caring for the body.
- Factual knowledge about addictions and the process of change.
- Using plain language that everyone can understand, e.g. "quitting," rather than "cessation".
- Linking cessation intervention to physical activity or other health promotion activities.
- Supporting the use of NRTs and encouraging doctors to distribute nicotine patches.

- Using positive role models like youth to children and counselors to youth.
- Providing well-rounded lifestyle change supports (referrals to other programs and activities to help replace unhealthy habits).

Ongoing Lessons and Challenges

Wabano continued to offer Sacred Smoke group sessions after the completion of the pilot project in May 2005. During the period of March 2005 through December 2007, five program intakes were undertaken involving 42 Sacred Smoke weekly group sessions and 386 participant encounters (this represents an average of nine attendees at each of the 42 weekly sessions). This programming placed a large burden on staff and management who had other responsibilities and priorities and these efforts were supported by minimal funding. A number of key observations and insights were made during this time concerning ongoing program implementation and participation - in terms of administration, personnel, organizational capacity and infrastructure, harm reduction approaches, and customizing the program to meet the individual needs of clientele.

1. Staff, in-kind and administrative costs must be recognized by funders and those considering implementing such programs.

The organization and implementation of such a program entails various substantive costs including:

- A dedicated staff member to organize and facilitate the program. The program is typically added to his or her existing work with limited training and orientation provided to the staff member.
- Managerial and finance staff are required to oversee budgets, evaluation, reporting and provide program guidance.
- Administrative support is called upon to prepare and distribute promotional materials.
- The program includes the cost of food and refreshments and their preparation as well as costs associated with transportation and childcare, facility space, and overhead costs.
- Honoraria for elders and traditional resource people as well as the cost of their transportation.
- Time and preparation of other health professionals as guest presenters is also an ancillary cost.

As a rough guideline, it was suggested that organizations should budget \$5 in-kind for every \$1 externally sourced.

2. Knowledgeable and skilled Aboriginal personnel are critical to success of the program.

Wabano has been fortunate in having passionate advocates for smoking cessation involved in this program from its inception. The 2005 evaluation report recognized that

the type of knowledge and skills required of an effective facilitator is also very diverse. This is supported by Wabano's current experience and cessation intervention research findings.

Staff involved must be skilled facilitators who are knowledgeable of traditional teachings and can master a wide array of smoking cessation and health information. Participants agreed that facilitators must be Aboriginal and non-smokers. The personal commitment from program staff to quit and remain smoke-free is critical in order to truly serve as role models in effectively implementing credible cessation interventions. Staff recommends having a health promoter on staff. Continuity is also very important as many participants learn of the program by word-of-mouth from previous participants. This is difficult when, sometimes, staff turnover is unavoidable with programs funded on a short-term basis.

Wabano found that the pilot project strengthened connections among the participating Aboriginal Health Access Centres on both personal and agency levels and awareness levels of important issues like transportation. Thus communications were enhanced for the betterment of health care service delivery in general.

3. Supportive infrastructure and capacity within the organization is key.

Apart from the availability of staff, administrative and managerial support for the program is also important. All of the programs at Wabano are interlinked, meaning that the programs are cross-promoted and referred to one another. For example, the prenatal program can encourage smoking moms to access Sacred Smoke. In a similar fashion, nurse practitioners and physicians in the clinic will encourage their smoking clients to consider the program.

“One thing that makes it work is that there is broader support from the organization as a whole, other practitioners and team members. Apart from the small amount of funding we received towards the project, the only reason it worked was that we had the infrastructure to support it.”
(Aboriginal Cessation Intervention staff, Wabano Centre for Aboriginal Health)

More importantly, there are other services and programs in place to support the participants' cessation attempt such as mental health counseling, the elders and traditional programming and so forth.

As a more concrete example, currently, the organization is engaged in a pilot NRT program funded by the Ministry of Health Promotion (Smoke Free Ontario Strategy). Consequently, medical practitioners are actively screening for smoking and referring prospective participants to Sacred Smoke and suggesting NRT's. In a reciprocal fashion, Sacred Smoke facilitators are able to alert their participants to the availability of the NRT program within the centre to support their cessation efforts.

“In some respects, it’s just like starting a diet, you are almost resigned to the fact that you will fall off your diet, and if failure and shame are attached to the activity then you won’t succeed. But if you look at it in the opposite way – I am going to do more physical activity and you start to feel good about it, then you will have more success in losing the weight. We look at the Sacred Smoke program in the same way – supporting any positive change or attempt!”
(Aboriginal Cessation Intervention staff, Wabano Centre for Aboriginal Health)

4. The program must be positively framed and emphasize harm reduction.

It is recognized that smokers may attempt quitting a number of times before they achieve long-term success. Wabano’s experience highlights the importance of assuming a true harm reduction approach. They emphasize and celebrate any change in smoking awareness and behavior more so than complete cessation. This lessens the chance of blame, shame or guilt by participants.

The Director of Health Services explained in the evaluation report, “success in this type of program can’t be measured by numbers alone,” adding that “someone reducing from a pack of cigarettes to five a day is a success.”

Ultimately, if they quit that’s great but it’s about the process and looking at the whole self; looking at what commercial tobacco is doing to them and to their family members and having people take ownership of their health. Success is the graduation night and seeing people who have reduced the cigarette smoking because of the social supports and social relationships they’ve developed out of that group experience, especially for people in a harm reduction process.

By way of another example, Wabano offers another program at their centre promoting healthy sexuality, safe sex and AIDS awareness. The program is entitled, “Diva Nites” and offers participants a chance to come together to learn more about healthy sexuality in a relaxed, positive and fun environment. Their philosophy is that no one learns in a negative atmosphere, from scare tactics, or when they are feeling badly, so the Diva Nites entail much laughter, good food (chocolate) and positive feedback. This approach is supported by the literature.

In a similar fashion, Sacred Smoke emphasizes the positive outcomes associated with smoking cessation, traditional teachings and supportive sharing more so than the negative messaging and harmful effects of smoking. With all the other issues impacting on their clientele, like mental health issues, children's aid issues, physical violence, etc., support is essential.

In the past year, Wabano has implemented a healthy lifestyle program entitled "Pump and Stretch." Participants of all ages come together for weekly physical activity guided by an Aboriginal fitness instructor who also shares a bit of health information and education. An average of 25 participants took part in these sessions. What has been observed is that participants, on their own, realize that their smoking is impacting their breathing and consequently, their health. At this point, it represents an opportune time for a brief intervention by the Health Promoter to share some information, or suggest the cessation program, the NRT program, and a visit with a health professional or other appropriate referrals.

"You can do a lot if you make it about health promotion – you can do cool things about fitness and linking in your intervention, referral or education."

Over the past two years, Wabano has offered an outdoor health camp for youth during the March Break. Fifty Aboriginal kids aged seven through 17 participate in a week of camping, winter sports, activities and fun outdoor experiences.

"Perhaps because they were out on the land and felt good engaging in fun, physical activities or because they were aware that the young ones were looking up to them, a surprising and unanticipated change happened – the older youth did not smoke."

This unplanned peer mentoring and role modeling is something that the centre would like to foster on a longer term, sustained basis. This could include initiating more joint activities between the older and younger kids who attend programming at the centre. Linking the Little Arrows program (for kids aged 7 to 12) with the Cyber-Café homework club (for youth aged 13 to 17) for more joint activities is one avenue the centre is currently exploring.

Wabano feels the chance of success is better if a system of support is put in place rather than a stand alone, short term program. Sacred Smoke is one program that addresses the education, information, traditional approach and peer mentoring/group counselling components of cessation counselling. Within the centre, support is also offered via the physicians and nurse practitioners who can reinforce with one-on-one counselling and clinical interventions such as NRT. At the same time, clients are able to access one-on-one support through the Health Promoter, Mental Health Counsellor, Elder or other therapist. Health promotion activities also reinforce the message and provide opportunities for physical activity as a method of stress reduction and nutritional advice.

5. Facilitators must respond to the diverse needs of participants.

Wabano recognizes that they serve a very diverse clientele. Ottawa's Aboriginal population encompasses Inuit, Métis and First Nations from all areas of the nation and it is also a very transient population. Traditional teachings differ amongst these groups so for example, some of the teachings around the Medicine Wheel or traditional uses of tobacco may not resonate with groups like the Inuit for whom tobacco is not an indigenous plant.

