Health Canada Santé Canada

First Nations and Inuit Tobacco Control Strategy

Implementation Evaluation Report

Approved by

Departmental Executive Committee on
Finance, Evaluation and Accountability (DEC-FEA)
Health Canada

March 31, 2008

Canada

TABLE OF CONTENTS

Management Response to the Implementation Evaluation of the First Nations and Inuit Tobacco Control Strategy

Background

In April 2001, the federal government announced the five-year $559.8 million Federal Tobacco Control Strategy (FTCS). As part of this strategy, a $50 million budget was allocated for the First Nations and Inuit Tobacco Control Strategy (FNITCS) which was to be managed by the First Nations and Inuit Health Branch (FNIHB). This First Nations and Inuit component of the FTCS was aimed at addressing the high rates of tobacco use in First Nations and Inuit communities.

As part of the accountability requirements for the FNITCS, a formative evaluation was initiated by the Evaluation Firm August Solutions during the 2005/2006 fiscal year. The objective was to determine whether the program had been implemented and managed as intended. Specifically, the evaluation examined how the implementation process was planned versus how the strategy was carried out.

In 2003, the FNITCS was affected by variations in the allocated financial resources through the federal government "1 Billion dollars reallocation initiative" exercise which impacted on the strategy because of emerging priorities. On September 25, 2006, the government announced the results of its expenditure review and one of the implicated programs was the FNITCS. It was decided to gradually eliminate the annual program budget while continuing to provide already engaged contribution funds to First Nations and Inuit communities until the end of 2007-08 fiscal year.

Representatives from the Community Programs Directorate (CPD), the Business, Planning and Management Directorate (BPMD) and Departmental Performance Measurement and Evaluation Directorate (DPMED) reviewed the draft of the final formative evaluation report and made recommendations for changes.

The recommended changes suggested by BPMD and DPMED were reviewed and discussed with the Evaluator. Recommended changes that were feasible included separating information, clarifying the intent of statements, reducing duplication and/or redundant information. However, three of the recommended changes could not be incorporated into the report because they would have required significant revision to the evaluation design. Consequently, it was decided that these three issues would be presented and discussed in a management response. These issues are as follows: (1) the decision to undergo a formative evaluation rather than a summative evaluation, (2) the methodology used to conduct the evaluation, and (3) the establishment of performance indicators and related documents.

Issues

1) Formative (Process) versus Summative (Impact) Evaluation

While the implementation of the Federal Strategy began in 2001, the FNITCS component was still in the planning phase. The evaluation commitment for this program was to have an evaluation of the FTCS completed by the end of year five (2005-06) taking into consideration the one year extension that was granted.

Early in the development of the program framework, FNIHB agreed to use a participatory approach for the planning and delivery of the program. Not only did this process allow for a personalized community-based approach to the delivering of the program, but it also delayed the program's implementation. As a result, the program was not able to initiate a formative evaluation in 2004 as planned. Instead, one took place in 2005-06.

During this period of time, FNIHB undertook a review of its contribution authorities and used the opportunity to streamline its program structure. By adopting a cluster-based approach to programming, the Branch was able to realign programs as well as streamline planning, monitoring and reporting processes. The cluster-based approach was approved by Treasury Board (TB) in March, 2005. In addition, FNIHB reviewed its evaluation commitments and submitted to the Treasury Board Secretariat (TBS) a list of the incomplete evaluations along with a plan on moving FNIHB evaluation commitments into the new cluster-based evaluation strategy. Recognizing that the evaluation of the FNITCS was just beginning, TBS agreed that FNIHB would only require a formative assessment of the program achievements, and that a results and impacts evaluation would be performed as a part of a future Mental Health and Addictions (MHA) cluster evaluation.

2) Methodology

The FNITCS used a decentralized model and participatory approach for the delivery of the program. This format resulted in a variety of models of program implementation. Being qualitative in nature, the main objective of the formative evaluation was to examine the various types of implementation processes across the country and if possible, to contribute to the development of baseline information. Five key methodologies (i.e., site visits, sharing circles (focus groups), in-person interviews, telephone survey, documentation and literature review) were used to collect qualitative data from targeted groups on key evaluation questions to highlight similarities, differences and any comparable issues encountered during the implementation of the program, along with measures taken to correct them over time. Given that the focus of the evaluation was on implementation issues, this evaluation did not intend to produce statistically valid quantitative analysis.

While the sampling frame chosen was limited, the response rates were very good from each group sampled and provided information on the effectiveness of various types of implementation and lessons learned from the various models used to implement the FNITCS.

3) Establishment of performance indicators and related documents for the FNITCS

The FNITCS Program Framework identified success targets as general trends and not as specific quantitative targets to be achieved by a specified date. This was an intentional action on the part of the Framework developers. While the long-term goals of the FNITCS were youth and adult smoking reduction, etc., the initial outcomes of the FNITCS were to address these issues by building community capacity for the development and delivery of tobacco control strategies that meet the needs of specific communities.

The evaluation concluded that for the most part, the performance measurement system and a national information baseline that would focus on outcomes were not established. Consequently, the limited data collection would have made it difficult to measure program results and impacts. It was recommended that performance indicators and an RMAF type document be developed.

While the formative evaluation was taking place, the MHA RMAF covering the program and related performance indicators was in the process of being updated. By the time the draft evaluation report was submitted to MHA, the 2006 version of the RMAF had been finalized and approved internally by FNIHB.

4) Recommendations and Conclusions of the FNITCS Evaluation

The closure of the FNITCS prior to the completion of the final formative evaluation report has implications on how the department will implement or utilize the recommendations and conclusions contained in the report.

FNIHB recognizes that there are valuable lessons to be learned from this formative evaluation and its recommendations. It is suggested that the recommendations be communicated to other community-based programs that are currently being implemented for their consideration. As well, these recommendations can be used to inform any new program development, including any new tobacco control approach to address tobacco use among First Nations and Inuit people.

The recommendations and conclusions from the FNITCS evaluation are listed and described in the Executive Summary and report attached to this response.

First Nations and Inuit

Tobacco Control Strategy

Implementation Evaluation Report

13 March 2007

Prepared for:
First Nations and Inuit Health Branch

Prepared by:
Auguste Solutions & Associates Inc.
- - - - - -
Auguste Barrieau, MBA
James Coflin, MSW
Pierre Barrieau, MSc

TABLE OF CONTENTS

TABLE OF CONTENTS (cont'd)

Page

SECTION 1.0 ACKNOWLEDGEMENTS

This evaluation report of the First Nations and Inuit Tobacco Control Strategy could not have been completed without the first-hand knowledge of First Nations and Inuit Elders and the men and women who deliver tobacco control projects within their communities. Thank you.

We thank all those First Nations and Inuit that warmly received us on their territories, and who actively participated in the evaluation of the First Nations and Inuit Tobacco Control Strategy.

We especially appreciate those many Elders and community representatives who voluntarily took time from their busy schedules and travelled to regional Sharing Circles. Thank you for your contributions.

We also greatly appreciate the 189 First Nations and Inuit project holders who graciously accepted, on a voluntary basis, to participate in an in-depth telephone survey that was designed to gather a greater understanding of the tobacco control projects being delivered within the communities. Thank you for your contributions.

The national and regional First Nations and Inuit Health Branch staff went out of their way to help plan and organize the regional field work, to coordinate First Nations and Inuit travel to the Sharing Circles, and to supply our evaluators with a wide range of documentation and information required to support the evaluation process.

The National Advisory Circle's Evaluation Sub-committee provided valuable information to evaluators, and provided useful comments and suggestions to the drafts and final version of this report. Thank you for your contributions.

I also wish to thank each of the members of the evaluation team who worked on this project: James (Jim) Coflin, Ernie Boyko, Pierre Barrieau, David Saville, Genevieve Richard and Cecile LeBlanc.

Any errors or omissions that may have crept into this report are my responsibility and not the responsibility of the others who contributed to the production of this evaluation report.

We'lalin
Thank you
Merci

Auguste Barrieau, MBA
Evaluation Director
Auguste Solutions & Associates Inc.

SECTION 2.0 EXECUTIVE SUMMARY

2.1 Introduction

The First Nations and Inuit Health Branch's First Nations and Inuit Tobacco Control Strategy is included within the Federal Tobacco Control Strategy's accountability mechanisms. The results of formative (process) evaluation for the First Nations and Inuit Tobacco Control Strategy was to be available by the end of 2005/06. A one year extension to the delivery of evaluation results was given to the Federal Tobacco Control Strategy, and thus also to the First Nations and Inuit Tobacco Control Strategy.

This evaluation report is being delivered about one year after its originally planned date. Additional reasons for the delay of this report were:

- The scope of the evaluation was increased by about 50%, including an increase in the number of First Nations communities to be visited, and a significant expansion of the number of individuals to be included within the in-person and telephone surveys;
- FNIHB's internal management review process of the evaluation had not been included within the original timeline; and
- The closure of the First Nations and Inuit Tobacco Control Strategy prior to the completion of the evaluation added to the complexity and time required to complete the report.

The evaluation was conducted in close collaboration with: (i) Elders and community members from 189 First Nations and Inuit communities; (ii) the First Nations and Inuit Health Branch; and (iii) the National Advisory Circle's Evaluation Sub-committee.

The scope of this evaluation did not include measuring the results and successes of the First Nations and Inuit Tobacco Control Strategy as that will be the focus of the summative (results-based) evaluation to be conducted at a yet-to-be-specified date.

The intended audiences for the conduct of this evaluation are identified within the Request for Proposals (RFP). The evaluation:

> *. . . will serve to inform decision-makers, including health care workers, of the overall efficiency of the program implementation. The results* (of this evaluation) *will influence revisions to the Program, decision-making about how best to work with First Nation and Inuit communities in a participatory manner, and provide recommendations for continuous program improvement.*

The purpose of this formative evaluation is to examine the process of implementing the First Nations and Inuit Tobacco Control Strategy, and to address three evaluation issues: [1]

1. Was the Strategy implemented as proposed in the First Nations and Inuit Tobacco Control Strategy Program Framework?

2. Were success targets, performance measurement indicators and a performance measurement system established that will allow for the evidence-based measurement of the First Nations and Inuit Tobacco Control Strategy's results?

3. Are there ways to improve the delivery of the First Nations and Inuit Tobacco Control Strategy from the perspective of its effectiveness and/or its efficiency?

This evaluation also addresses the *six specific objectives of this evaluation* identified in the Request for Proposal:

1. *To assess how the participatory approach of the FNITCS has been adopted nationally, regionally and at the community level*;

2. *To identify the strengths and challenges of a flexible national framework strategy that is intended to allow the regions and the communities to assess and determine how it promoted the incorporation of best practices.*

3. *To examine specific implementation opportunities and considerations which are different or similar between First Nations and Inuit communities*.

4. *Identify and document various models of delivery and best practices nationally, regionally and at the community level.*

5. *To determine the extent to which regional characteristics and/or the community type have influenced the development, planning and implementation of the FNITCS; how these developments differ from, or are consistent with, the FNITCS original program framework; and were the intended outputs stated in the logic model achieved.*

6. *To assist in the data collection and reporting for the program's five-year comprehensive evaluation by collecting baseline data to enable the creation of a longitudinal design*.

[1] The three evaluation issues were inspired from Treasury Board Secretariat's policies and guidelines on program evaluation and then jointly adapted to the specifics of the First Nations and Inuit Tobacco Control Strategy by the Evaluation Sub-committee, FNIHB and the evaluators.

2.2 Methodologies Employed

The evaluation team visited the First Nations and Inuit Health Branch's eight regional offices, participated in nine Sharing Circles, conducted 101 in-person interviews [2]and surveyed, by telephone, 189 community members involved in the delivery of the First Nations and Inuit Tobacco Control Strategy projects at the community level. The evaluation methodology also included an updated literature review and a document review that comprised about 1,315 documents provided by the First Nations and Inuit Health Branch's national and regional offices.

Participants of the Sharing Circles were selected and invited by the First Nations and Inuit Health Branch's regional staff. Participants were selected because of their knowledge and involvement in the First Nations and Inuit Tobacco Control Strategy. Elders, project holders, First Nations and Inuit Health Branch staff and members of the National Advisory Circle's Evaluation Sub-committee were the principal participants in the Sharing Circles. Their participation was voluntary.

Participation by project holders and First Nations and Inuit Health Branch regional and national staff in the in-person interviews and the telephone survey was voluntary. More than 90% of the project sites were contacted with about 30% of those contacted for the telephone survey deciding that they did not want to participate. Reasons for their decisions not to participate in the telephone survey were not solicited, but some did provide names of other individuals in their community who were in a better position to respond to our questions.

Eight short narrative stories were prepared to illustrate the different types of tobacco control projects funded by the First Nations and Inuit Tobacco Control Strategy. The stories illustrate the variety of tobacco control projects that were designed and implemented. The eight projects were not formally evaluated to determine their relative successes; rather, the stories are presented to provide a better understanding of the work that has been undertaken.

The agreement with the project holders was that their narrative stories would be reviewed within their First Nations communities before the narrative stories would be included within the evaluation report. The cancellation of the First Nations and Inuit Tobacco Control Strategy made the completion of the narrative stories and their review within the First Nations communities impossible. It was decided, and a contract amendment was issued, that the unfinished narrative stories would not be included within this evaluation report, and that instead they would be submitted as draft working papers under separate cover.