Additionally, the clientele who access the centre's programs may vary from single young moms or unemployed individuals who can participate during the day to young professionals or parents who are only able to access programs in the evening. In addition, the centre serves a large number of urban Aboriginal homeless. As the centre serves all age groups, education and income levels, it is mindful of the need to avoid offering this program in a "one-size-fits-all" fashion. Programs need to be

"All of our youth are smoking. In particular, young single moms are smoking. For them, smoking is social – they are able to talk and hang out. So it's important to look at the problem holistically. The young single mom is oftentimes poor and very socially isolated. There is no reinforcement, no space, no time to come together to exercise any improvement."

**(Aboriginal Cessation Intervention staff,
Wabano Centre for Aboriginal Health)**

tailored since, "for every single poor mom there is the suburban mom who is affluent." Findings from the literature support this practice without question.

Similarly, urban approaches may differ from those in rural First Nation communities. It has been Wabano's experience that the incorporation of traditional teachings and ceremonies has been a big draw for participants in Sacred Smoke, many of whom have not had exposure to this type of knowledge previously. It serves not only to attract them to the program in the first place, but to reinforce and support their cessation attempt by instilling pride, self-respect and responsibility for their bodies and health. Therefore, a cultural component to the program is fundamental.

Furthermore, Wabano frames its work in a population health approach and recognizes that there may be additional extenuating risk factors that influence a participant's success with the program. This includes influences such as family situations, income, employment level, education and other determinants of health. In fact, the economic circumstances factor prominently for many of their clients.

Wabano's experience points strongly to the need to know cessation clients and their situations and recognize their need for different supports. Similarly, different programs and supports are needed depending on the clients' stage of change.

Recommendations by Wabano Centre for Aboriginal Health

A long term strategic plan is recommended by Wabano for government to support Aboriginal youth cessation intervention implementation and evaluation at the community level over a three-year term with substantial funding (e.g. \$100,000). Given the resources required to deliver effective cessation interventions in the Aboriginal community, yearly project funding does not allow enough time or financial support to an organization like Wabano to make lasting impacts on Aboriginal tobacco cessation.

It is their belief that evidence-based program development and evaluation would allow for better program integration, sustainable staffing and resource allocation and the provision of a variety of NRTs to choose from beyond just the nicotine patch. Once firmly established and tested, these cessation interventions could serve as practical models for others to replicate.

Other recommendations by Wabano to those considering implementing an Aboriginal cessation intervention include:

- Partner with high schools, Health and Wellness programs, or Indian Friendship Centres and increase efforts to link cessation programming to health clients through other programs (e.g. diabetics and those with respiratory problems). Seek volunteers to help run the program. This helps to share the burden placed on resources.
- Start the program in September or January when family schedules return to normal. Offer classes when people are available – day or night.
- Offer a sweat lodge ceremony by a healer at the start and at the end of the program.
- Dedicate staff to the program or ensure training is facilitated by more than one non-smoking staff member, e.g. a nurse and a cultural coordinator.
- Train staff in addictions, tobacco cessation counseling, cultural traditions, grief counseling, and stress management before implementing the intervention. One day of preparation for leading this kind of project is inadequate.
- Use multi-media in classes, for instance traditional tobacco teachings on DVD, and hand out real tobacco samples for discussion.
- Offer food at the classes.

Certainly the cessation intervention approaches taken by Wabano Centre for Aboriginal Health are consistent with those recommended by researchers, as identified in the literature, and serve as an excellent model from which others can learn and follow, if harm reduction is the primary goal.

CESSATION PROGRAM DESIGN FEATURES FOR THE ABORIGINAL POPULATION – SACRED SMOKE MODEL

LENGTH	FORMAT	PURPOSE	CURRICULUM OUTLINE
<ul style="list-style-type: none"> 8 weeks 2 hours per session – one session per week Based on implementing one module per week Discussion of possibly decreasing length of session to 6 weeks 	<ul style="list-style-type: none"> Group education and counseling approach Adapted from the Accessible Chances for Everyone to Stop Smoking Program (ACCESS) in Ottawa by Ottawa Public Health Use of plain language – quitting rather than cessation for example Program integration model 	<ul style="list-style-type: none"> Providing prospective quitters with knowledge, skills and peer support to assist their effort at smoking cessation 	<p>Based on Aboriginal teachings and incorporate the Seven Grandfather Teachings on: bravery, honesty, respect, humility, love, wisdom and truth</p> <p><u>Module Highlights:</u></p> <p>Health risks associated with smoking and health benefits associated with quitting.</p> <p>Self assessment and personal motivations, hopes and fears about quitting.</p> <p>Nicotine replacement therapies.</p> <p>Family, friends and environment, seeking support.</p> <p>Alternative stress-management techniques.</p> <p>Tobacco habits and triggers.</p> <p>Coping strategies, skills and behaviors to avoid smoking.</p> <p>Fagerstrom Test for nicotine dependence.</p> <p>How to cut down and cope with pressures to smoke.</p> <p>Quit plan development.</p> <p>Tobacco addiction, chemicals in cigarettes.</p> <p>How to self-manage the physical symptoms of withdrawal.</p> <p>Emotional changes involved in smoking cessation.</p> <p>Practical smoking cessation tools such as quit plans, tracking sheets for cigarettes and smoking habits, self-assessment and evaluation tools, medicine bags, peer support, and journaling.</p>
<p>SIZE OF GROUP</p> <ul style="list-style-type: none"> 6 to 8 ideal 			
RECRUITMENT	CLIENT SUPPORTS	RESOURCES	
<ul style="list-style-type: none"> Promoted through flyers and posters internally and externally with community partners E-mail notifications to other organizations Internal cross-referrals from other programs Word of mouth referrals from previous/existing clients to the program 	<ul style="list-style-type: none"> Offer childcare Provide transportation to and from Provide food Offer program in the evenings – flexible scheduling Access to pharmacotherapies (NRT) 	<ul style="list-style-type: none"> Program manual comprised of a facilitator’s guide, teaching objectives, presentation materials, handouts and work sheets Knowledgeable and skilled Aboriginal personnel <ul style="list-style-type: none"> Cessation counseling skills Social determinants of health Requires financial and administrative supports 	

Case Study #2

Anishnawbe Mushkiki – Sema Kenjigewin Aboriginal Tobacco Misuse Program

Anishnawbe Mushkiki is an Aboriginal community health centre located in Thunder Bay that is “dedicated to improving the health of Aboriginal people by means of a wholistic approach combining western, traditional, and alternative medicine.”²⁴ The centre provides primary care, health promotion, mental health services and traditional medicine services to all Aboriginal people in Thunder Bay. The centre has been operational for six years.

Program Description

In early 2006, with funds received from the Smoke-Free Ontario Strategy, staff at Anishnawbe Mushkiki conducted focus groups with elders, young adults, pregnant women and children to determine educational needs regarding tobacco education (both prevention and cessation). Findings from the focus groups indicated that cessation programming should be targeted for young adults, youth and women and prevention strategies should be targeted for children.

Curriculum for the Sema Kenjigewin Aboriginal Tobacco Misuse Program was based on Health Canada’s Quit4Life Program and the Medicine Bag Help for Smokers Program developed by the Nechi Institute. The program was implemented in the fall of 2007 as part of the Menodawin Healthy Eating Active Living (HEAL) program. Despite the need to tailor cessation interventions to the specific characteristics of targeted populations and their corresponding social and economic contexts, Greaves et al (2003) cautions that “the transfer of an intervention from one setting to another may reduce its effectiveness if elements are changed or aspects of the materials are culturally inappropriate.”²⁵ Various methods need to be incorporated to properly address these needs. Increased tracking of smoking patterns (including spontaneous quitting), mental health and violence issues, and partner relationships is advised, as are nutritional improvements, physical activity and stress reduction techniques.

Acknowledging the factors that challenge successful cessation is important to relapse prevention and harm-reduction approaches. The research of Greaves et al (2003) resonates with the traditional teachings of the Medicine Wheel, or Life Cycle teachings that are being adapted for use by Aboriginal health services nation wide to empower Aboriginal communities and organizations to address cessation while keeping culture intact.²⁶

The Sema Kenjigewin Aboriginal Tobacco Misuse Program is a 12-week facilitated group counselling program aimed at changing the behaviour of those who misuse commercial tobacco. Based on the Medicine Wheel teachings, it provides a framework that is relevant to Aboriginal people. In the document *Honouring Our Health: An Aboriginal Tobacco Strategy for British Columbia*, some of the best practice suggestions were to adapt resources to suit community/cultural needs; for instance, include elders

and cultural advisors in the development and delivery of programs, and ensure programs are culturally appropriate, such as using Talking Circles. In First Nations applications, the traditional use of tobacco may very well need to be addressed in tobacco cessation programs (Schwartz, 2005 and Reading and Allard, 1999). Cessation programs customized to First Nations people would, therefore, include information on the spiritual use of tobacco in comparison to commercial tobacco.