[2] Refer to Section 4.2 project interviews.

2.3 Methodological Challenges

Numerous methodological challenges were identified and addressed during the conduct of the evaluation:

- Limited statistical information specific to First Nations and Inuit smoking rates was found, and there were no national smoking-related statistics that covered a multi-year period. This made it difficult to identify trends and possible changes.
- Limited financial expenditure information was found, with information gaps at the regional and national levels, making it impossible to produce an accurate comparison of total expenditures versus allocated budgets.
- The information available to establish a national information baseline was limited. The information that was found: focused upon outputs and not on outcomes; had significant gaps; and was either mostly regional or project-specific. National comparisons could not be made.
- Inuit projects outside of Québec mostly reported to organizations other than the First Nations and Inuit Health Branch. Limited access to that information prevented a comparison between First Nations and Inuit tobacco control projects.
- Gaps were identified in the project-specific documentation that is typically held and maintained by the First Nations and Inuit Health Branch's national and regional offices. This reduced the accuracy and completeness of the comparisons of the processes and practices employed to implement the program.
- Interviews and Sharing Circles were held with representatives of those communities that were successful in obtaining funding for their tobacco control projects. This means that the evaluation lacks comments and suggestions from community representatives who were not successful in obtaining project funding.
- Limited information was found that could be used to compare levels of participation and participatory processes among the First Nations and Inuit Tobacco Control Strategy and other programs and initiatives funded by the First Nations and Inuit Health Branch. The evaluators were not able to fully answer the first evaluation objective.

The impacts of the methodological challenges upon this formative (process) evaluation and potential future summative (results-based) evaluations are:

- **This Evaluation**: The methodological challenges did not seriously impact the overall conduct of this formative (process) evaluation, nor the identification of the global findings presented within this evaluation report, as the primary focus of this report addresses the implementation of the First Nations and Inuit Tobacco Control Strategy

and not the results achieved by the Strategy. The primary negative impact of the methodological challenges is reduced levels of quantitative information to support some of the findings.

- **Future Evaluations**: The lack of national tobacco use statistics specific to First Nations and Inuit, and the lack of a national information baseline focussed on outcomes, will most likely have a major negative impact upon a future summative (resulted-based) evaluation.

2.4 First Nations and the Inuit Tobacco Control Strategy

Health Canada's legislative, regulatory and policy efforts on tobacco control are rooted in the Tobacco Act of 1997 and in regulations which came into effect in June 2000. The focus of the Act was to regulate the manufacture, sale, labelling and promotion of tobacco products in Canada. The Act aims to protect all Canadians, with particular emphasis on youth, from the health consequences of tobacco use.

In April 2001 the federal government announced the Federal Tobacco Control Strategy, with a five-year budget allocation of $559.8 million, as *a framework for a comprehensive, fully integrated and multifaceted approach to tobacco control.*

After discussions with national Aboriginal organizations, Health Canada came to the conclusion that the Federal Tobacco Control Strategy designed for mainstream Canada would not work as well with on-reserve First Nations people nor with Inuit in Inuit communities. It was decided to develop a tobacco control strategy specific to the needs and requirements of First Nations and Inuit communities.

The Program Framework for the First Nations and Inuit component of the Federal Tobacco Control Strategy identified three target populations:

- *First Nations people living on reserves south of 60° latitude;*
- *First Nations communities north of 60° latitude; and*
- *Inuit in Inuit communities.*

Studies conducted/funded by federal government and Aboriginal organizations, indicate that in 2002, the prevalence of smoking among First Nations (59%) and Inuit (66%) was more than double the rate for the rest of Canada (23%). Equally alarming is that 42% of First Nations youth started smoking before the age of 15.[3]

The five-year $559.8 million Federal Tobacco Control Strategy was approved by Treasury Board in 2001. Included was a $50 million budget allocation for the First Nations and Inuit Tobacco Control Strategy which is to be managed by First Nations and Inuit Health Branch. The First Nations and Inuit Tobacco Control Strategy's annual budget allocation was originally established at $6.0 million in the first fiscal year (2001/02), $10.0 million in each of the two following years (2002/03 and 2003/04) and $12 million in each of the last two years (2004/05 and 2005/06).

The First Nations and Inuit Tobacco Control Strategy's Program Framework's program vision is:

> *Healthier First Nations and Inuit Communities free of tobacco misuse and addiction.*

The Program Framework's mission statement is:

> *To promote and support policy, program and project initiatives designed to create healthy First Nations and Inuit communities free of tobacco misuse and addiction.*

The objectives of the First Nations and Inuit Tobacco Control Strategy are as follows:

1. *To build the capacity within First Nations and Inuit communities to develop and deliver comprehensive, culturally sensitive and effective tobacco control programs at a pace acceptable to those communities.*

2. *To promote the health of First Nations and Inuit people by decreasing the prevalence of tobacco smoking and spit tobacco use among all age groups, but in particular among youth and pregnant women.*

3. *To decrease the uptake of smoking among youth. Since smoking in First Nations and Inuit communities starts at a younger age, youth is considered to include children.*

[3] Section 3 of this report provided more detailed statistical information as well as identifying the various sources from which the statistics were obtained.

4. *To decrease the impacts of environmental tobacco smoke on the health of First Nations and Inuit communities.*

5. *To engage the leadership of First Nations and Inuit in learning about, voicing opinions and supporting tobacco control strategies. This program includes Elders as leaders as they are holders of traditional knowledge and their opinions and support will be an important component in developing and building community capacity in Tobacco Control strategies.*

2.5 Roll-out of the First Nations and Inuit Tobacco Control Strategy

The roll-out of the First Nations and Inuit Tobacco Control Strategy was guided by the Program Framework which states that:

> *The First Nations and Inuit Tobacco Control Strategy will be primarily delivered through partnerships between health advocates and service personnel within communities. In the communities partnerships are envisioned among Chief and Council, Community Health Nurses, Community Health Representatives, Community Health Boards, Principals and teachers, Parent and School Boards/Committees, Youth workers, Addictions workers, and community police. Essential to this community-based delivery are supportive partnerships between FNIHB staff and regional First Nations and Inuit organizations and associations.*

The roll-out and management of the program were assisted by National and Regional Advisory Circles, as well as through the participation of seven national Aboriginal Organizations: (i) the Aboriginal Nurses Association of Canada; (ii) the Assembly of First Nations; (iii) the Inuit Tapiriit Kanatami; (iv) the National Aboriginal Health Organization; (v) the National Indian and Inuit Community Health Representative Organization, (vi) the National Native Addictions Partnership Foundation; and (vii) the Pauktuutit Inuit Women of Canada.

The overall First Nations and Inuit Tobacco Control Strategy allocation for each year was determined by the Branch through its annual budget exercise, with approximately 30% of that amount assigned for headquarters operations, national contribution agreements and contracts. The balance is distributed among the regions based on a formula that includes a base amount, community populations and remoteness factors.

The annual allocations do not represent the amount of money that was actually spent on the First Nations and Inuit Tobacco Control Strategy. The interviews with First Nations and Inuit Health Branch personnel, and the analysis of data provided by four regions indicate that actual national

expenditures for the First Nations and Inuit Tobacco Control Strategy in any given year were lower than the amounts allocated; this varied from region to region, and occurred for one or both of the following reasons:

- First Nations and Inuit Health Branch headquarters and/or regional management reassigned a portion of the First Nations and Inuit Tobacco Control Strategy allocation to cover costs for other programs; and/or
- Funds from the approved First Nations and Inuit Tobacco Control Strategy budget were committed for specific projects through contribution agreements during the year, but were not spent because some of the projects reported surpluses, were terminated early, or were never implemented because the funding was approved too late in the year.

The following table, provided to the evaluators by First Nations and Inuit Health Branch, presents the budget allocations. [4]

Table: Budget Allocations in $000s

	2001-02	2002-03	2003-04	2004-05	2005-06	Total
North	511	657	669	744	956	3,537
ATL	411	373	441	780	588	2,593
QC	411	534	656	730	636	2,967
ON	411	679	843	947	1,238	4,118
MB	411	623	761	852	1,105	3,752
SK	411	515	631	701	895	3,153
AB	411	530	620	688	877	3,126
BC	411	565	713	797	1,028	3,514
Regions Totals	3,388	4476	5334	6,239	7,323	26,760
HQ	1,370	1,524	2,366	3,729	3274	12,263
Total	4,758	6,000	7,700	9,968	10,597	$39,023

[4] The scope of the evaluation did not include a financial review. The evaluators used financial information that was provided to them by FNIHB.

2.6 Conclusions

The major conclusions for the three evaluation issues and the six evaluation objectives are:

➥ **Conclusions for the Three Evaluation Issues:**

Issue 1: *Was the Strategy implemented as proposed in the First Nations and Inuit Tobacco Control Strategy Program Framework?*

It was found that the First Nations and Inuit Tobacco Control Strategy was implemented as proposed. Community-based organizations and some partnerships were successfully established to deliver the First Nations and Inuit Tobacco Control Strategy within First Nations and Inuit communities.

Management and administrative processes were observed within FNIHB's national and regional offices. However, not all processes were adequately documented.

It is concluded that the Program Framework and the terms of reference and/or objectives for the Advisory Circles and First Nations and Inuit Health Branch staff need to be updated to focus more on program improvement and delivery now that the program implementation phase has been completed.

Issue 2: *Were success targets, performance measurement indicators and a performance measurement system established that will allow for the evidence-based measurement of the [First Nations and Inuit] Tobacco Control Strategy's results?*

The First Nations and Inuit Tobacco Control Strategy Program Framework identified success targets as general trends, not as specific quantitative targets to be achieved by a specified date.

The study also concluded that, for the most part, the performance measurement system and a national information baseline that focuses on outcomes were not established, making it very difficult to quantifiably measure program results and successes.

An additional conclusion is that the methodologies and sampling processes employed to conduct the Canadian Tobacco Use Monitoring Survey does not include data that identifies respondents as being either First Nations or Inuit. Therefore the Canadian Tobacco Use Monitoring Survey can not be used to help establish the information baseline for the First Nations and Inuit Tobacco Control Strategy.

Comparisons between the results achieved by the Federal Tobacco Control Strategy and the First Nations and Inuit Tobacco Control Strategy are further complicated because: (i) the Federal Tobacco Control Strategy

identified its objectives in specific quantitative terms (see page 22 of this report); whereas (ii) the First Nations and Inuit Health Branch decided that it would express its objectives as either increasing or decreasing trends, and without specifying a target achievement date.

Issue 3: *Are there ways to improve the delivery of the [First Nations and Inuit] Tobacco Control Strategy from the perspective of its effectiveness and/or its efficiency?*

It was concluded that increases in effectiveness and efficiency would best be achieved by having consistent project funding levels provided in a timely manner; providing ongoing training at all levels; and supporting information sharing at all levels.

➥ **Conclusions Relative to the Six Evaluation Objectives:**

Participatory practices were not employed at all levels;

Flexible programming was more suitable for communities with greater readiness and infrastructure for tobacco control programming;

Addressing different cultural and traditional beliefs and practices was the major defining characteristic that distinguishes First Nations and Inuit tobacco control projects;

A best practices process has not been developed; and

Community remoteness was the variable that had the most impact on project costs and implementation effectiveness.

2.7 Recommendations

The recommendations are:

- ❑ Produce and communicate an updated Program Framework and/or other document(s) that will:
  - Define success targets;
  - Present a performance measurement strategy;
  - Present a logic model;

- Outline an evaluation strategy that will allow for the measurement of program results and success; and
- Update the terms of reference and/or objectives for the Advisory Circles and First Nations and Inuit Health Branch staff.

❑ Conduct a management review to address and resolve the funding and structural barriers to the efficient and effective implementation of First Nations and Inuit Tobacco Control Strategy projects.

❑ Establish and populate an information baseline based upon outcomes that will support the management and ongoing evaluation of the First Nations and Inuit Tobacco Control Strategy.

❑ Develop a methodology for the identification and communication of best practices.

SECTION 3.0 BACKGROUND AND CONTEXT

This section of the report introduces the background and sets the context for the development of the First Nations and Inuit Tobacco Control Strategy. It includes:

- An overview of the high incidence of smoking within First Nations and Inuit communities;
- The differences between the traditional uses and the misuses of tobacco; and
- A short description of the First Nations and Inuit Tobacco Control Strategy.

3.1 Smoking in Inuit and First Nations Communities: an Overview

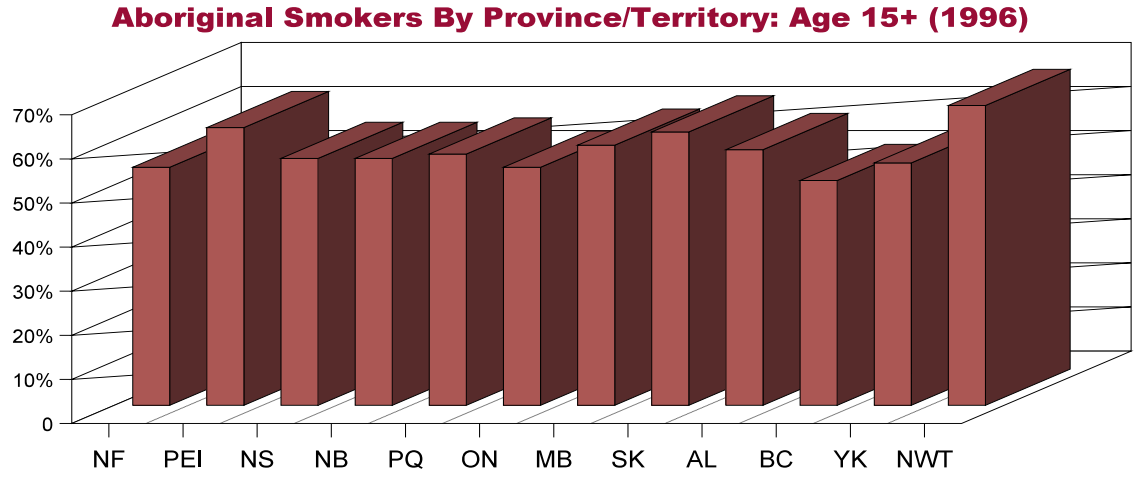
In 1996, Health Canada funded a national survey on the smoking habits of Aboriginal persons, entitled Eating Smoke: A Review of Non-Traditional Use of Tobacco Among Aboriginal People.[5] [6] The survey found that:

> *. . . 57% of the Aboriginals smoked compared to an overall average of 32% for the general population.* The following chart (Figure 1) depicts 1996 regional Aboriginal smoking levels.

[5] Eating Smoke: A Review of Non-Traditional Use of Tobacco Among Aboriginal People, March 1996. Produced for Health Canada by Jeffery L. Reading, PhD.

[6] The study addresses the total Aboriginal population including First Nations, Inuit and Metis.

Figure 1
Aboriginal Smokers



3.2 Smoking Rates

First Nations Smoking Rates: The Statistics Canada Aboriginal Peoples Survey[7] for 2001 reported that First Nations smoking rates remained relatively unchanged at 57% when compared to 1995 statistical information.[8] The First Nations Regional Longitudinal Health Survey for 2002-03[9] was a national survey addressing First Nations on-reserve communities, and it reported that an estimated 59% of First Nations members smoked.

Note: The 57% and 59% smoking rates for First Nations should not be interpreted as though there was a 2% increase in smoking rates within First Nations. The two surveys had factors of error which, when combined, exceed the 2% difference. It is statistically possible that there may have been a slight decrease in smoking rates within First Nations. Conversely, it is also possible that smoking rates increased by more than 2%. The sample sizes of the two surveys were too small to provide more precision in First Nations smoking rates.

Inuit Smoking Rates: Little in-depth statistically reliable information is available about Inuit smokers. In 1995, the Pauktuutit Inuit Women of Canada (previously known as the Pauktuutit Women's Association of Canada) produced a report entitled Guidelines for Inuit Communities Working on Reducing Tobacco Use, in which they found that:

---

[7] Aboriginal Peoples Survey, 2001, Statistics Canada, Ottawa Ontario, 2004.

[8] The Statistics Canada report did not survey all First Nations communities.

[9] First Nations Regional Longitudinal Health Survey, (RHS) 2002/03, Chapter 9, page 106.

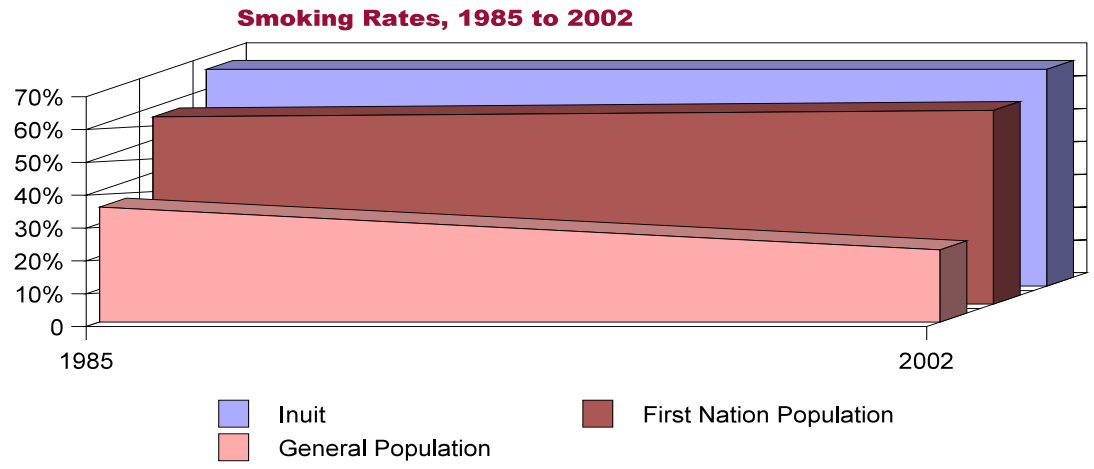
- *. . . tobacco use among our adult population aged 15 and up is very high; and*
- *. . . more than seven in 10 Inuit adults smoke.*[10]

Smoking rates for Inuit are generally believed to be about 66%.[11] There is no Inuit equivalent to the First Nations Regional Longitudinal Health Survey that can be used to provide more statistically correct smoking rates that include all Inuit in all regions of Canada.

General Canadian Population Smoking Rates: Since 1996, Health Canada's Canadian Tobacco Use Monitoring Survey reports that the overall average of the general Canadian population who smoke has dropped steadily by an average of about 0.8% per annum; from 35% in 1985 to 19% in 2005.

Using the statistics and information presented on the previous pages, Figure 2, below, shows that while smoking levels remained relatively unchanged for First Nations and Inuit, there was a significant decrease in smoking in the general Canadian population for the period from 1985 through to 2002.

Figure 2
Averaged Smoking Rates



Note: Figure 2 above shows general trends averaged across the eighteen year period from 1985 to 2002. The information within this figure is not to be used to draw statistics for any specific year within the expressed date range.

[10] Guidelines for Inuit Communities Working on Reducing Tobacco Use, Pauktuutit Women's Association of Canada, 1995, page 1.

[11] Guidelines for Inuit Communities Working on Reducing Tobacco Use, Pauktuutit Women's Association of Canada, 1995, page 1.

3.2.1. Initiation to the Misuse of Tobacco

The First Nations and Inuit Tobacco Control Strategy describes the 'misuse of tobacco' as the use of tobacco for purposes other than traditional uses.[12] Examples of tobacco misuse includes smoking cigarettes and cigars as well as chewing tobacco, also known as snuff or spit tobacco. The misuse of tobacco is also referred to as the commercial use of tobacco or as the non-traditional use of tobacco.

First Nations Initiation to the Misuse of Tobacco: The First Nations Regional Longitudinal Health Survey for 2002-03 [13] addressed the ages at which former smokers had started smoking.[14] The information is quite revealing in that:

- 3.8% of First Nations youth were initiated to the misuse of tobacco before the age of 10;
- 41.8% of First Nations youth start smoking before the age of 15; and
- 82.4% of the total 2154 First Nations respondents were initiated to the misuse of tobacco before the age of 20.

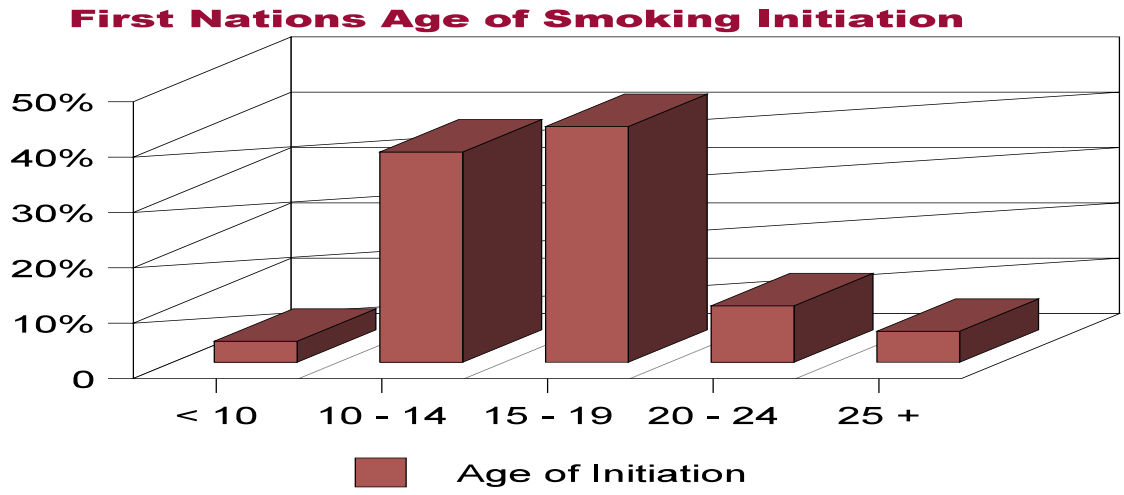
Figure 3 supports the First Nations and Inuit Tobacco Control Strategy decision that 'prevention' activities should be focussed on the youth if significant reductions in tobacco misuse are to be achieved.

[12] First Nations and Inuit Tobacco Control Strategy Program Framework, page 2, August 6, 2002, First Nations and Inuit Health Branch.

[13] First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Chapter 9, page 107.

[14] First Nations Regional Longitudinal Health Survey (RHS) 2002/03 provides the reported age of initiation to smoking by former smokers, figure 3 page 107, but does not provide similar information for all smokers.

Figure 3
FN Initiation/Starting to Misuse Tobacco



Inuit Initiation to Tobacco: In 1995 the Pauktuutit Inuit Women of Canada [15] reported that:

> *Inuit children begin smoking early. By the age of nine, 8% of Inuit children smoke, some starting as early as five. In the 15 to 19 year age group, 69% of Inuit youth smoke and the rate for adult smokers peaks at 72%.*

3.2.2 Women and Smoking

First Nations Pregnant Women's Smoking Rates: The First Nations Regional Longitudinal Health Survey for 2002-03, [16] which was released in 2005, addressed First Nations smoking rates for pregnant women. The information in the study suggests that one-third of pregnant women smoke less by becoming occasional smokers and that only about 2%[17] of pregnant women quit smoking once they become pregnant.

Figure 4 shows that First Nations women do not appreciably quit smoking once they become pregnant, supporting the decision of the First Nations and Inuit Tobacco Control Strategy to focus on pregnant women as well as on youth.

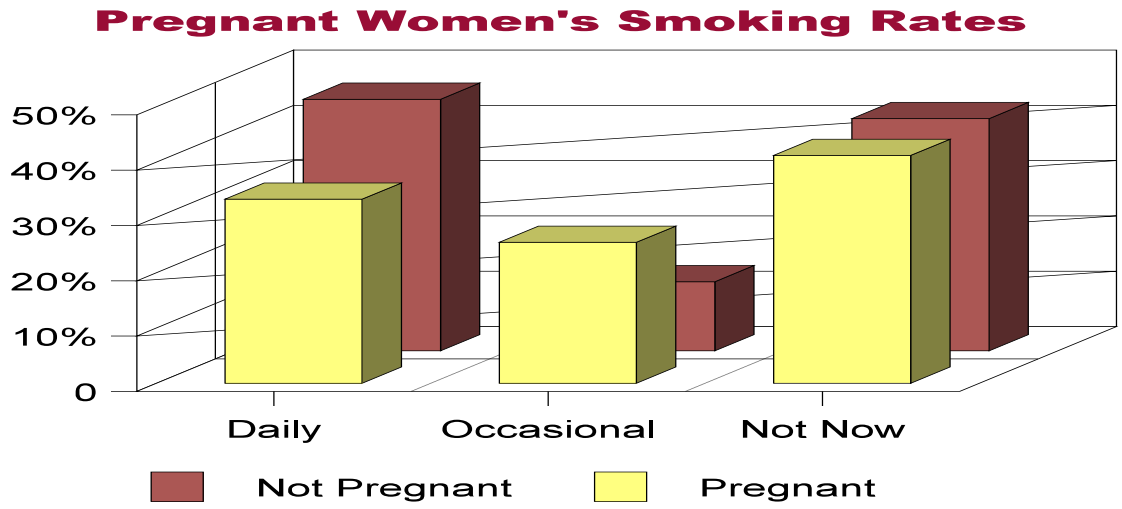
---

[15] Inuit and Tobacco, A Report Under The National Inuit Tobacco Use Reduction Program, Pauktuutit Inuit Women of Canada , 1995,page 6.

[16] First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Chapter 9, page 107.

[17] First Nations Regional Longitudinal Health Survey (RHS) 2002/03, Chapter 9, page 107.

Figure 4
Pregnant Women's Rates



Inuit Pregnant Women's Smoking Rates: The National Indian and Inuit Community Health Representatives Organization (NIICHRO) website states:

> *The Heart and Stroke Foundation reports that 60 per cent of Aboriginal women aged 15 or older are regular smokers (compared to an overall 26 per cent rate for Canadian women). In the Northwest Territories, up to 80 per cent of Inuit women are smokers.*[18]

In a study funded and conducted by the Department of Indian Affairs and Northern Development in 1997,[19] Dr. Stephen Hodgins, Director of Public Health, Nunavik Regional Board of Health and Social Services, attributed one-third of deaths in Nunavik to smoking. He also attributed much of the serious infections and death, as well as many developmental problems among Nunavik infants, to second-hand smoke exposure. This study, conducted within one Inuit community, reported that:

---

[18] National Indian and Inuit Community Health Representatives Organization's website, http://www.niichro.com/FHealing%20Hearts/heal_3.html. Dates and sources for the information are not provided.