The resource manual which includes the curriculum outline with lesson objectives, materials and supplies needed, presentation materials, handouts and worksheets is a key resource for operating this program.

Key Program Elements

Participants met for two hours per week to discuss a range of topics including:

- Traditional versus commercial tobacco
- Health effects of smoking
- Reasons why people smoke
- Challenges of quitting
- Dealing with stress and anxiety
- Dealing with withdrawal
- Support systems
- Preparing to quit – action plans
- Staying smoke-free – dealing with sabotage and relapse

Providing a comprehensive and wholistic approach in a positive and supportive learning environment was one of the objectives of this program. During the focus group that was conducted by the researchers, program participants commented that the program was very informal and casual, “not like being in a class at all.”

Client Eligibility/Accessibility

The program was promoted through flyers available at Anishnawbe Mushkiki and other health and Aboriginal organizations in Thunder Bay. Some participants learned of the program by word-of-mouth. The program was offered on-site at Anishnawbe Mushkiki in Thunder Bay. The inaugural session, held in the fall of 2007, included six participants, including older adults. The group met once per week for two hours per week for 12 weeks. The final session was a celebration of the participants' accomplishments.

Anishnawbe Mushkiki offered incentives such as healthy snacks, smoking aids such as stress balls, handouts and a grand prize draw, however, the program was unable to provide either childcare or transportation. It was learned during the next intake that none of the 5 potential clients would be able to attend due to the lack of childcare. Anderson et al (2002), who developed clinical practice guidelines for treating tobacco

use and dependence, found three types of counselling and behavioural therapy to be effective:

- Practical counselling that includes problem solving
- Social support as part of the treatment, and
- Social support outside of the treatment.

Social support has a significant influence in tobacco cessation as a person's social environment helps that person to quit and remain a non-smoker (de Guia et al, 2000; McDonald, 2003). For the purposes of this case it can be argued that social supports needs to encompass such factors as: access to safe and reliable childcare, transportation to and from the program, referral to other support services and accessibility to pharmacotherapies if desired.

Of the six individuals who started the program, three finished the program and have quit smoking. These individuals were very committed in attending all 12 sessions and asked the facilitator to reschedule some of the sessions to accommodate their work schedules.

The program facilitator has recommended that the program be condensed into an eight-week program by covering two of the topics at one session, in order to make better use of existing resources.

Program Evaluation

Participants were asked to complete a pre-program survey during the first week and a post-program survey during the 12th week to gather baseline data. Data from these surveys show the following about the three participants who completed the program:

- All would recommend the program to a friend.
- All found the program to be informative and supportive.
- The participants would have liked additional speakers for health issues.
- The participants would have liked to be provided with smoking cessation aids (i.e., NRT).
- Since the program ended, all participants have successfully quit smoking (this includes a three month follow-up with participants).

The curriculum developer and program facilitator are currently in the process of completing an evaluation of the entire program.

Focus Group Summary

Three people who had completed the Sema Kenjigewin Tobacco Misuse Program were invited to participate in a focus group to discuss their experience with the cessation program. A series of questions on program logistics, participant motivation, and supports were asked in a group setting (see appendix A for the questions).

Focus group participants stated that their main reason for quitting was for health reasons. As one participant stated, “I was tired of smoking – tired of being addicted.” They also faced pressure from their families to quit smoking. Another incentive to quit was to save money.

All three participants had been smokers for 35 to 40 years and had made numerous attempts to quit smoking using various methods such as “Cold Turkey,” Zyban (bupropion sustained release) and the nicotine patch. One individual had tried quitting six times in the last 10 years; another person had tried quitting at least twice; the third tried quitting at least five times. Reasons that these methods didn’t work for them previously were:

- Lack of willpower
- Lack of commitment
- Trying just to please others
- Did not have knowledge base

As part of the cessation program, participants developed and implemented their own personal quit plans and they have all quit smoking. The cessation program helped them by providing information, by providing support (from the facilitator and from the other participants) and by facilitating autonomy and self-efficacy. The information received had a lasting impact and addressed denial.

Another important factor that influenced their experience was the facilitator. The facilitator was Aboriginal and a former smoker so the participants felt as if she understood them. The facilitator made the sessions very personal and made sure that they all had a chance to talk during the sessions. One focus group member explains that, **“Aboriginal people are different. We want to feel like we’re part of the process of helping ourselves.”** This message is clear when talking to Aboriginal people about what they need in a cessation intervention, as found in the literature review.

The sessions were informal and participants could work at their own speed. Participants had support from the facilitator, from each other and from their families in their efforts to quit smoking. Co-workers who smoked were also supportive of their efforts to quit. “Everything was done with love, [which is] one of our teachings.”

The material and exercises that was presented were effective. Examples include participants tracking how frequently they smoked and cost sheets where participants calculated how much money they spend on tobacco products.

The challenges mentioned by participants were the lack of financial support for childcare, transportation, and the cost of nicotine patches (which they all used to help them quit smoking and had tried before). The participants recommended that pharmacotherapies be subsidized. As one participant commented, “It’s cheaper to buy cigarettes than [it is] to buy ‘the patch’ ” and another commented on NRTs, “medical

services only covers them once per lifetime. It's hard to come up with the money for the patch and one box only covers 7 days." These experiences echo those of others lacking funds to access NRTs as discussed in the literature.

A study at the Alaska Native Medical Centre tracked rates of people abstaining from smoking at three month intervals for one year following a tobacco cessation program. The program combined behavioural modification and the use of nicotine patches and showed that long-term abstinence rates were comparable to rates in similar studies (Hensel et al, 1995). However, another study showed that the rate of pharmacotherapy use among First Nations people living in British Columbia was very low (3.8 %) compared to other Canadian smokers. This study by Wardman and Khan (2004) involved the extraction of prescription medicine claims from the 2001 Non-Insured Health Benefits database for nicotine gum, nicotine patch and Bupropion. There may be barriers for Aboriginal people to accessing pharmacotherapy agents due to a lack of information as to the nature of NRTs, their side effects, and their availability, along with a belief that people should not rely on medication to quit smoking. And in another study by Valentine et al (2003), there was a perceived financial barrier and lack of awareness of the availability of pharmacotherapies under non-insured health benefits.

The cultural aspect to the cessation program was important to the participants. In addition to the information on traditional use of tobacco and the Medicine Wheel, every session had a cultural component. Participants and facilitator sat in a circle in which everyone was equal (one of the teachings); food was provided; elders came in to speak; and there was a lot of laughter. Participants were encouraged, not confronted, and they felt that they were not being judged. All of these program elements are consistent with the cessation intervention recommendations found in the literature review.

During the focus group with program participants who succeeded in quitting smoking at Anishnawbe Mushkiki, two main reasons for quitting were identified. One is that smoking is no longer socially acceptable in Thunder Bay – public places are no longer smoker-friendly. The other is the high cost of smoking. Calculating how much it costs to smoke was a very effective exercise during the program. Therefore it can be speculated that community or regional tobacco control efforts can have an impact on tobacco cessation and this element warrants further investigation. As described by both Anishnawbe Mushkiki and Wabano, there is a strong social aspect to quitting and remaining smoke-free. Children, grandchildren, spouses, and co-workers were supportive of the Anishnawbe Mushkiki participants in their efforts to quit smoking. The program also provided support among the participants and from the program facilitator. This is true of the Sacred Smoke program at Wabano as well.

On-going Lessons and Challenges

The program staff described identical on-going lessons and challenges as those experienced at Sacred Smoke at the Wabano Centre for Aboriginal Health in Ottawa – in terms of administration, personnel, organizational capacity and infrastructure as well as harm reduction approaches.

Funding is essential to meet the wholistic needs of clients, including food, childcare, transportation and guest speaker and Elder honoraria. As one staff person commented, “You can’t run this kind of program on a shoestring – it’s expensive.”