[19] Health and What Affects it in Nunavik: How Is the Situation Changing? Kuujjuaq: Department of Public Health, Nunavik Regional Board of Health and Social Services, 1997. Department of Indian Affairs and Northern Development's website, http://www.ainc-inac.gc.ca/ps/nap/air/kanqiq/heallif_e.html.

- *79% of Inuit women of childbearing age smoked, a rate unchanged from 1992 for Nunavik as a whole;*
- *Only two out of the six pregnant women smoked;* and
- *On average, women started smoking at 13 years of age. Most smoked every day, smoking an average of 10 cigarettes per day* (all women) *and 5 per day* (pregnant women).

Note: The sample use for this study was quite small and limited to one community. The statistics should not be extrapolated and used to represent the entire Inuit population.

3.3 Traditional Tobacco Use Versus the Misuse of Tobacco

Traditional tobacco use is not the same as smoking commercial tobacco. [20] Numerous documents refer to past and current traditional uses of tobacco within many First Nations communities for spiritual, cultural and healing purposes. The traditional use of tobacco by First Nations was common in many, but not all, regions of the country prior to and after the arrival of the first Europeans.[21]

The National Indian and Inuit Community Health Representatives Organization explains traditional First Nations tobacco use on their website: [22]

> *For Aboriginal people, tobacco has traditionally been seen as a gift from the Creator. One of the most respected plants, tobacco was burned in sacred ceremonies. Its smoke was believed to carry prayers to the Creator. Tobacco was thrown on fires before trying to communicate with the spirit world; thrown on water before travel to ensure safe passage; and smoked in a sacred pipe to cement political and economic agreements between tribes.*
>
> *Traditionally, Aboriginal people used tobacco only in special ceremonies. That began changing when European settlers arrived in North America. These settlers traded a new type of tobacco used for recreational smoking. Tobacco did not lose its religious significance for Aboriginal people, but the original tobacco used for ceremonies became rare because it was no longer traded.*

---

20 National Indian and Inuit Community Health Representatives Organization's website, http://www.niichro.com/2004/.

21 Offering Smoke, The Sacred Pipe and Native American Religion, 1989, Jordan, page 3.

22 National Indian and Inuit Community Health Representatives Organization's website, http://www.niichro.com/2004/.

The tobacco in today's commercial cigarettes bears little resemblance to the indigenous plant used in traditional ceremonies. For 500 years, tobacco has been selectively bred to increase its nicotine potency. It is now a highly addictive substance. In today's Aboriginal community, the respect afforded to traditional tobacco is often overshadowed by widespread misuse of commercial tobacco.

While it has been reported that Inuit do not employ tobacco for traditional purposes, [23] Peter Ernerk, an Inuk MLA in the Northwest Territories in the 1980s disagrees. He believes that:

. . . the prevalence of smoking among Inuit can be partly explained by history, although smoking played no role in traditional Inuit culture prior to contact with Europeans.[24]

Tobacco was introduced to Inuit by white traders and its use was subsequently promoted by the Hudson Bay agents, as well as many priests. As the addiction spread, Inuit embraced tobacco as part of their culture, and remained largely unaware of its ruinous effects until quite recently, although the dangers of smoking have been common knowledge elsewhere in Canada for at least three decades.

Tobacco's status benefited from Inuit naming customs, too. If my namesake smoked a lot in his lifetime, then my mother or my father would have given me some tobacco when I was a kid, indicating that my namesake smoked a lot. I would be taught to smoke tobacco at a very early age. As people were being brought up in my time, you used to see little kids smoking right in the amautik, maybe two or three years old, in Repulse Bay. That's where a lot of encouragement came also, from our parents.

3.4 Federal Tobacco Control Strategy

Health Canada reports that:[25]

Smoking is the single most serious public health problem in Canada, killing more Canadians than car accidents, murders, suicides and alcohol combined.

---

[23] Offering Smoke, The Sacred Pipe and Native American Religion, 1989, Jordan, page 3.

[24] The Killer Who Lives at Home, Dwane Wilkin, Nunatsiaq News, Nunavut Edition Special Report, May 27, 1998, http://www.nunatsiaq.com/archives/nunavut980531/nvt80529_10.html.

[25] Health Canada website. http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/introduction_e.html.

- *Every year more than 45,000 Canadians die as a result of disease and illness caused by tobacco use.*
- *Tobacco use costs the health care system in excess of $3 billion every year.*
- *Lost productivity of a smoking employee is more than $2500 a year, with the total economic burden to Canadian society rising to $15 billion a year.*
- *More than five million Canadians use tobacco products, 82% of whom are daily smokers.*

The federal government is convinced that the most effective way to prevent and reduce tobacco use in Canada is to address the problem at all levels of society. Support for other federal departments, and coordination with provincial and territorial governments and non-governmental organizations, with respect to policy development and joint programs, make for a solid foundation. With increased emphasis on young people, Aboriginal and First Nations communities, and other groups, the Strategy remains flexible to respond to widely varying needs.[26]

Health Canada's legislative, regulatory and policy efforts on tobacco control are rooted in the Tobacco Act of 1997 and a range of new regulations that came into effect in June 2000. The focus of the Act was to regulate the manufacture, sale, labelling and promotion of tobacco products in Canada. It aimed to protect all Canadians, with particular emphasis on youth, from the health consequences of tobacco use.

In April 2001, the government announced the Federal Tobacco Control Strategy, with a five-year budget allocation of $559.8 million, as *a framework for a comprehensive, fully integrated and multifaceted approach to tobacco control.*

The Federal Tobacco Control Strategy, which is the federal government's contribution to the national tobacco control plan endorsed in 1999 by federal, provincial and territorial Ministers of Health,[27] had four components:

Protection – *Creating the physical, legal and regulatory environments that support non-smoking as the norm in Canada.*

Prevention – *Preventing people, especially youth, from taking up smoking.*

Cessation – *Programs and services to help people quit smoking.*

---

26 Health Canada website, http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/madm-msma_e.html.

27 Health Canada website. http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/res/news-nouvelles/fs-if/ftcs-sflt_e.html.

Harm Reduction – *Reduce the health hazards of tobacco products and ensuring that misleading information is not provided to consumers.*

The primary mission of the Federal Tobacco Control Strategy was to reduce tobacco-attributable disease and death among Canadians. Priority areas of focus included:

- *Youth;*
- *Young adults;*
- *First Nations and Inuit populations;*
- *Increasing the rate of smoking cessation among Canadians of all ages; and*
- *Reducing exposure to second-hand tobacco smoke.*

The ten-year objectives of the Federal Tobacco Control Strategy, to be reached by 2011, are:

- *To reduce the national smoking prevalence from 25% to 20%;*
- *To reduce the number of cigarettes sold in Canada by 30%;*
- *To increase retailer compliance with youth access laws from 69% to 80%;*
- *To reduce the number of people exposed to second-hand smoke in enclosed public places; and*
- *To explore how to mandate changes to tobacco products to reduce health hazards.*

3.5 First Nations and Inuit Tobacco Control Strategy Program Framework

First Nations and Inuit Health Branch, after discussions with national Aboriginal organizations, came to the conclusion that the Federal Tobacco Control Strategy designed for mainstream Canada would not be effective with First Nations on-reserve and Inuit in Inuit communities. The primary reasons provided for making this conclusion were:

- The Federal Tobacco Control Strategy had been ongoing for many years in mainstream Canada, and had excluded First Nations and Inuit communities. First Nations and Inuit therefore did not share the same experience and knowledge that had been gained by others;
- The Federal Tobacco Control Strategy did not include a strategy for the delivery of a Tobacco Control Strategy with First Nations and Inuit communities; and

- The Federal Tobacco Control Strategy did not acknowledge or address the traditional use of tobacco.

It was decided that the First Nations and Inuit Tobacco Control Strategy would be developed specifically to address the needs and requirements of First Nations and Inuit communities.

The population targeted for the First Nations and Inuit component of the Federal Tobacco Control Strategy included:[28]

- *First Nations people living on reserves south of 60º latitude;*
- *First Nations communities north of 60º latitude; and*
- *Inuit in Inuit communities*.

The Framework stated that the First Nations and Inuit Tobacco Control Strategy was to give special emphasis to:[29]

- *Tobacco control among pregnant women and youth; and*
- *Reducing second-hand smoke exposure in all First Nations and Inuit communities*.

The intended impacts of the First Nations and Inuit Tobacco Control Strategy[30] were identified as follows:

1. *Leadership support for tobacco control strategies will increase over the life of the FNITC Strategy and tobacco control will be increasingly recognized as a health priority in First Nations and Inuit communities*.

2. *Over the years of the Strategy's implementation, smoking prevalence in Canada among adult First Nations people on-reserve and Inuit in Inuit communities will be reduced, with reductions occurring in each year of program operations.*

3. *Youth smoking rates will be reduced over the life of the program.*

---

[28] First Nations and Inuit Tobacco Control Strategy Program Framework, page 1, August 6, 2002, First Nations and Inuit Health Branch.

[29] First Nations and Inuit Tobacco Control Strategy Program Framework, the page before page 1, August 6, 2002, First Nations and Inuit Health Branch.

[30] First Nations and Inuit Tobacco Control Strategy Program Framework, August 6, 2002, page 4, First Nations and Inuit Health Branch.

4. *The rates of spit tobacco use among youth will be reduced.*

5. *Each region will witness substantially reduced smoking rates.*

6. *Over the life of the program, an increasing percentage of residences and shared spaces on reserves and Inuit communities will be free of commercial tobacco smoke.*

The First Nations and Inuit Tobacco Control Strategy addresses the high rates of smoking tobacco in First Nations and Inuit communities. It receives its funding through a five-year, $50 million allocation from the Federal Tobacco Control Strategy. The First Nations and Inuit Health Branch's budget allocation over the current five-year period is:

- $6 million in first fiscal year (2001/02);
- $10 million in each of the following two years (2002/03 and 2003/04); and
- $12 million in each of the last two years (2004/05 and 2005/06).

The overall First Nations and Inuit Tobacco Control Strategy allocation for each year was determined by the Branch through its annual budget exercise, with approximately 30% of that amount assigned for headquarters operations, national contribution agreements and contracts. The balance is distributed among the regions based on a formula that includes a base amount, community populations and remoteness factors.

The annual allocations do not represent the amount of money that was actually spent on the First Nations and Inuit Tobacco Control Strategy. The interviews with First Nations and Inuit Health Branch personnel, and the analysis of data provided by four regions indicate that actual national expenditures for the First Nations and Inuit Tobacco Control Strategy in any given year were lower than the amounts allocated; this varied from region to region, and occurred for one or both of the following reasons:

- First Nations and Inuit Health Branch headquarters and/or regional management reassigned a portion of the First Nations and Inuit Tobacco Control Strategy allocation to cover costs for other programs; and/or
- Funds from the approved First Nations and Inuit Tobacco Control Strategy budget were committed for specific projects through contribution agreements during the year, but were not spent because some of the projects reported surpluses, were terminated early, or were never implemented because the funding was approved too late in the year.

3.5.1 Program Management

The responsibility for the national management of the First Nations and Inuit Tobacco Control Strategy is located in the First Nations and Inuit Health Branch's Community Programs Directorate in Ottawa. The core of First Nations and Inuit Tobacco Control Strategy unit has been made up of two program officers reporting to a manager who also carries responsibilities for other programs and initiatives managed and administered by the directorate. In 2005-06, a third program officer position was added.

Eight First Nations and Inuit Health Branch regional offices administer and deliver the First Nations and Inuit Tobacco Control Strategy through contribution agreements. The regional offices work either directly with community organizations or through regional First Nations and Inuit organizations and Tobacco Control Facilitators. [31]

Over the years, each of the regional offices has established working relationships and project delivery practices with Inuit and First Nations communities as well as with their regional organizations and leadership.

3.5.2 National and Regional Advisory Circles

The National Advisory Circle was established in late 2001 and is composed of individuals who are knowledgeable tobacco control specialists, some with strong academic backgrounds, and some with extensive hands-on community experience.[32] The national Aboriginal Organizations that are members of the National Advisory Circle are:[33]

- The Aboriginal Nurses Association of Canada;
- The Assembly of First Nations;
- Inuit Tapiriit Kanatami;
- The National Aboriginal Health Organization;
- The National Native Addictions Partnership Foundation; and
- Pauktuutit Inuit Women of Canada.

---

31 Tobacco Control Facilitators, also known as Regional Facilitators or Regional Tobacco Control Facilitators are contracted by First Nations and Inuit Health Branch to assist in the coordination and/or delivery of the First Nations and Inuit Tobacco Control Strategy.

32 The membership of the National Advisory Circle is presented on page 100 of this report.

33 The representatives of the National Aboriginal Organizations that are part of the National Advisory Circle are presented on page 100 of this report.

The National Advisory Circle works closely with the First Nations and Inuit Health Branch's national and regional offices as well as with the Regional Advisory Circles and the Aboriginal Health Commissions established in each region. The National Advisory Circle performs an advisory function in support of the First Nations and Inuit Tobacco Control Strategy and plays a major role in the development of the First Nations and Inuit Tobacco Control Strategy Framework, in the production of key documents, in assisting with major tasks such as the evaluation of the First Nations and Inuit Tobacco Control Strategy and in the provision of tobacco control advice.

The National Advisory Circle employs a participatory process in its operation and encourages the use of participatory practices at all levels within the First Nations and Inuit Tobacco Control Strategy.

3.5.3 Vision and Mission Statement

The program vision and mission statement underlie the objectives and intended impacts of the First Nations and Inuit Tobacco Control Strategy. The program vision, as specified within the Program Framework, is:

> *Healthier First Nations and Inuit Communities free of tobacco misuse and addiction.*

The mission statement, also specified within the Program Framework is:

> *To promote and support policy, program and project initiatives designed to create healthy First Nations and Inuit communities free of tobacco misuse and addiction.*

3.5.4 Core Values

The First Nations and Inuit Tobacco Control Strategy's Program Framework presents core values that are to be used to guide the way in which the First Nations and Inuit Tobacco Control Strategy is to be implemented within First Nations and Inuit communities:[34]

Respect *is a core value of traditional North American cultures. In conception and implementation, concerted efforts will be made to show respect for traditional tobacco use and reverence for its sacred qualities. Respect will also be shown for individual differences in values and needs, as well as for variations in cultural practices, sacred beliefs and customary law. This core value will also be reflected in the expression of gratitude to all those who contribute to and participate in tobacco control prevention and education activities.*

[34] First Nations and Inuit Tobacco Control Strategy Program Framework, August 6, 2002, page 2, First Nations and Inuit Health Branch.

Trust. *The strategy will be based upon capacity-building processes and training materials that build and enhance trusting relationships between tobacco control facilitators, leaders, administrators, service providers and community members.*

Responsibility *for achieving the goals of the tobacco control strategy is situated in the choices of community leaders to support tobacco control efforts and to serve as role models. This responsibility even more fully rests with community members who can make the personal choice to practise lifestyles free of tobacco misuse; it also rests with adults who can eliminate second-hand smoke in their homes and work sites and parents who can discourage tobacco misuse among children and youth.*

Freedom *of the individual in making choices regarding tobacco use will be honoured, as will the basic right of all people to be free of exposure to second-hand tobacco smoke.*

Holism *in prevention and intervention will play a major influence in program development and service implementation decisions. A holistic perspective implies that everybody in the community has a role to play and this is expressed in several aspects of the strategy. The overall initiative is premised upon a population health approach in which tobacco control is viewed as one piece of an overall community health promotion strategy.*

Kindness *and compassion will have supremacy in the presentation of information and in providing counsel, although the health impacts of tobacco misuse will be presented consistently and clearly. Whatever actions taken as part of developing and implementing the tobacco control strategy should be done with kindness.*

Humility *will define the orientation to community leadership, to community members and to those in receipt of services by those delivering programs.*

3.5.5 Program Objectives

The program objectives of the First Nations and Inuit Tobacco Control Strategy are: [35]

1. *To build the capacity within First Nations and Inuit communities to develop and deliver comprehensive, culturally sensitive and effective tobacco control programs at a pace acceptable to those communities*;

[35] First Nations and Inuit Tobacco Control Strategy Program Framework, August 6, 2002, page 4, First Nations and Inuit Health Branch.

2. *To promote the health of First Nations and Inuit people by decreasing the prevalence of tobacco smoking and spit tobacco use among all age groups, but in particular among youth and pregnant women;*

3. *To decrease the uptake of smoking among youth. As smoking in First Nations and Inuit communities starts at a younger age, youth is considered to include children;*

4. *To decrease the impacts of environmental tobacco smoke on the health of First Nations and Inuit communities*; and

5. *To engage the leadership of First Nations and Inuit in learning about, voicing opinions and supporting tobacco control strategies. This program includes Elders as leaders as they are holders of traditional knowledge and their opinions and support will be an important component in developing and building community capacity in tobacco control strategies*.

3.5.6 Participatory Processes

First Nations and Inuit Health Branch staff and the Advisory Circles continue to emphasize the need to maintain participatory processes at all levels of the First Nations and Inuit Tobacco Control Strategy. The National Advisory Circle described participatory processes as follows:[36]

> *Participatory processes frame the work within the context of "working with" individuals and communities. In addition to this, participatory processes facilitate individuals and communities being a part of the decision-making team regarding: the questions to be asked; the processes to be undertaken; the analysis (if appropriate) and interpretation of the results; and the information contained within the Final Report with any disagreements being clearly delineated.*[37] [38] [39]

---

[36] The description of participatory practices was provided by Vivian R Ramsden, RN, PhD, co-chair of the Evaluation Sub-committee, First Nations and Inuit Tobacco National Strategy's National Advisory Circle.

[37] Who are the question-makers? A participatory evaluation handbook, Capeling-Alakija S, Lopes C, Benbouali A, Diallo D, New York, NY: OESP Handbook Series. 1997.

[38] Participatory Methods to Facilitate Research, Canadian Family Physician, Ramsden VR & Cave AJ. 2002; pages 48, 548-549, 553-554.

[39] Methods in Community-Based Participatory Research for Health, Israel BA, Eng E, Schulz AJ, Parker EA.San Francisco, CA: Jossey-Bass. 2005.

Moving from a 'power-over' model to a 'power-with' model builds a sense of cooperation in working with others and builds sustainable change. This form of collaboration stresses the importance of facilitating participatory processes which provide access, ownership and resource supports to, and with, individuals and communities working together on tobacco control strategies.

Integrated into this is the use of current evidence and participatory research/evaluation methodology; thus, identifying strengths and opportunities for change (asset mapping/ needs assessment), planning and designing programs, facilitating the programs being implemented with communities and evaluating all elements of the First Nations and Inuit Tobacco Control Strategy. It respects First Nations on reserve and Inuit in Inuit communities by recognizing that they have the knowledge and are capable of working out their own unique solutions to the problems they face, such as dealing with the health risks of tobacco misuse. It promotes teamwork among individuals, health workers and other service agencies in the communities, both government and non-government. It offers the hope of holistic and innovative solutions that are made possible when individuals with all kinds of resources and skills work together to solve problems. Participatory processes also offer opportunities for joint funding of innovative projects which are affordable, practical and accountable.

Often within health care systems, consultation has been utilized to demonstrate citizen participation; however, the information gleaned may or may not be heard or applied in practice.[40] [41] *On the other hand, participatory processes guide how the partnership evolves and facilitates the redistribution of power through negotiation with all members of the team including elders, the leadership and individuals within each of the communities.*

[40] A Ladder of Citizen Participation, Journal of the American Planning Association, Arnstein, SR. 1969;35(4):pages 216-224.

[41] Building and Sustaining Partnerships, First Nations and Inuit Health Branch, Health Canada website www.hc-sc.gc.ca/fnih-spni/pubs/tobac-tabac/2003_sust-maint_part/part_7_e.html#keeping.

SECTION 4.0 PLAN, ISSUES, OBJECTIVES AND METHODOLOGIES

This section of the report provides an overview of the evaluation's structure and the methodologies that were employed.

4.1 Evaluation Plan

The First Nations and Inuit Health Branch's First Nations and Inuit Tobacco Control Strategy is included within the Federal Tobacco Control Strategy's accountability mechanisms. The results of the formative (process) evaluation for the First Nations and Inuit Tobacco Control Strategy was to be available by the end of 2005/06. A one year extension to the delivery of evaluation results was given to the Federal Tobacco Control Strategy, and thus also to the First Nations and Inuit Tobacco Control Strategy.

This evaluation report is being delivered about one year after its originally planned date. Additional reasons for the delay of this report were:

- The scope of the evaluation was increased by about 50%, including an increase in the number of First Nations communities to be visited, and a significant expansion of the number of individuals to be included within the in-person and telephone surveys; and
- FNIHB's internal management review process of the evaluation had not been included within the original timeline.

The scope of this evaluation did not include measuring the results and successes of the First Nations and Inuit Tobacco Control Strategy as that will be the focus of the summative (results-based) evaluation to be conducted at a yet-to-be-specified date.

The intended audiences for the conduct of this evaluation are identified within the Request for Proposals (RFP). The evaluation:

> *. . . will serve to inform decision-makers, including health care workers, of the overall efficiency of the program implementation. The results* (of this evaluation) *will influence revisions to the Program, decision-making about how best to work with First Nation and Inuit communities in a participatory manner, and provide recommendations for continuous program improvement.*

The purpose of this formative evaluation is to examine the process of implementing the First Nations and Inuit Tobacco Control Strategy, and to address three evaluation issues: [42]

1. Was the Strategy implemented as proposed in the First Nations and Inuit Tobacco Control Strategy Program Framework?

2. Were success targets, performance measurement indicators and a performance measurement system established that will allow for the evidence-based measurement of the First Nations and Inuit Tobacco Control Strategy's results?

3. Are there ways to improve the delivery of the First Nations and Inuit Tobacco Control Strategy from the perspective of its effectiveness and/or its efficiency?

This evaluation also addresses the *six specific objectives of this evaluation* identified in the Request for Proposal:

1. *To assess how the participatory approach of the FNITCS has been adopted nationally, regionally and at the community level*;

2. *To identify the strengths and challenges of a flexible national framework strategy that is intended to allow the regions and the communities to assess and determine how it promoted the incorporation of best practices.*

3. *To examine specific implementation opportunities and considerations which are different or similar between First Nations and Inuit communities*.

4. *Identify and document various models of delivery and best practices nationally, regionally and at the community level.*

5. *To determine the extent to which regional characteristics and/or the community type have influenced the development, planning and implementation of the FNITCS; how these developments differ from, or are consistent with, the FNITCS original program framework; and were the intended outputs stated in the logic model achieved.*

6. *To assist in the data collection and reporting for the program's five-year comprehensive evaluation by collecting baseline data to enable the creation of a longitudinal design*.

---

[42] The three evaluation issues were inspired from Treasury Board Secretariat's policies and guidelines on program evaluation and then jointly adapted to the specifics of the First Nations and Inuit Tobacco Control Strategy by the Evaluation Sub-committee, FNIHB and the evaluators.

4.2 Approach and Methodologies

A *participatory evaluation approach* incorporating six evaluation methodologies was employed to:

- An update the tobacco control literature review conducted in 2002 was produced;
- A review of documents gathered from the First Nations and Inuit Health Branch's national and regional offices was conducted;
- A telephone survey of First Nations and Inuit project holders was conducted;
- Travel to the regional offices to conduct Sharing Circles and in-person interviews was undertaken; and
- Talking Circles and participatory analysis (Sharing Circles) were conducted; and
- Eight narrative stories that describe the types of tobacco control projects being implemented within the communities. The cancellation of the First Nations and Inuit Tobacco Control Strategy hindered the process and therefore the narrative stories were not completed.[43]

At the January 6, 2006 meeting in Vancouver, the National Advisory Circle's Evaluation Sub-committee and the evaluators reviewed the requirements as specified within the Request for Proposals and the proposal submitted by the evaluators. The agreed-upon methodologies were as follows:

Sharing Circles were to be held in each of the eight First Nations and Inuit Health Branch regions. Each of the eight regional Sharing Circles was structured and organized to meet regional realities and preferences, with most Sharing Circles to include between seven and 11 persons, generally including:

- Five or six Elders and project community representatives, including one representative for the narrative story;
- First Nations and Inuit Tobacco Control Strategy regional consultant(s);

[43] The agreement with the project holders was that their narrative stories would be reviewed within their First Nations communities before the narrative stories would be included within the evaluation report. The cancellation of the First Nations and Inuit Tobacco Control Strategy made the completion of the narrative stories and their review within the First Nations communities impossible. It was decided, and a contract amendment was issued, that the unfinished narrative stories would not be included within this evaluation report, and that instead they would be submitted as draft working papers under separate cover..

- Demonstration project representative(s);
- Regional Advisory Circle representative(s); and
- Others as needed to represent the regional character of the Strategy.

Note: Participants to the Sharing Circles, held in the eight communities visited by the evaluation team, were selected based upon their knowledge of the Tobacco Control Strategy and their willingness to participate.

Note: A ninth Sharing Circle was held with members of the Evaluation Sub-committee and First Nations and Inuit Health Branch national staff.

Project Interviews, which were conducted with community-based project staff in the eight visited communities, totalled about 40 interviews, plus an additional 47 participants' interviews [44] with the Sharing Circles and the National Advisory Circle. Interviews were conducted on a voluntary basis in each region at the same time as the visits were conducted for the Sharing Circles. Additional in-person interviews were also held with representatives of the demonstration projects, narrative stories, the National Advisory Circle, the national Aboriginal organizations and First Nations and Inuit Health Branch staff in Ottawa.

FNITCS Consultant and Facilitator Interviews, 14 in number, representing all regions, were conducted in person with regional consultants and facilitators. Some of the in-person interviews, all conducted on a voluntary basis, included more than one respondent. Also interviewed were other key individuals identified by First Nations and Inuit Health Branch and First Nations and Inuit Tobacco Control Strategy staff.

A **Telephone Survey** of about 200 project holders, was to be conducted, on a voluntary basis, using a detailed interview questionnaire. A total of 189 telephone surveys were completed and the information was placed into an SPSS database for statistical analysis.

A **Document Review** and analysis of program documents were conducted to gain a better understanding of the First Nations and Inuit Tobacco Control Strategy. The volume of documents from which the review was conducted included (approximate numbers):

- Contribution agreements (300);
- Project evaluation sheets (400);
- Strategic management documents (10);
- Financial budgets, reports and guides (150);

[44] These 47 interviews do not include (double-count) Circle participants who were interviewed elsewhere for this project.