A dedicated staff person is essential to deliver the program. Adding this type of responsibility to someone’s normal duties is simply not practical. The program facilitator recommended offering the program on an outreach basis, going to where the people are rather than expecting them to come to a centre, but this would take additional time and staff. Anishnawbe Mushkiki had an experienced curriculum developer and a very knowledgeable program facilitator with a health background. The facilitator, Aboriginal and a former smoker, made effective links with the clientele on a personal basis.

“My role is to act as the resource person, the person that provides the information and who’s there as a support person. But not necessarily somebody that’s demanding people to quit smoking and scaring people with the health effects. You don’t want to scare people away. They come to you because they want support and they need your help and that’s the environment I create for this program.”
(Aboriginal Cessation Intervention staff, Anishnawbe Mushkiki)

Focus group participants thought the experience was very positive compared to the interventions with their family physicians and in one instance, a Tobacco Cessation Specialist. The facilitator provided information but let the participants decide for themselves if they were going to quit – participants felt that this was important.

The participants knew that smoking was not healthy but they had tuned out the messages in the media and ignored pictures and warnings on cigarette packages. Self-efficacy and autonomy was very important to the participants - they quit because they wanted to not because someone had told them to.

Recommendations by Anishnawbe Mushkiki

Anishnawbe Mushkiki identified sustainability as an overarching challenge in their programming experience. They developed curriculum and invested money to train a staff person to implement a tobacco cessation program, however, the organization could not sustain the program due to lack of funding. Staff reiterates the need for more long-term support from government:

If we were able to sustain or obtain financial funds from the government I imagine that this program would work. Providing that we had funds for

resource people, providing that we had funds to sustain the program and also to provide smoking cessation aids would benefit this program a little better.

The dramatic results of the STOP Study are significant and help support what is being said by the staff at Anishnawbe Mushkiki. The results revealed an improvement between two and four times the typical quitting rates. At least 12% of participants had successfully quit smoking and remained abstinent for six months as a direct result of the nicotine replacement therapy supplied by CAMH. This compares with normal quit rates of 7% for Ontarians under the age of 45, and 3% for those over 45 years of age. The STOP Study showed success on the 'hard to treat' population (Centre for Addiction and Mental Health, 2007). "We're proud that 1,600 Ontarians have successfully quit smoking because of the STOP Study," says the Clinical Director of Addiction Programs, CAMH and Principal Investigator of the STOP Study. Studies reveal that attempts to quit smoking are more successful when done with the help of a nicotine cessation aid. Unfortunately, many people do not use this resource, partially due to cost. By demonstrating the numbers who quit when provided with free access to NRTs, the STOP Study shows that access is a significant factor. Anishnawbe Mushkiki's desire of wanting to offer NRT is consistent with literature results that these methods can have positive benefit especially in coordination with counseling.

For future reference it is mentioned that their 12-week program be shortened to eight weeks, a decision much like that of Wabano. What remains unknown is whether Anishnawbe Mushkiki would have had a 50% success rate of absolute cessation had the program been shorter than 12 weeks. If the six-week program is offered in the future, it is suggested that quit rates be compared between the two models to determine any changes in outcomes.

Practicalities aside, the approaches taken to delivering Sema Kenjigewin meet with the suggestions identified in the literature review. When compared in conjunction to those of Sacred Smoke, present another credible model for others to learn from and follow in Aboriginal tobacco cessation.

CESSATION PROGRAM DESIGN FEATURES FOR THE ABORIGINAL POPULATION – SEMA KENJIGEWIN MODEL

LENGTH	FORMAT		CURRICULUM OUTLINE
<ul style="list-style-type: none"> • 12 weeks • One session per week at two hours each session • Recommending that the program be condensed to an 8 week format 	<ul style="list-style-type: none"> • Facilitated group counseling program • Adapted from the Health Canada's Quit4Life Program and the Medicine Bag Help for Smokers Program developed by Nechi Institute • Medicine Wheel approach • Program was implemented as part of the Menodawin Healthy Eating Active Living (HEAL) program <ul style="list-style-type: none"> ◦ Program integration approach • Providing a comprehensive and wholistic approach in a positive and supportive learning environment – promotion of self-efficacy and autonomy • Sessions were informal and participants could work at their own speed when completing the exercises • sessions conducted in a circle, rather than a classroom setting, elders came in to speak, food was offered, and there was lots of laughter which is the hallmark of a comfortable environment conducive to learning in Aboriginal communities 		<p>Participants met for two hours per week to discuss a range of topics including:</p> <ul style="list-style-type: none"> • Traditional versus commercial tobacco • Health effects of smoking • Reasons why people smoke • Challenges of quitting • Dealing with stress and anxiety • Dealing with withdrawal • Support systems • Preparing to quit – action plans • Staying smoke-free – dealing with sabotage and relapse
SIZE OF GROUP			
<ul style="list-style-type: none"> • 6 to 10 ideal 			
PURPOSE			
<ul style="list-style-type: none"> • Aimed at changing the behaviour of those who misuse commercial tobacco 	CLIENT SUPPORTS	RESOURCES	
<ul style="list-style-type: none"> • Promoted through flyers in organization and with external partners /organizations • Word of mouth 	<ul style="list-style-type: none"> • access to safe and reliable childcare • transportation to and from the program • referral to other support services and accessibility to pharmacotherapies if desired • use of small-scale incentives for participants such as: stress balls 	<ul style="list-style-type: none"> • access to positive role-models <ul style="list-style-type: none"> ◦ facilitator was Aboriginal and was a previous smoker • involvement of Elder's • access to guest speakers • requires a full-time cessation counselor to deliver • incorporation of interactive learning tools 	

LESSONS LEARNED

Smoking rates among Aboriginal peoples differ from the general Canadian population, and Aboriginal peoples in Ontario have differing rates and risks associated with cancer. Literature confirms that smoking rates for Aboriginal youth and pregnant women are of significant concern. Nicotine addiction, easy access to tax-free tobacco, social acceptance of smoking, lack of education around tobacco use, and cultural traditions are all risk factors in Aboriginal tobacco cessation. Language, cessation intervention access (both physical and financial), and competing community priorities present barriers to participation in cessation interventions as well. As effective as mainstream tobacco cessation interventions are with the general population, they have limited success in the Aboriginal population, necessitating the need for tobacco cessation interventions tailored for Aboriginal communities.

Research Findings on Aboriginal Tobacco Cessation

Research on the effectiveness of Aboriginal tobacco cessation interventions reveal, emerging, as opposed to “best” or “promising,” practices due to limited information (in terms of studies that are recent, scientifically valid and incorporate the Canadian context). Information that was uncovered on existing Aboriginal tobacco cessation interventions through the literature review and environmental scan provided evidence of success using a combination of approaches customized to the unique needs of the respective individuals and communities, whether urban, rural, First Nations, Inuit or Métis.

The First Nations and Inuit Tobacco Control Strategy designed specifically to accommodate the needs of Aboriginal populations identified Aboriginal Elders, tobacco control workers, educators, and health practitioners as being members of the communities with a stake in Aboriginal tobacco control. Aboriginal health organizations have similarly identified a role for parents, children, grandparents and other family members to join together in Aboriginal tobacco control, for protective, preventive and cessation purposes combined. This multi-pronged approach to health care is supported by the Smoke-Free Ontario Strategy.

Aboriginal Culture and Tobacco

In terms of cessation intervention design and development for Aboriginal populations, it is critical to ensure smoking cessation programs are reflective of local community culture; however, it is important to note that cultural appropriateness may mean different things depending on the local community.

Traditional teachings about the differences between the sacred uses of tobacco and the misuse of commercial tobacco, while positive and inspirational to many do not resonate with all Aboriginal smokers and are new concepts to some as noted by focus group

participants. “A strategy rooted in traditional tobacco beliefs would not necessarily influence community members following Christian beliefs.”²⁷ Therefore, it is important to consult widely with the smoking community as well as Elders to ensure that programming appeals to a wide cross-section of community members.

Aboriginal Tobacco Cessation Intervention Models

Of the very few Aboriginal cessation projects identified through the environmental scan, Sacred Smoke, from Wabano Centre for Aboriginal Health, and Sema Kenjigewin Aboriginal Tobacco Misuse Program, from Anishnawbe Mushkiki, present emerging practices which can be potentially replicated and/or adapted for Aboriginal populations. Both Aboriginal and non-Aboriginal health delivery agencies would find these cessation interventions of interest, and though they were designed to address Aboriginal tobacco cessation in an urban setting, First Nations and other rural applications are possible with modifications. In fact, with increased resources, staff from these interventions would prefer increased networking opportunities between urban and First Nations communities than is presently being done.

In a wholistic sense, Sacred Smoke and Sema Kenjigewin Aboriginal Tobacco Misuse Program present emerging practices, as they respond to the emotional, physical, social and mental needs of Aboriginal smokers. These projects were designed with Aboriginal cultural and social relevance in mind and, as such, incorporate curriculum, teaching strategies, and counseling methodologies in keeping with Aboriginal values and observant of Aboriginal literacy levels, lifestyle, community behaviour, and family income levels.

Physical exercise was linked to both of the interventions for a variety of reasons, and this practice was successful in engaging smokers and non-smokers in learning about health and the impacts of smoking. Wabano complimented the Ontario Federation of Indian Friendship Centres on its “back door” approach to tobacco cessation with seniors by incorporating cessation curriculum into existing recreation programs (aquatics, aerobics, etc).²⁸

Further, use of the Medicine Wheel, Elders, talking circles, and other traditional teachings supports literature findings on the importance of taking a long-term, ‘blanket’ approach to cessation - in recognition of the fact that change in behaviour on individual and community levels does not take place in a vacuum. Smoking withdrawal symptoms can undermine progress in any smoking cessation intervention or program, thus requiring ongoing support for smokers.

Tobacco Cessation Interventions

Approaches to cessation that have not yet been thoroughly studied in the Aboriginal population but offer great potential for adaptation include brief clinical and intensive interventions. Brief clinical interventions are generally coordinated to take place at each health appointment with a health care provider who asks clients whether or not they use

tobacco, and if they do, they are advised to quit. In a First Nations example, brief clinical interventions could involve a joint effort by all health care workers (dentists, nurses, doctors, and community health representatives, etc., combined) to conduct brief clinical interventions of all clients at each health care appointment by using the 5 A's (Ask, Advise, Assess, Assist and Arrange) and the 5 R's (Relevance, Risks, Rewards, Roadblocks and Repetitions). According to Dr. Lee Jong-Wook, former Director-General of the World Health Organization:

Doctors, nurses, midwives, dentists, pharmacists, chiropractors, psychologists, and all other professionals dedicated to health can help people change their behaviour. They are on the frontline of the tobacco epidemic and collectively speak to millions of people. (2008, pg 31)

The delivery of consistent joint tobacco screening by health care workers has numerous benefits:

- Creates a better informed community about the impact of smoking on one's overall health as well as that of the community as a whole
- Addresses the goals of prevention, protection and cessation
- Addresses the social acceptance of smoking in Aboriginal communities through the encouragement of denormalization, in keeping with the Federal Tobacco Control Strategy
- Increases opportunities for harm reduction, in keeping with the National Tobacco Control Strategy
- Improves tobacco cessation intervention resource efficiency (human, financial, and physical)
- Allows opportunities to reach all target groups (such as youth and pregnant women smokers)

This best-practice advice is supported by the U.S. Centers for Disease Control and Prevention (2007) which suggests that all patients be screened for tobacco use and be offered more intensive counselling and approved medications. The CDC (2007) reports that results of a survey by the CTUMS in 2005 indicate that only half of those smokers who were surveyed and who had visited health-care providers in the previous 12 months had received smoking-cessation advice. However, when provided, cessation advice can increase smoking cessation rates from approximately 5 to 10%, and when professionals follow up with patients, the rate doubles (CDC, 2007).

Even brief interventions by healthcare providers can help adult smokers to quit (CDC, 2007). Doctors and other healthcare professionals using multiple types of intervention to deliver individualized advice on multiple occasions produce the best results. Frequent and consistent interventions over time are more important than the type of intervention.²⁹

Brief clinical interventions result in a small but significant increase in the odds of quitting. One study found that physician advice is more effective if the client has another

existing disease (de Guia et al, 2000). The clinical practice guidelines for treating tobacco use and dependence (updated by Anderson et al, 2002) suggest that all health-care practitioners should, at minimum, provide every client who is interested in quitting smoking with a brief intervention called the 5 A's (Ask, Advise, Assist and Arrange).

In terms of more intensive cessation interventions, practical counseling for individuals and groups in an Aboriginal community or organization might take place using wholistic means through schools, health agencies, community centres, or Friendship Centres during days and evenings, weekdays and weekends. The delivery of cessation counseling has numerous benefits:

- Provides individualized cessation support
- Encourages social support within the treatment which can extend between clients outside the counseling sessions
- Creates opportunities to use traditional practices for teaching and counseling
- Offers opportunities for traditional tobacco use
- Increases opportunities to customize counseling in different languages and at different reading levels
- Identifies needs for client support with transportation, childcare, nutrition, physical exercise, family violence, mental health, stress reduction, and prescription medicine, thus increasing participation levels
- Allows opportunities to track outcomes and conduct follow-up, improving program assessment and evaluation

Providing a variety of materials, interactive tools, multi-media, and integrating the use of Aboriginal role models who have quit smoking into the program is both practical and effective in either approach.

Challenges to Aboriginal Tobacco Cessation

At both Anishnawbe Mushkiki and Wabano, program participants were encouraged to see their healthcare providers in order to obtain a prescription for pharmacotherapy. All three participants at Anishnawbe Mushkiki used the nicotine patch and strongly recommended that pharmacotherapies should be subsidized and more readily available to program participants. Program developers recognize that clients have difficulty affording this medication and need subsidies to follow the prescription for the proper length of time. Another barrier was access to the program due to wide geographic distances and limited access to transportation.

Regardless of the type of cessation intervention, one major challenge to program delivery in an Aboriginal community or organization is resource availability. All interventions require the use of trained and dedicated staff, easy access to updated and consistent tobacco cessation information, physical space and financing. Inadequate funding led to the shortening of the cessation interventions investigated from their original length of time, contrary to research that has demonstrated tobacco cessation as a long term process of behavioural change.

Certainly any joint efforts between organizations or communities in cessation interventions require leadership and community coordination as well. Information sharing is even more challenging in an urban Aboriginal setting in which health care services are generally delivered by standalone agencies.

Current Program Status

According to the Program Coordinator, Sacred Smoke should be viewed as a smoking-cessation, harm-reduction program and it should run for six weeks. This is reflected in the evaluation results which employed both qualitative as well as quantitative methods. Success is measured through participants' experiences and any type of healthy behavioural change such as a reduction in cigarettes smoked, increased physical activity, healthier food choices, better stress reduction and coping strategies, etc. Therefore, many synergistic activities are happening to "wrap" the participants with the services and support they need. The pilot project funding ended so the centre currently operates the program independently.

The program at Anishnawbe Mushkiki discontinued due to lack of funding. This program was designed based on Medicine Wheel teachings and provided information about the traditional use of tobacco versus commercial tobacco. Participants appreciated not only the information presented by an Elder about traditional tobacco, but also the cultural appropriateness of the program and cited this as a reason why their quit attempts were more successful. Cultural appropriateness relates not only to traditional knowledge or teachings, but the way in which the program was delivered. For example, sessions were conducted in a circle rather than a classroom setting, elders came in to speak, food was offered, and there was lots of laughter. This type of environment is conducive to learning within Aboriginal communities. They would prefer to shorten their program to eight weeks if ever offered again.

Gaps in Knowledge

The present study identified a number of areas in which knowledge is either lacking or inaccessible and requiring further investigation. One of the gaps in knowledge is social marketing in Aboriginal health promotion. Social marketing campaigns can provide affordable, community-driven communication techniques that are relevant, current, and meaningful to specific target audiences (e.g., youth, pregnant women, children, etc.) with the aim of reducing tobacco use and promoting smoke-free lifestyles and environments. While this strategy has shown to be effective in mainstream audiences, little information currently exists to guide Aboriginal tobacco control workers with this approach.

Another identified gap is information on tobacco cessation models geared specifically for Aboriginal youth and pregnant women. Given the limited information pertaining to these groups and the high prevalence of smoking, it is worthy of further investigation.