- First Nations and Inuit Tobacco Control Strategy related studies (15);
- First Nations and Inuit Tobacco Control Strategy products (e.g., kits, manuals, guides) (25);
- Minutes of meetings (30); and,
- Other documents/files(e.g., contracts) (50).

A **Literature Review** was conducted by updating the 2002 study *Promising Strategies and Best Practices* and by searching websites and academic journals for new research and publications. One focus of the literature review included a review of Canadian, US, New Zealand and Australian websites addressing Aboriginal uses and misuses of tobacco and tobacco products.

The **Analytical Processes/Methodology**, while not formally identified within the Request for Proposals as a methodology, is an evaluation methodology. The analytical processes/research methodology employed a multilevel process, described as follows:

Three evaluation issues were developed. Evaluation issues addressed the central strategic concerns at the program level.

Tier One questions were developed. Two or three Tier One questions were developed for each of the evaluation issues. Tier One questions are high-level questions and are used to address the evaluation issues.

Tier Two questions were developed. The Tier Two questions are more detailed and are used to answer higher-level Tier One questions.

Evaluation tools were developed. Interview guides and a telephone survey were developed and employed to answer Tier Two questions. The literature review and document review were also used to answer some of the Tier Two questions.

This research methodology allows for a direct link between the information gathered through the use of the evaluation tools which, in turn, was used to answer the Tier Two questions, then used to answer the Tier One questions and then the evaluation issues. The hierarchical tree (Figure 5 on next page) identifies the relationships between the evaluation issues and the Tier One and Tier Two questions.

4.3 Methodological Challenges

Numerous methodological challenges were encountered during the conduct of the evaluation:

- Limited statistical information specific to First Nations and Inuit smoking rates was found, and there were no national smoking-related statistics that covered a multi-year period, making it difficult to identify trends and possible changes.

- Limited financial expenditure information was found, with information gaps at the regional and national levels, making it impossible to produce an accurate comparison of total expenditures versus allocated budgets.
- The information available to establish a national information baseline was limited. The information that was found was: (i) focussed upon outputs and not outcomes; (ii) had significant gaps; and (iii) was either mostly regional or project-specific. National comparisons could not be made.
- Inuit projects outside of Québec mostly reported to organizations other than the First Nations and Inuit Health Branch. Limited access to that information prevented a comparison among First Nations and Inuit tobacco control projects.
- Gaps were identified in the project-specific documentation which is typically held and maintained by the First Nations and Inuit Heath Branch's national and regional offices. This reduced the accuracy and completeness of the comparisons of the processes and practices employed to implement the program.
- Interviews and Sharing Circles were held with representatives of those communities that were successful in obtaining funding for their tobacco control projects. The result is that the evaluation lacks comments and suggestions from community representatives who were not successful in obtaining project funding.

  Note: The scope of the evaluation, and instructions received from the National Advisory Circle excluded interviews from being conducted with those communities that were not successful in obtaining project funding.

- Limited information was found that could be used to compare levels of participation and participatory processes among the First Nations and Inuit Tobacco Control Strategy and other programs and initiatives funded by the First Nations and Inuit Health Branch. The evaluators were not able to fully answer the first evaluation objective.
- The First Nations and Inuit Tobacco Control Strategy, at the time the evaluation was conducted, did not possess an approved Results-based Management Accountability Framework, nor a commonly agreed upon Logic Model. The Logic Model remained in draft format during the conduct of the evaluation.

(list continues on page 36)

Figure 5 - Issues and Questions

Issues Issues are expressed at a strategic level	Tier One Questions Intermediate level questions	Tier Two Questions Detailed level questions
Issue #1 Implementation		
	1.1 Program infrastructure	
		1.1.1 Planning
		1.1.2 Organizational structures
		1.1.3 Processes and reporting
		1.1.4 Partnerships
	1.2 Program management	
		1.2.1 Communicating objectives
		1.2.2 Foundations
		1.2.3 Educational resources
		1.2.4 Selection criteria
		1.2.5 Funding and approval
	1.3 Community delivery	
		1.3.1 Project creation
		1.3.2 Integration and coordination
		1.3.3 Barriers
		1.3.4 Consistency
Issue #2 Success and Performance		
	2.1 Success targets	
		2.1.1 Success targets
		2.1.2 Performance systems
	2.2 Performance systems	
		2.2.1 Performance data
		2.2.2 Data accuracy
		2.2.3 Data use
	2.3 Baselines	
		2.3.1 Baseline measures
		2.3.2 Replicability
Issue #3 Effectiveness and Efficiency		
	3.1 Program improvements	
		3.1.1 Effectiveness and efficiency
		3.1.2-Administrative efficiencies
	3.2 Lessons learned	
		3.2.1 Operations
		3.2.2 Success

The impacts of the methodological challenges upon this formative (process) evaluation and potential future summative (results-based) evaluations are as follows:

- **This evaluation:** The methodological challenges had no serious impact on the overall conduct of this formative (process) evaluation, nor upon the identification of the global findings presented within this evaluation report, because the primary focus of this report addresses the implementation of the First Nations and Inuit Tobacco Control Strategy and not the results achieved by the Strategy. The primary negative impact of the methodological challenges is reduced levels of quantitative information to support some of the findings.

- **Future evaluations**: The lack of national-level tobacco use statistics for First Nations and Inuit, and the lack of a national information baseline focused on outcomes, will most likely have a major negative impact upon a future summative (results-based) evaluation.

4.4 Sharing Circle Results

Sharing Circles are 'self-directed' by the participants. As a starting point, the participants were provided discussion topics that they were encouraged to address and expand upon as they deemed appropriate. The participants were also free to explore areas related to the discussion points or to address topics related to the First Nations and Inuit Tobacco Control Strategy that they believed were relevant and important.

An important dimension or characteristic of Sharing Circles is that each participant's views and opinions are as important as those of the other participants. It is recognized during Sharing Circles that there are many different correct interpretations of events and many different solutions. No attempt is made to seek or obtain a consensus among the participants.

Three discussion topics were presented at the Sharing Circles, with follow-up questions included to help explore the areas addressed within the evaluation. The topics and questions were as follows:

1 Are the [First Nations and Inuit Tobacco Control Strategy] control projects succeeding?

1.1 How is success measured?

1.2 How have community leaders, youth and other residents reacted to the [First Nations and Inuit Tobacco Control Strategy] tobacco control activities?

1.3 Is the First Nations and Inuit Tobacco Control Strategy achieving its objectives?

2 How is the implementation of the First Nations and Inuit Tobacco Control Strategy going?

2.1 Were implementation plans prepared? Are they being followed?

2.2 Is the program well planned and managed? By the First Nations and Inuit Health Branch? By Tribal Councils? By communities?

2.3 Are health care professionals and others getting the information, materials and training they need to plan and deliver projects?

3 What worked well?

3.1 What advice would Circle participants offer to someone just starting out to implement a [First Nations and Inuit Tobacco Control Strategy] tobacco control project?

3.2 What kinds of things could they do to increase the chances that their program would be successful?

The topics and questions addressed within the Sharing Circle typically resulted in qualitative, rather than quantitative, information being provided. Participants sometimes nodded their heads in agreement. To report on the results of the Sharing Circles it is necessary to use general terms such as some, many and most. More precise quantitative terms cannot be utilized for the Sharing Circles.

4.5 Interview and Survey Results

Three interview questionnaires/guides (presented starting on page ? of this report) were employed for the in-person interviews. The questionnaires contained mixes of qualitative and quantitative type questions and were used as a starting point during the in-person interviews. The in-person interviews were open-ended and as the interviewees opened new areas of discussion, that information was also gathered.

SECTION 5.0 EVALUATION ISSUES AND EVALUATION QUESTIONS

This section of the report describes the development of the evaluation issues and introduces the evaluation questions that were specifically developed to evaluate the First Nations and Inuit Tobacco Control Strategy and includes an explanation of how Treasury Board's generic evaluation issues were adapted and used.

5.1 Developing the Evaluation Issues

Evaluation issues, usually expressed as questions, are part of the structure of the formal evaluation process employed by the federal government to evaluate its programs and initiatives. These questions are used to guide the evaluation team during the evaluation of the First Nations and Inuit Tobacco Control Strategy. Evaluation issues address the high-level questions that the First Nations and Inuit Health Branch and other government organizations consider central to all evaluations. Treasury Board policy specifies the generic evaluation issues to be used in the evaluation of all federally funded programs and initiatives.

The evaluators met with First Nations and Inuit Health Branch staff and the Evaluation Sub-committee to discuss the generic evaluation issues and to adapt them to the specifics of the First Nations and Inuit Tobacco Control Strategy. They agreed upon the following evaluation issues:

1. Was the First Nations and Inuit Tobacco Control Strategy implemented as proposed in the First Nations and Inuit Tobacco Control Strategy Program Framework?

2. Were success targets, performance measurement indicators and a performance measurement system established that will allow for the evidence-based measurement of the First Nations and Inuit Tobacco Control Strategy's results?

3. Are there ways to improve the delivery of the First Nations and Inuit Tobacco Control Strategy from the perspective of its effectiveness and/or its efficiency?

5.2 Evaluation Questions

Evaluation questions were developed to answer the three agreed-upon evaluation issues. The development of evaluation questions was done in partnership with the National Advisory Circle's Evaluation Sub-committee and First Nations and Inuit Health Branch staff. The Tier

One evaluation questions, which are answered and discussed in Sections 6, 7 and 8 of this report, are:

EVALUATION ISSUE #1 Was the First Nations and Inuit Tobacco Control Strategy implemented as proposed in the First Nations and Inuit Tobacco Control Strategy Program Framework?

Eval. Question 1.1 Were appropriate organizations, processes and partnerships established to develop and implement the First Nations and Inuit Tobacco Control Strategy?

Eval. Question 1.2 Were the First Nations and Inuit Health Branch's national and regional offices successful in supporting and funding the implementation of the First Nations and Inuit Tobacco Control Strategy?

Eval. Question 1.3 Was the First Nations and Inuit Tobacco Control Strategy successful in delivering community-based programming?

EVALUATION ISSUE #2 Were success targets, performance measurement indicators and a performance measurement system established that will allow for the evidence-based measurement of the First Nations and Inuit Tobacco Control Strategy's results?

Eval. Question 2.1 Were success targets established at the national, regional and community levels?

Eval. Question 2.2 Were performance measurement systems established for the evidence-based measurement of results?

Eval. Question 2.3 Have information baselines been established to ensure that the data and information required to measure performance will be available?

EVALUATION ISSUE #3 Are there ways to improve the delivery of the First Nations and Inuit Tobacco Control Strategy from the perspective of its effectiveness and/or its efficiency?

Eval. Question 3.1	Are there ways to improve the efficiency and effectiveness of the national and regional components in carrying out their responsibilities for the delivery of the First Nations and Inuit Tobacco Control Strategy?
Eval. Question 3.2	Are there lessons learned and best practices that could be used to improve the efficiency and effectiveness of the Tobacco Control Strategy?

SECTION 6.0 EVAL FINDINGS, ISSUE #1: IMPLEMENTATION

This section of the report addresses Evaluation Issue #1:

> *Was the First Nations and Inuit Tobacco Control Strategy implemented as proposed in the First Nations and Inuit Tobacco Control Strategy Program Framework?*

The primary focus of this formative evaluation was to determine how well the First Nations and Inuit Tobacco Control Strategy was implemented and to see if there are some aspects of it that could be improved.

The document review provided evaluators with a range of documents that addressed the implementation of the First Nations and Inuit Tobacco Control Strategy. It was determined that the First Nations and Inuit Tobacco Control Strategy Program Framework, published in August 2002, was the first officially approved document that provided an implementation strategy and plan.

The document review did not identify any formal updates or replacements to the 2002 Program Framework. The 2002 Program Framework was therefore used as a measure against which implementation could be examined.

6.1 Evaluation Question 1.1: Program Infrastructure

Question

Were appropriate organizations, processes and partnerships established to develop and implement the First **Nations** and Inuit Tobacco Control Strategy?

6.1.1 Discussions (EQ 1.1)

6.1.1.1 Were Plans Developed?

National Plans: First Nations and Inuit Health Branch's national staff, assisted by the National Advisory Circle, led the planning for the implementation of the First Nations and Inuit Tobacco Control Strategy. The work was completed in consultation with representatives of the First Nations and Inuit Health Branch's regional offices who, in turn, consulted with the provincial/territorial First Nations and Inuit political organizations within their regions.

The key product of the planning effort was the First Nations and Inuit Tobacco Control Strategy's Program Framework [45] which sets out the program's strategic objectives and provides guiding values for its implementation. It also presents a general schedule for the delivery of key national and regional outputs including: demonstration projects, training, program guides, planning documents and processes, human resources, and organizational structures.

The Program Framework has not been revised or replaced by an equivalent document to reflect the accumulated experience or emerging tobacco control issues. It is noted that the national office did not develop a communication strategy and plan for the implementation of the initiative. Among other things, a communication plan might have identified what information, documents and publications would have been delivered to specific groups and by what means.

Regional Plans: The review of the documents made available to the evaluation team did not find any report or document that would constitute a 'regional tobacco control plan.' Each region, however, did complete an environmental scan.

Based on the scans, input from regional Advisory Circles and other considerations, the regions did establish initial implementation and/or work plans. The format and content of these original plans varied from region to region. For the most part, the plans emerged during the 2002-03 and 2003-04 fiscal years as a result of a series of decisions about regional priorities, planning structures, funding allocations, project proposal and approval processes.