Cessation counselor training is another topic in which Aboriginal communities appear to need support. Those communities that have implemented cessation interventions have communicated that their staff require certified training. The Training Enhancement in Applied Cessation Counselling and Health Project (TEACH) developed in 2006 by the Centre for Addictions and Mental Health in Toronto, is geared towards training health-care professionals in the public, private and non-profit sectors who provide counselling services to people who use tobacco. The program is designed to enhance the knowledge and skills in the delivery of intensive tobacco cessation interventions. Intensive tobacco dependence treatment can be provided by any suitably trained clinician who has the resources available. Yet few, if any, training programs exist for intensive interventions with specialized populations. Evidence shows that the greater the contact time spent with clinicians, the higher the estimated abstinence rate of the smoker.³⁰ Anything less than eight sessions results in less than a 25% chance of abstinence. As the Project Director explains:

One of the objectives of the TEACH Project is to develop and maintain sustainable knowledge transfer and exchange among professionals in direct clinical practice. Participants who fulfill the TEACH program requirements become part of a provincial Community of Practice group, and will have the opportunity to participate in follow-up trainings, receive regular updates, and network with colleagues who are also engaged in cessation counseling.³¹

The vast majority of attendees in this Project have been nurses, few of which work directly with Aboriginal communities. If the TEACH Project were to do specialized trainings for Aboriginal health practitioners, it would be necessary to integrate knowledge of the complexities, challenges and backgrounds in Aboriginal society in order to appreciate the forces that create unhealthy community environments today.³²

In summary, from what was identified through research as well as the case studies, effective Aboriginal tobacco cessation interventions are characterized by:

1. Reflection of local community culture and language.
2. Provision of current, easy to understand, accurate, relevant information for both smokers and health care workers (with a particular focus on nicotine replacement therapy).
3. Incorporation of interactive learning tools.
4. Use of Aboriginal role models.
5. Engagement of families in prevention, protection, and cessation programming.
6. Acceptance of harm reduction approaches and respect for program participant autonomy.
7. Capacity building at the community level.
8. Sustainability of program investments over the long term.
9. Supports with childcare, transportation, meals, and pharmacotherapies.

IDENTIFICATION OF EMERGING PRACTICES

For Consideration in Aboriginal Program Cessation Design

The main lessons learned in Aboriginal tobacco cessation by program managers and key staff at Wabano and Anishnawbe Mushkiki can be grouped in terms of program design, administration, support, and evaluation.

Program Design

- Observe the diversity of participants and recognize their different interests: First Nations, Métis and Inuit.
- Be cognizant of the various client supports needed regarding family situations, income, employment level, education and other determinants of health.
- Cultural appropriateness makes a difference to participants.
- Keep the classes informal and fun and ensure all participants have the opportunity to speak.
- Elder teachings about traditional uses of tobacco, giving thanks, respecting and caring for the body are important to those who practice traditional First Nations culture.
- Factual knowledge about addictions and the process of change is essential.
- The program must be positively framed and emphasize harm reduction.
- Linkages with other promotional activities provide opportune “teachable moments”.
- Foster autonomy and self-efficacy among participants.
- Individual quit plans are required.
- Accessibility to pharmacotherapies improves chances of success.
- Take a wholistic approach to behavioural change (incorporate emotional, physical, social and mental needs).

Administration

- The development and implementation of a cessation intervention program entails various substantive costs.
- Personnel are critical to the success of the program, and they should be Aboriginal, non-smokers, and trained in cessation counseling, in addition to health promotion, harm reduction approaches, addictions and a familiarity with the traditional uses of tobacco.
- Resources required include dedicated facilitator/ staff, managerial and finance staff, administrative support, food and beverages, transportation, childcare, facility space, overhead, elder honoraria, and guest speaker fees.

- “Wrap-around support”, or integrating tobacco cessation programming with other prevention programming is important (e.g., youth, senior’s, healthy eating active living programs).

Support

- Supportive infrastructure within the organization is key (i.e., each program supports one another through cross referrals, finance, administration and supervisory supports).
- Social support is critical to success.
- Training all health care workers that interact with Aboriginal communities on brief counselling techniques will create a better informed community.
- Capitalize on non-smoker role models, particularly among the youth:
 - Mentoring and role modeling opportunities.

Evaluation

- Qualitative data is equally important to quantitative data in evaluating program outcomes.
- Pre and post evaluations with clients should:
 - Examine smoking behaviours before and after the intervention.
 - Ask participants questions about program design and supports (e.g. is there anything that can be improved upon within the program design itself?).

Model Replication

Adapting smoking cessation interventions to a larger Aboriginal population could be accomplished with primary investment in the cessation training of existing healthcare staff and dedicating additional staff to operate smoking cessation interventions alone.

In terms of priority populations, research confirms that Aboriginal youth tobacco cessation is in need of program development in Ontario, with refinements and research required to properly address the wholistic needs of Aboriginal youth. Programs should be piloted across several sites to determine if they are suitable for further replication.

Some general conclusions to help guide others in the development of Aboriginal tobacco cessation interventions include:

- Implement a system that ensures the smoking status of every patient is routinely collected and is up to date (i.e., current smoker, ex-smoker, non-smoker).
- Establish consensus around which smoking cessation approaches work best with Aboriginal populations.
- Provide culturally and educationally appropriate materials on smoking cessation (including NRTs).
- Arrange smoking cessation training for all healthcare workers.
- Offer smoking cessation support for healthcare workers who smoke.

- Make health facilities smoke-free.
- Network with local smoking cessation providers to aid in establishing relationships and partnerships.
- Contact health and education authorities to collaborate on the collection and sharing of community smoker data.

CESSATION PROGRAM DESIGN FEATURES FOR THE ABORIGINAL POPULATION

Aboriginal Diversity	Cultural Relevance	Program Integration	Program Supports
<ul style="list-style-type: none"> • Be cognizant of diversity within the Aboriginal population <ul style="list-style-type: none"> ○ First Nation, Metis and Inuit ○ On and off reserve • Traditional approaches to tobacco use may not work for some individuals – this will need to be assessed at the onset 	<ul style="list-style-type: none"> • Language considerations (spoken, written and literacy level) • Provide Aboriginal examples to share with clients • Partner with Aboriginal communities or organizations – if possible have someone Aboriginal deliver the cessation program • Incorporate the following domains into the design – physical, mental, emotional and spiritual elements • Educate about the traditional uses of tobacco vs. commercial uses • Involve Elders and role models – Aboriginal people who have quit smoking (cessation) or who have never started (prevention – youth) 	<ul style="list-style-type: none"> • Education about tobacco can be incorporated into many existing program models within the communities such as: <ul style="list-style-type: none"> ○ Youth (prevention) ○ Nutrition or Diabetes (referrals) ○ Cultural programs (traditional uses) ○ Healing and Wellness • Cross referrals among programs are extremely important • Develop a unison process to aid in assessing smoking behaviours and how referrals will be conducted internally to the organization or externally 	<ul style="list-style-type: none"> • Personnel are critical to the success of the program, and they should be Aboriginal, non-smokers, and trained in cessation counseling, among other things such as health promotion, harm reduction approaches, addictions and a familiarity with the traditional uses of tobacco • Resources required include dedicated facilitator/ staff, managerial and finance staff, administrative support, food and beverages, transportation, childcare, facility space, overhead, elder honoraria, and guest speaker fees

CONCLUDING REMARKS

This study initially was commissioned to identify promising practices in Aboriginal tobacco cessation. It was discovered during the literature review and environmental scanning process that not enough information and evidence existed to identify these practices for the Aboriginal population. The objectives of the study then re-focused on examining lessons learned and emerging practices for tobacco cessation efforts. The researcher's utilized the following criteria to aid in identifying emerging practices:

- Minimization of barriers for implementation in Aboriginal communities
- Optimization of replication for the Aboriginal population
- Strength of evidence found within the literature search to support case study findings

The two intensive case studies with Wabano and Anishnawbe Mushkiki aided in identifying lessons learned and emerging practices that warrant further investigation by other researchers. As a result of the in-depth case study approach the following areas of research are suggested for follow up:

- Implementation of the emerging practices identified in this study to determine if the practices identified are easily replicated in other Aboriginal communities or by mainstream cessation program counselors when working with the Aboriginal population.
- Rigorous evaluation designs are recommended to analyze program results. Evaluation design needs to include qualitative as well as quantitative methods.
- As identified in the literature, the impact of tobacco taxes, smoke free policies and environments and the denormalization of smoking cannot be overlooked in the context of any smoking cessation initiative.
- Tobacco cessation programs must be integrated within the larger tobacco control community. At this present time, the author is unaware of population-level strategies pertaining exclusively to the Aboriginal population therefore warranting further research and investigation to determine the impact provincial and federal legislation, jurisdictional issues affect the Aboriginal population.