Community Plans: Many First Nations and Inuit communities contributed to national and regional implementation planning through initial consultations on the Framework and the subsequent environmental scans. Beyond this involvement, any implementation planning at the community level was related to project-specific planning which included:

---

[45] *Program Framework First Nations and Inuit Tobacco Control Strategy*. Health Canada. (Prepared by the First Nations and Inuit Health Branch and the First Nations and Inuit Tobacco Control Advisory Circle with the Assistance of Socio-Tech Consulting Services). August 2002.

- identifying local needs;
- deciding whether to seek First Nations and Inuit Tobacco Control Strategy funding; and
- determining what services and organizations would be involved in the process.

6.1.1.2 Were Organizations Established?

National Organizations: The First Nations and Inuit Health Branch's national office for the Tobacco Control Strategy was established in May 2001 and became fully operational in September of that year, after approval of the Treasury Board submission.

The First Nations and Inuit Health Branch's national First Nations and Inuit Tobacco Control Strategy office has responsibility for a range of activities including ongoing program management, corporate support, initiative planning, the development and delivery of national training and tools, and demonstration project management. It also participates in and supports national partnerships, most notably partnerships with national Aboriginal organizations active in the health sector and the Federal Tobacco Control Strategy administered by Health Canada.

The National Advisory Circle, established in late 2001, is composed of individuals with expertise in tobacco control. The National Advisory Circle's membership includes representatives from the following national Aboriginal organizations:

- The Aboriginal Nurses Association of Canada;
- The Assembly of First Nations;
- Inuit Tapiriit Kanatami;
- The National Aboriginal Health Organization;
- The National Native Addictions Partnership Foundation; and
- Pauktuutit Inuit Women of Canada .

The other members include seven tobacco control and community health experts associated with universities, institutes and/or federal and provincial health agencies, and two regional consultants from the First Nations and Inuit Tobacco Control Strategy program. [46] All but a few of the members have been part of the National Advisory Circle since 2001.

[46] Program consultants, also known as regional consultants or regional program consultants or regional program coordinators are First Nations and Inuit Health Branch employees.

Regional Organizations: Each of the regional offices established First Nations and Inuit Tobacco Control Strategy program management and administrative capacities within their organizational structures.

The delivery of the First Nations and Inuit Tobacco Control Strategy in the regions is supported by the regional organizations' common services such as financial management and control, communications, and community liaison.

Regional Advisory Circles were established in each of the regions and, for the most part, have been operating since the second and third year of the First Nations and Inuit Tobacco Control Strategy. There have been short periods where a Regional Advisory Circle may have been inactive, and in some instances, part or all of the Regional Advisory Circle membership has had to be reconstituted.

Community Organization: The type and complexity of organizational structures established at the community level are varied and depend upon three primary considerations:

- The level of integration of the First Nations and Inuit Tobacco Control Strategy with other health and wellness programs being delivered in the community versus the First Nations and Inuit Tobacco Control Strategy being a stand-alone project within the community.
- The size and funding levels of individual projects (more than 75% of the projects were between $5000 and $10,000).
- The organization/individual who is delivering the project within the community.

6.1.1.3 Were Management and Administration Established?

National Management and Administration: The national office's administrative and management activities focus on annual financial planning at the national level and on the management of national projects, including national demonstration projects. The document review and interviews with First Nations and Inuit Health Branch staff indicated that the national office did not develop any administrative or management directives or administrative guidelines specific to the First Nations and Inuit Tobacco Control Strategy, deciding instead to employ the administrative and management practices common to all First Nations and Inuit Health Branch programs and initiatives.

The national office's annual work plans are developed through ongoing planning processes that include direct consultations with the National Advisory Circle and regular teleconferences and meetings with regional First Nations and Inuit Tobacco Control Strategy program coordinators and facilitators.

Regional Management and Administration: The First Nations and Inuit Health Branch delegates a high level of program management authority to its regional offices. Within the delegated authorities, the First Nations and Inuit Health Branch regional offices have developed standard procedures, practices and guidelines that are adapted to the region's circumstances and needs. Every effort was made not to create new or different management and administrative processes for individual program areas in order to avoid the complexities and burden of multiple approaches and requirements.

In the case of the First Nations and Inuit Tobacco Control Strategy, the regions applied their standard program management policies and procedures, including the overall form and content of contribution agreements, financial controls and accountability processes. The regional First Nations and Inuit Health Branch program consultants/managers are also responsible for developing annual work plans in consultation with their respective Advisory Circles and others as required by regional First Nations and Inuit Health Branch policies and practices. Generally, the structure and content of the annual work plans prepared since 2003/04 have been similar following the implementation of a national work plan template. The documents tend to lay out planned activities under the heading of 'objectives'. Some examples:

- To build capacity and develop the skills of health and community workers.
- To educate and create awareness of the harm of tobacco misuse.
- To design, develop, implement, coordinate and evaluate tobacco control programs and initiatives.
- To collaborate with First Nations and Inuit governments, federal, provincial and territorial governments, local social, health and educational authorities, and other organizations.

For each of the objectives, the region identified: the key activities planned to achieve the objective; the First Nations and Inuit Tobacco Control Strategy component addressed (e.g., protection, cessation, prevention, coordination, etc.); outputs (e.g., meetings, reports, training sessions, awareness video, etc.); time frame; planned operations and maintenance (O&M) and contributions budgets; partners; and target populations.

Community Management and Administration: The project management and administration processes used by First Nations and Inuit communities and their service-providing agencies varied in response to factors such as community size, the administrative and governance structures in place and the nature of the funded project. Neither the documents review nor the interviews with community project representatives and First Nations and Inuit Health Branch personnel identified any community management and administrative issues or concerns particular to the First Nations and Inuit Tobacco Control Strategy.

6.1.1.4 Were Partnerships Established?

Partnerships within the First Nations and Inuit Tobacco Control Strategy Framework have been defined as: [47]

> *. . . a coming together of concerned individuals and organizations to address an issue within a community. Successful partnerships will identify common interests, create and implement a project, and ultimately achieve positive results to improve the quality of life in a community.*

National Partnerships: The First Nations and Inuit Health Branch has developed partnerships with most national Aboriginal Organizations, especially those directly involved in health-related issues, and with the Federal Tobacco Control Strategy.

The document review and interviews demonstrated that the partnership with the Federal Tobacco Control Strategy, which is managed by the Healthy Environments and Consumer Safety Branch within Health Canada, has tended to focus on social marketing, evaluation and initiative management within the federal government. The Federal Tobacco Control Strategy has a broad mandate that includes tobacco control activities targeting Aboriginal populations other than on-reserve residents of First Nations and Inuit in Inuit communities.

Regional Partnerships: The level and form of regional partnerships, as identified in a review of recent regional work plans and interviews with First Nations and Inuit Health Branch staff, varied from partnership to partnership. The regions identified partnerships with provincial/ territorial government agencies and departments, non-governmental groups and coalitions, as well as organizations and institutions involved in tobacco control training.

Community Partnerships: The most common community partnerships identified in the survey were with health services, Band Councils, schools and the National Native Alcohol and Drug Abuse Program. (See Table 1 on the next page.)

---

[47] *Building and Sustaining Partnerships, A resource Guide to Address Non-Traditional Tobacco Use*, First Nations and Inuit Health Branch, page 15, October 2003.

Table 1
Community Partnerships

Partners - Contributions	Funding	Advice	Staff	Other	Total	%
Health centre/services	7	16	70	43	136	75.6%
Band Council/ local government	10	24	13	75	122	67.8%
Schools or education system	0	9	41	70	120	66.7%
NNADAP	2	13	53	44	112	62.2%
Elders' Council or similar group	0	29	6	32	67	37.2%
Non-governmental groups	3	17	4	34	58	32.2%
Youth Council or similar group	2	19	16	13	50	27.8%
Social services	3	6	14	18	41	22.8%
Provincial/Territorial Health	2	10	2	22	36	20.0%
Police	1	6	14	10	31	17.2%
Tribal or Regional Council	5	8	2	16	31	17.2%
Other	0	2	2	5	9	5.0%

From the results from the telephone survey, it was determined that a large majority (93.9%) of the projects represented in the survey were managed and/or delivered by people who identified themselves as affiliated with health services and/or the National Native Alcohol and Drug Abuse Program.

In the case of schools, the cooperation, as described in interviews, tended to centre on access to school classrooms and other school facilities to deliver education and awareness activities to students. There were, however, examples of more extensive partnerships that were expressed in joint projects such as efforts to support the integration of tobacco prevention materials in health curricula.

With respect to Band Councils and local Inuit governments, the people participating in the in-person community interviews identified two issues that engaged officials. The first was their role in reviewing and approving project funding proposals. The other was debating policies, especially those policies relating to the smoke-free status of community offices and facilities and, less frequently, addressing measures to reduce the availability of commercial tobacco to youth.

Somewhat fewer than 25% of the in-person interviewees stated that maintaining partnerships was quite difficult because of inconsistent First Nations and Inuit Health Branch funding practices. They stated that First Nations and Inuit Health Branch funding was not guaranteed and sometimes funding was not available for a significant portion of the fiscal year.

6.1.2 Findings (EQ 1.1)

The primary findings developed from Evaluation Question 1.1 are as follows:

- Implementation and project-specific work plans were produced at the national, regional and community levels.
- National, regional and community organizational structures are in place.
- Through the examination of documents and interviews with FNIHB staff and consultants, it was found that appropriate management and administrative processes and controls, relative to project size and risk, are in place; however, not all processes are adequately documented.
- Nationally, First Nations and Inuit Tobacco Control Strategy partnerships have been established with national First Nations and Inuit organizations with health-related mandates and interests as well as with the Health Canada organization responsible for the Federal Tobacco Control Strategy, of which the First Nations and Inuit Tobacco Control Strategy is a part.
- At the regional level, First Nations and Inuit Tobacco Control Strategy programs have partnered with federal and provincial/territorial agencies, non-governmental groups and, less frequently, educational institutions. While some of the relationships are structured and ongoing, the majority are occasional partnerships established around training events and/or are designed to share public education and awareness resources.
- Community projects tend to partner with others within the health and wellness sector, as well as with schools and Band Councils. Partnerships with other organizations, especially organizations outside the community, tend to be less common and more situational.
- National and regional partnerships have been established to support the First Nations and Inuit Tobacco Control Strategy. Community projects tend to partner with others within the health and wellness sector as well as with schools and Band Councils. Those community partnerships with other organizations, especially organizations outside the community, tend to be less common and more situational.
- A large portion of the partnerships are ‘internal’ program partnerships. For example, a Community Health Representative responsible for tobacco control would often report a partnership with health services when tobacco awareness activities were delivered in conjunction with diabetes, the Canadian Prenatal and Nutrition Program and/or other heath promotion initiatives. The community interviews in the regions reflected this pattern, with individuals within health services and the National Native Alcohol and Drug Abuse Program working together to pool resources to support a larger event in the community.

6.1.3 Recommendations (EQ 1.1)

As part of its ongoing management and administration practices, it is recommended that the First Nations and Inuit Health Branch and its First Nations and Inuit Tobacco Control Strategy partners undertake a management review of where it is today and where it should be in the next three to five years. The management review should include:

- An update of all strategic and guidance documents, including the First Nations and Inuit Tobacco Control Strategy Program Framework, so that the strategic documents:
  - Reflect the experience and knowledge gained to date;
  - Address the new issues that have been identified, such as the production of commercial tobacco on reserves and the economic impact it has upon the community; and
  - Provide community support;
- An update of the First Nations and Inuit Tobacco Control Strategy organizational structure including national, regional and community organizations, including an examination of the roles and responsibilities of each of the organizations;
- A review of the regional planning and reporting format and content requirements as to the levels of detail and levels of effort appropriate at the national, regional and community levels. The relatively small size of First Nations and Inuit Tobacco Control Strategy projects should be a major consideration when developing community planning and reporting requirements and guidelines; and
- A review of partnering with the objective to identify how more effective and longer-term partnerships can be established to support the First Nations and Inuit Tobacco Control Strategy at the community level.

6.2 Evaluation Question 1.2: Program Management

Question
Were the First Nations and Inuit Health Branch's national and regional offices successful in supporting and funding the implementation of the First Nations and Inuit Tobacco Control Strategy?

6.2.1 Discussions (EQ 1.2)

6.2.1.1 Clear Communications of Objectives

National Communications: The primary vehicle at the national level for communicating the First Nations and Inuit Tobacco Control Strategy's objectives to regional and community participants was the publication and distribution of the First Nations and Inuit Tobacco Control Strategy Program Framework document.

Following the approval of the Program Framework in 2002, the office had printed copies of the document prepared and distributed to regional offices, to national and regional First Nations and Inuit organizations with interests in health issues and to other regional Aboriginal organizations and governments. The document was also published on the First Nations and Inuit Health Branch's website.

Regional Communications: The First Nations and Inuit Health Branch's regional offices and Regional Advisory Circles did not undertake any specific communication activities to inform communities and others about the First Nations and Inuit Tobacco Control Strategy's objectives and approaches. However, they have designed project proposal guides that highlight the objectives, thus ensuring, at the very least, that the people directly involved in project development and proposal writing are aware of the Strategy's objectives.