APPENDICES

Appendix A: Program Manager Interview Guide

Program Development

1. How long has the program been in existence? How has it been funded over the years? How is the program structured?
2. How was this cessation program developed? Who was involved? Were any elders or cultural advisors involved in the development? In the delivery?
3. What cessation program did you use or was one developed specifically? Did you need to adapt it to suit the community?
4. What was the approach? Was it individual counseling or a support group? Were any medical aids used concurrently (ie the patch)?
5. What type of training did you receive to help you deliver this program? Did you have on-going support to assist you in delivering this program?
6. How did people find out about the program (ie posters, referrals)? Were they referred to the program? How did they join?
7. Are there any other tobacco prevention programs going on here in the community/city? Do you have linkages with other programs (Aboriginal and non-Aboriginal)?

Program Implementation

8. Briefly can you describe the program?
9. Was the length of the program too long, too short, or just about right?
10. How often did you meet?
11. Did you have any supports to make it to the program ie travel money, childcare?
12. Were any incentives offered to participants ie a meal?
13. Was the meeting time convenient? Did you have good attendance?
14. Was the location convenient?
15. Was there any form of pre and post assessment or client self-evaluation?

Program Evaluation

16. What are the challenges of running this type of program?
17. What worked well? What was effective? What seemed to work well? What did participants like about the program?
18. What didn't work so well? What could have been done differently? What did participants not like?
19. Did you notice any differences between what worked well for women and what worked well for men?
20. Did the participants complete any evaluations? (obtain copies if possible) From your perspective what are the main things you learned from these evaluations?
21. Do you have any suggestions for best practices or processes that others could learn from?
22. Do you have any other comments or suggestions?

Letter of Information – Program Managers

Best or Promising Practices in Aboriginal Tobacco Cessation

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Purpose of the Study:

We are undertaking research on two projects that deliver tobacco cessation programming to Aboriginal people. It is anticipated that the research will contribute to:

- Identifying best or promising practices in Aboriginal tobacco cessation programming
- Gaining an understanding of the lessons learned in the development and implementation of Aboriginal tobacco cessation programs
- Recommending best or promising practices that can help communities develop effective grassroots strategies for tobacco cessation

Procedures involved in the Research:

We request to conduct a personal interview with you. We will ask you about your program's design, delivery, evaluation and impact on Aboriginal tobacco cessation. If agreeable to you, we will audio-record this interview. We would also like to complete interviews with 4 participants who have completed the program – 2 who have been successful in their tobacco cessation effort and 2 who have not. We will seek your assistance in recruiting these participants. A separate informed consent form will be provided to them.

Potential Harms, Risks or Discomforts:

It is not likely that there will be any harms or discomforts associated with participation. There may be a chance that others who know you well may be able to attribute your quotes to you. For this reason we ask that you only share comments, information or perspectives that you would feel comfortably sharing widely. You do not need to answer questions that make you uncomfortable or that you do not want to answer.

Potential Benefits:**Individual Benefits:**

As a participant you will be given the chance to influence future program improvements on Aboriginal tobacco cessation.

Provincial Benefits:

This research will identify lessons learned and recommendations for improvement that could inform other programs or organizations. It will serve to raise awareness of best or promising practices to assist Aboriginal communities to develop effective grassroots strategies for tobacco cessation.

Payment or Reimbursement:

There will be no payment for your participation.

Confidentiality:

Anything that you say or do in the study will not be attributed to you personally. Anything that we find out about you that could identify you will not be published or disclosed to anyone else, unless we receive your permission. Your privacy will be respected.

The information you share will be summarized along with information obtained from other participants. Only the researchers will have access to the tape recorded interview. The recording will not be shared with the Aboriginal Cancer Care Unit or Cancer Care Ontario. All measures of privacy, confidentiality and security will be respected. This includes keeping the information secured in a locked filing cabinet for a period of at least seven years.

This information will be summarized in a report that will be presented to the Aboriginal Cancer Care Unit at Cancer Care Ontario. The highlights of this report will be presented at a Knowledge Exchange Forum hosted by the Aboriginal Cancer Care Unit on April 3, 2008.

b) Legally Required Disclosure:

Information obtained will be kept confidential to the full extent of the law and we will treat all information provided to us as subject to researcher-participant privilege.

Participation:

Your participation in this study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to stop participating, there will be no consequences to you. If you do not want to answer some of the questions you do not have to, but you can still participate in this project in the future.

Information About the Study Results:

You may obtain information about the results of the study by contacting Theresa Sandy, Project Coordinator, Aboriginal Tobacco Strategy at (416) 971-9800 Ext. 3372. You can request a copy of the research report after it has been received and approved by Cancer Care Ontario.

Highlights of the final report will be shared in a Knowledge Exchange Forum to be held on April 3rd, 2008 in Toronto.

Information about Participating as a Study Subject:

If you have questions or require more information about the study itself, please contact Theresa Sandy, Project Coordinator, Aboriginal Tobacco Strategy at (416) 971-9800 Ext. 3372.

If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact Theresa Sandy, Project Coordinator, Aboriginal Tobacco Strategy at (416) 971-9800 Ext. 3372.

Appendix B: Program Participant Interview Guide

Program logistics – “I’d like to ask some general questions about the program and the kinds of things that made your participation convenient to you.”

1. How did you find out about this tobacco program?
2. How often did you meet?
3. Was the length of the program too long, too short, or just about right?
4. Were you offered any incentives to come to this program ie a meal, travel money, childcare? If YES, what were they? Did it make a difference for you? If not, would that have made a difference to you?
5. Was the meeting time convenient?
6. Was the location convenient?

Participant motivation – “Next, I’d like to talk a bit about how this program helped or did not help you in your tobacco cessation effort.”

7. What made you decide to quit using tobacco?
8. How many times had you tried to quit before? What ways did you use to quit before? Why do you think they didn’t work?
9. How was this experience different from your other attempts to stop smoking?
10. What did you like about this program?
11. What didn’t you like about this program?
12. What could have been done differently to help you stop using tobacco?
13. Would you say that as a result of this program, you were successful in quitting?
14. If so, what was it about this program that made the difference for you?
15. If you were not successful in quitting, would you say it was because the program was not helpful or some other reason?

Other supports – “These next few questions relate to different things that may have supported you in efforts to quit.”

16. What other supports did you have? (ie family, friends, health care providers)
17. What things were helpful to you in helping you quit tobacco?
18. Did the program have a cultural aspect? In what ways was the program culturally appropriate? Was that important to you?
19. Did you use any medical aids during this program? Which one?
 - Nicotine patch
 - Nicotine gum
 - Nicotine inhaler
 - Nicotine nasal spray
 - Bupropion SR
 - Clonidine

Nortriptyline

20. Was it suggested by the program staff to take nicotine replacement?
21. How did you obtain it? (ie health care professional, over the counter, health clinic)
22. Do you think it (nicotine replacement) helped you quit?
23. Do you have any other comments, questions or suggestions?

Letter of Information – Program Participants

Best or Promising Practices in Aboriginal Tobacco Cessation

Investigators: Lorrilee McGregor, M.A.
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Whitefish River First Nation
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Community Based Research
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Email: m_sutherland_7@sympatico.ca

Sponsoring Organization Aboriginal Cancer Care Unit
Cancer Care Ontario
(416) 971-9800

Purpose of the Study:

We are undertaking research on two projects that deliver tobacco cessation programming to Aboriginal people. It is anticipated that the research will contribute to:

- Identifying best or promising practices in Aboriginal tobacco cessation programming
- Gaining an understanding of the lessons learned in the development and implementation of Aboriginal tobacco cessation programs
- Recommending best or promising practices that can help communities develop effective grassroots strategies for tobacco cessation

Procedures involved in the Research:

We request to conduct a personal interview with you. We will ask you about your involvement in the program, factors that contributed to your success in tobacco cessation and factors that inhibited your success. In order to ensure the accuracy of our note-taking we would like to audio-record this interview.

Potential Harms, Risks or Discomforts:

It is not likely that there will be any harms or discomforts associated with participation. There may be a chance that others who know you well may be able to attribute your quotes to you. For this reason we ask that you only share comments, information or perspectives that you would feel comfortably sharing widely. You do not need to answer questions that make you uncomfortable or that you do not want to answer.

Potential Benefits:**Individual Benefits:**

As a participant you will be given the chance to influence future program improvements on Aboriginal tobacco cessation.

Provincial Benefits:

This research will identify lessons learned and recommendations for improvement that could inform other programs or organizations. It will serve to raise awareness of best or promising practices to assist Aboriginal communities to develop effective grassroots strategies for tobacco cessation.

Payment or Reimbursement:

An honorarium of \$50 will be offered upon completion of your voluntary participation in this research study.

Confidentiality:

Anything that you say or do in the study will not be attributed to you personally. Anything that we find out about you that could identify you will not be published or disclosed to anyone else, unless we receive your permission. Your privacy will be respected.

The information you share will be summarized along with information obtained from other participants. Only the researchers will have access to the tape recorded interview. The recording will not be shared with the Aboriginal Cancer Care Unit or Cancer Care Ontario. All measures of privacy, confidentiality and security will be respected. This includes keeping the information secured in a locked filing cabinet for a period of at least seven years.

This information will be summarized in a report that will be presented to the Aboriginal Cancer Care Unit at Cancer Care Ontario. The highlights of this report will be presented at a Knowledge Exchange Forum hosted by the Aboriginal Cancer Care Unit on April 3, 2008.

b) Legally Required Disclosure:

Information obtained will be kept confidential to the full extent of the law and we will treat all information provided to us as subject to researcher-participant privilege.

Participation:

Your participation in this study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to stop participating, there will be no consequences to you. If you do not want to answer some of the questions you do not have to, but you can still participate in this project in the future.

Information About the Study Results:

You may obtain information about the results of the study by contacting Theresa Sandy, Project Coordinator, Aboriginal Tobacco Strategy at (416) 971-9800 Ext. 3372. You can request a copy of the research report after it has been received and approved by Cancer Care Ontario.

Highlights of the final report will be shared in a Knowledge Exchange Forum to be held on April 3rd, 2008 in Toronto.

Information about Participating as a Study Subject:

If you have questions or require more information about the study itself, please contact Theresa Sandy, Project Coordinator, Aboriginal Tobacco Strategy at (416) 971-9800 Ext. 3372.

If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact Theresa Sandy, Project Coordinator, Aboriginal Tobacco Strategy at (416) 971-9800 Ext. 3372.

CONSENT FORM

I have read the information presented in the information letter about a study being conducted by Lorrilee McGregor and Mariette Sutherland of Community Based Research on behalf of Cancer Care Ontario.

I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so. I have been given a copy of this form.

I understand that I am participating in an interview to discuss Aboriginal tobacco cessation programming, development, and implementation.

I consent to the recording of this session.

Date: _____

Signature of Participant

Name of Participant

Appendix C: Research Participant Consent

February 18, 2008

Dear _____:

Subject: **“Best or Promising Practices in Aboriginal Tobacco Cessation”
A Cancer Care Ontario Research Initiative**

Ahnee! Sekoh!

My name is Mariette Sutherland and I am a research associate with Community Based Research based in Whitefish River First Nation. I am writing to introduce myself and Lorrilee McGregor and the research project we are working on and to seek your support and assistance in gathering the information needed for this project.

The Aboriginal Cancer Care Unit at Cancer Care Ontario has initiated a study to identify best or promising practices in Aboriginal tobacco cessation. The objectives of this study are to:

- Identify best or promising practices in Aboriginal tobacco cessation programming
- Gain an understanding of the lessons learned in the development and implementation of Aboriginal tobacco cessation programs
- Recommend best or promising practices that can help communities develop effective grassroots strategies for tobacco cessation

A summary of these best or promising practices will be shared during a presentation at a Knowledge Exchange Forum hosted by the Aboriginal Cancer Care Unit to be held on April 3rd, 2008 in Toronto.

We hope to learn more about the tobacco cessation program that has been offered at the De dwa da dehs nye Aboriginal Health Centre via an in person visit to your project's location and in-depth interview with you.

Additionally, in order to gain as many perspectives as we can to ensure our analysis results in a comprehensive and well-rounded report, we are hoping to conduct personal interviews with a small number (4) of program participants.

We will soon be in touch to seek your assistance in coordinating a convenient time to meet and complete the interviews. In the meantime, I am attaching a letter of

information and informed consent form for your advance perusal. We would be happy to answer any questions you have about this research project.

We look forward to working with you and your organization in completing this very important project. If you have any questions, please do not hesitate to contact either myself at (705) 368-3531 or by email at m_sutherland_7@sympatico.ca or Theresa Sandy, Project Coordinator, Aboriginal Tobacco Strategy at (416) 978-9800 Ext. 3372 or by email at Theresa.Sandy@cancercare.on.ca.

Miigwetch, niawen,

Mariette Sutherland
Community Based Research
Whitefish River First Nation
Birch Island, Ontario
POP 1A0

ENDNOTES

¹ From *Off-reserve Aboriginal Cancer Risk Factors*, by the Quality Council, March, 2008.

² From *Use and Misuse of Tobacco Among Aboriginal People – update 2006* (p. 681), by the Canadian Paediatric Society, *Paediatric Child Health*, Vol 11, No 10, December, 2006.

³ From *Guidelines for Inuit Communities Working on Reducing Tobacco Use* (p. 4), by Pauktuutit Inuit Women's Association of Canada, 1995.

⁴ From Cancer Care Ontario website – Cancer Quality Council of Ontario - <http://www.cancercare.on.ca/english/csqi2008/csqiprevention/csqi-oacrf/> - date obtained June 30, 2008.

⁵ From *Off-reserve Aboriginal Cancer Risk Factors*, by the Quality Council, March, 2008.

⁶ From *STOP Study Helps Ontario Smokers 'Go Weedless:' Nicotine Replacement Therapy Dramatically Improves Quit Rate,* by the Centre for Addiction and Mental Health (2007).

⁷ From *Use and Misuse of Tobacco Among Aboriginal People – update 2006* (p. 681), by the Canadian Paediatric Society, *Paediatric Child Health*, Vol 11, No 10, December, 2006.

⁸ *Ibid.*, (p. 682).

⁹ From *2008 Contraband Tobacco Enforcement Strategy*, by the RCMP, 2008.

¹⁰ From *Taking the Lead for Change: Tobacco Cessation Strategies for Aboriginal Communities* (p. 42), by the National Indian & Inuit Community Health Representatives Organization, 2005.

¹¹ From *Aboriginal Tobacco Control: Promising Strategies and Potential for Best Practices* (p. 13), by Marriot J. and Mable A.L., 2002.

¹² *Op cit.*, Canadian Paediatric Society (p. 682).

¹³ *Op cit.*, National Indian & Inuit Community Health Representatives Organization (p. 22), in *Tobacco Cessation Strategies During Pregnancy and Motherhood: Facilitator's Discussion Guide*.

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²⁰ *Ibid.*, (p. 5-5).

²¹ *Op cit.*, National Advisory Committee on Health and Disability (p. 15).

²² From *Aboriginal Traditions in the Treatment of Substance Abuse*, by R. McCormick, 2000.

²³ From *Sacred Smoke – Building Community Capacity Pilot Project Evaluation Report* (p. 10), by Wabano Centre for Aboriginal Health (2005).

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²⁵ From *Expecting to Quit: A Best Practices Review of Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women* (p. 37), by Greaves, L., Cormier, R., Devries, K., Bottorff, J., Johnson, J., Kirkland, S., and Aboussafy, D., 2003.

²⁶ Op cit., National Indian & Inuit Community Health Representatives Organization (p. 44), in *Taking the Lead for Change*.

²⁷ From the *2006-2007 Progress Report* (p. 11), by the Aboriginal Cancer Care Unit, 2007.

²⁸ From a presentation at the Aboriginal Tobacco Strategy Knowledge Exchange Forum, by the Ontario Federation of Indian Friendship Centres (2008).

²⁸ From *Guidelines for Smoking Cessation* (p. 13), by the National Advisory Committee on Health and Disability, Wellington, New Zealand, 2002.

²⁸ From a presentation at the Aboriginal Tobacco Strategy Knowledge Exchange Forum, by CAMH (2008).

²⁸ Ibid.

²⁸ Ibid.

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³⁰ From a presentation at the Aboriginal Tobacco Strategy Knowledge Exchange Forum, by CAMH (2008).

³¹ Ibid.

³² Ibid.

If you are interested in any information or would like to find out more please feel free to contact our office.

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Please take a look at our website for up-to-date information:

<http://www.cancercare.on.ca/english/home/about/programs/aborstrategy/>

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Cancer Care Ontario is the provincial agency responsible for continually improving cancer services. As the government's cancer advisor, Cancer Care Ontario works to reduce the number of people diagnosed with cancer and make sure that patients receive better care every step of the way.