Project proponents and project holders received information about the First Nations and Inuit Tobacco Control Strategy's objectives through project proposal guides and similar documents provided by the First Nations and Inuit Health Branch. However, it was noted during the interviews that, in some communities, the individuals who prepared and submitted project proposals were not necessarily the same individuals who were selected to deliver the First Nations and Inuit Tobacco Control Strategy projects. This suggests that there may have been gaps in information and knowledge if the project delivery team did not write the proposal, with one result being that the individuals delivering the projects may not be familiar with the First Nations and Inuit Tobacco Control Strategy's objectives and approaches.

The community telephone survey sought to assess whether the people participating in the interviews knew what the program's objectives were by asking them to identify the objectives. More than 85% of the respondents accurately identified the objectives associated with decreasing commercial tobacco use and uptake by youth (Table 2 on the next page). The level of awareness with respect to environmental smoke and capacity building were slightly lower, while people were least likely to identify the objective of engaging Elders and community leaders.

6.2.1.2 Were Human Resource Foundations Established?

National Foundations: Since its creation, the national office staff complement has included personnel assigned management and administrative support responsibilities, as well as First Nations and Inuit Tobacco Control Strategy program officers. There were two full-time program officers assigned to the office from mid-2001 to late 2005, with a third program officer position approved and added in 2005. The national full-time training position envisioned by the Program Framework was not staffed; however, training responsibilities were incorporated into the other responsibilities of the existing program officers.

From 2001 to March 2005, the First Nations and Inuit Tobacco Control Strategy staff in the national office reported directly to the manager of Addictions. In early 2005, the directorate created a new unit responsible for both directorate planning and the tobacco initiative. The structures and reporting processes (human resource foundations) employed within the First Nations and Inuit Tobacco Control Strategy, at the national level, parallels what is done in other First Nations and Inuit Health Branch health programs and initiatives.

Table 2
Awareness of Objectives

FNITCS Objectives	Yes	Partial	Not Identified	Total	% Yes	% Partial
To build the capacity to develop and deliver comprehensive, culturally sensitive and effective tobacco control programs at a pace acceptable to those communities.	127	33	20	180	70.6%	18.3%
To promote the health of First Nations and Inuit by decreasing the prevalence of tobacco smoking and spit tobacco use among all age groups, but in particular among youth and pregnant women.	154	14	12	180	85.6%	7.8%
To decrease the uptake of smoking among youth.	158	11	11	180	87.8%	6.1%
To decrease the impacts of environmental tobacco smoke/second-hand smoke.	118	34	28	180	65.6%	18.9%
To engage the community leadership.	87	60	33	180	48.3%	33.3%
To engage Elders as leaders.	89	55	36	180	49.4%	30.6%

Regional Foundations: The First Nations and Inuit Tobacco Control Strategy program Framework indicated that the eight First Nations and Inuit Health Branch regions were to hire program consultants to: (i) assist with program start-up; (ii) provide support to project sponsors during the proposal development stage; and (iii) provide ongoing support, as jointly prescribed by First Nations and Inuit Health Branch Regional management, the requirements of communities and the priorities established in regional plans for ongoing support.

Seven regions appointed full-time First Nations and Inuit Tobacco Control Strategy program consultants. The Northern Secretariat Region assigned the role of program consultant for each of the territories to individuals who also carry responsibilities for other First Nations and Inuit Health Branch program areas within those territories.

In addition to employing program consultants, the First Nations and Inuit Tobacco Control Strategy Program Framework states that the Regional Offices would appoint program facilitators to work with the Regional Advisory Circles and provide support for communities through facilitating training and developing proposals and community tobacco control strategies. The structures and reporting processes (human resource foundations) employed at the regional level parallel what is done at the regional level for other First Nations and Inuit Health Branch health programs and initiatives.

Community Foundations: Between 50% and 75% of the First Nations and Inuit Tobacco Control Strategy projects received funding to offset the costs of tobacco control activities, but little or no First Nations and Inuit Health Branch funding was allocated for staff positions. As a result, project holders are dependant on one or more existing health programs, the National Native Alcohol and Drug Abuse Program or other community-based staff to plan, coordinate and deliver the First Nations and Inuit Tobacco Control Strategy projects. The communities, Tribal Councils and regional agencies that receive funding for larger projects are able to recruit full-time staff.

As demonstrated in Table 3, 88.3% of the project holders that were surveyed reported that they worked 50% or less on the First Nations and Inuit Tobacco Control Strategy, while only 4.4% worked full-time on the First Nations and Inuit Tobacco Control Strategy.

Table 3
Level of Effort

Respondent's Level of Effort	Frequency	Percent
Less than 10%	63	35.0
10 to 25%	76	42.2
26 to 50%	20	11.1
More than 50%	10	5.6
Full time	8	4.4
Uncertain / Did not know	2	1.1
No response	1	0.6
Total	180	100

When asked what percentage of their working time was devoted to their tobacco project in recent months, 42% of the survey respondents reported that it required 10-25% of their time. In addition, about half the projects reported that their project efforts are augmented by the contributions of two or more staff, as shown in Table 4 below.

Table 4
Numbers of Other Workers Supporting the Project

Number of Others Working on Project	Frequency	Percent
One person	54	30.0
Two persons	34	18.9
Three or more persons	57	31.7
Uncertain / Did not know	4	2.2
None	31	17.3
Total	180	100

It would appear that the ability to implement smaller projects depends on the project holder's ability to recruit one or more of its staff to undertake the learning and make the ongoing commitment to tobacco reduction work. Projects employing full-time or part-time staff face the challenge of recruiting, training and supporting workers without any assurance of long-term funding and continuous employment.

The document review, the telephone survey and the interviews identified the instability and timing of First Nations and Inuit Tobacco Control Strategy funding practices as a major disruption. In personal interviews and Sharing Circles, project holders consistently voiced concerns about project delivery inefficiencies due to inconsistent funding and the personal stress this creates on project staff. It was also reported that the lengthy gaps when resources were not available to support tobacco control activities negatively affected staff motivation as well as community confidence, participation and buy-in to the project. It also contributed to an unnecessarily high level of staff turnover.

6.2.1.3 Training and Education Resources

Nationally and regionally, First Nations and Inuit Tobacco Control Strategy offices and Advisory Circles have worked to develop and deliver training events. In the first phase of the initiative some of the training efforts focused on project design, proposal writing and project management. More recently, some training events and resource materials specific to tobacco control have been developed. The majority of the training opportunities have focused on information and knowledge about the health impacts of tobacco misuse, prevention and cessation.

Throughout the life of the First Nations and Inuit Tobacco Control Strategy, the First Nations and Inuit Health Branch and the Advisory Circles emphasized the development of training curricula and tools that are culturally appropriate and respectful of the role that tobacco has in the traditions and ceremonies of many First Nations. The interviewees noted that most educational resources produced nationally and regionally were appropriate for use within the communities, as most had been adapted or developed for use in First Nations and Inuit communities.

The telephone survey respondents were asked to state whether they had participated in workshops, courses or other training events dealing with specific, listed subjects. They were also asked to indicate whether they had received and/or used self-study materials dealing with the same subjects:

- 67.2% of the respondents reported that they had attended training events; and
- 80.6% that they had received or used self-study materials.

Cessation interventions and the health effects of tobacco misuse were the most prevalent subjects for both training events and self-study materials, with 55% of the people surveyed reporting that they had attended smoking cessation training events while 73% had done self-study in that area.

This means that more than 30% of the respondents reported they had not received training or training materials related to developing and maintaining partnership or community development strategies; this, in turn, indicates that ongoing training is a continuing requirement.

6.2.1.4 Were Appropriate Criteria Established?

The review of national and regional project proposal guides and tools used for evaluating proposals did employ criteria linked to the First Nations and Inuit Tobacco Control Strategy's objectives and approaches as set out in the First Nations and Inuit Tobacco Control Strategy Program Framework.

The document review and interviews with First Nations and Inuit Health Branch personnel identified a high level of confidence that the processes used to evaluate proposals were understood, clear and open.

6.2.1.5 Funding and Approval Processes

National Funding and Approval Processes: The five-year $559.8 million Federal Tobacco Control Strategy was approved by Treasury Board in 2001. Included was a $50 million budget allocation for the First Nations and Inuit Tobacco Control Strategy which as to be managed by First Nations and Inuit Health Branch. The First Nations and Inuit Tobacco Control

Strategy's annual budget allocation was originally established at $6.0 million in the first fiscal year (2002/03), $10.0 million in each of the two following years (2003/04 and 2004/05) and $12 million in each of the last two years (2005/06 and 2006/07).

The overall First Nations and Inuit Tobacco Control Strategy allocation for each year is determined by the Branch through its annual budget exercise, with approximately 30% of that amount assigned for headquarters operations, national contribution agreements and contracts. The balance is distributed among the regions based on a formula that includes a base amount, community populations and remoteness factors.

Regional budget allocations were provided by FNIHB staff, which is summarized in Table 5 on the following page.

The annual allocations do not represent the amount of money that was actually spent, $39.0 million versus the originally planned $50.0 million. The interviews with First Nations and Inuit Health Branch personnel and the analysis of data provided by four regions indicate that actual national expenditures for the First Nations and Inuit Tobacco Control Strategy in any given year were lower than the amounts allocated; this occured for one or both of the following reasons:

- First Nations and Inuit Health Branch headquarters and/or regional management reassigned a portion of the First Nations and Inuit Tobacco Control Strategy allocation to cover costs for other programs and priorities; and/or
- Funds from the approved First Nations and Inuit Tobacco Control Strategy budget were committed for specific projects through contribution agreements during the year, but were not spent because some of the projects reported surpluses, were terminated early, or were never implemented because the funding was approved too late in the year.

Table 5
Budget Allocations in 000s

	2001-02	2002-03	2003-04	2004-05	2005-06	Total
North	511	657	669	744	956	3,537
ATL	411	373	441	780	588	2,593
QC	411	534	656	730	636	2,967
ON	411	679	843	947	1,238	4,118
MB	411	623	761	852	1,105	3,752
SK	411	515	631	701	895	3,153
AB	411	530	620	688	877	3,126
BC	411	565	713	797	1,028	3,514
Regions totals	3,388	4476	5334	6,239	7,323	26,760
HQ	1,370	1,524	2,366	3,729	3274	12,263
Total	4,758	6,000	7,700	9,968	10,597	$39,023

A small number of the community interviewees, fewer than 10%, noted that a significant percentage of First Nations and Inuit Tobacco Control Strategy funding was allocated to overhead expenses at the national and regional levels, and that this money needed to be redirected to the communities that are delivering the projects. They reiterated the need for an organization review to streamline the administrative processes.

The most frequent budget management issue identified in Sharing Circles (more than 90% of the respondents in the regional interviews and the telephone survey) was the lengthy delays in the release of First Nations and Inuit Tobacco Control Strategy funds. The major source of these delays was the release of allocations from headquarters to the regions. Funds were released in December for 2001/02, in September for 2002/03, in October for 2003/04, in June for 2004/05, and in May for 2005/06.

Once the funds have been released at the national level, the regional proposal review and approval processes, combined with the administrative requirements of preparing or amending contribution agreement with communities, add additional weeks to the delay in funding community tobacco control projects.

The consensus among the community project holders participating in Sharing Circles and regional interviews was that the delays caused by the First Nations and Inuit Health Branch's budget planning process were a prime cause of staff turnover and frustration in the communities and of inefficiencies in project delivery in the communities. Some proposed that a review of the entire funding approval process for initiatives is required because the delays in current project approval and funding processes are causing significant inefficiencies in program delivery, training and staff retention.

Regional Funding and Approval Processes: The project funding proposal and review approval processes used by the regions follow a common pattern. Funding at the regional level is based on the submission and acceptance of proposals that meet program criteria and on the signing of contribution agreements for those projects identified/selected for funding. Some interviewees, between 25% to 50%, stated that the First Nations and Inuit Health Branch demands too much support documentation and detail in its calls for project submissions. They also stated that most First Nations and Inuit Tobacco Control Strategy projects have a relatively small dollar value of just a few thousand dollars and that the work required to prepare proposals is excessive in relation to the funding received.

Community Funding and Approval Processes: The submission of project proposals by prospective project holders requires the production of a detailed work plan that includes a list of deliverables and milestones. The work plans tended to be produced in sufficient detail to allow the project holders to follow their plan and for the First Nations and Inuit Health Branch to monitor project delivery.

The majority of the projects are of a relatively low dollar value, under $10,000. More than 75% of community interviewees stated that developing individual project plans and reporting to the First Nations and Inuit Health Branch consumes too much of the total level of effort dedicated to the project. Some interviewees further stated that writing the project proposals and their end-of-project reports took more time than what was spent to deliver the project to the community. Interviewees also noted that reporting requirements, as specified by the contribution agreements, were sometimes vague and that some regional First Nations and Inuit Health Branch staff changed the reporting requirements and format in mid-year, sometimes adding to the reporting requirements specified within the contribution agreements.

Interviewees noted that contribution agreements are presented to them for signature without their having had the chance to make suggestions and changes. This is a problem for many as they believe that contribution agreements were designed for large complex projects and that the demands for reporting are excessive for the typical small dollar value projects funded under the First Nations and Inuit Tobacco Control Strategy.

6.2.2 Findings (EQ 1.2)

The following are the primary findings developed from Evaluation Question 1.2:

- The objectives and approaches were understood and communicated at the national and regional levels.
- An estimated $39 million of the $50 million budget allocation for the First Nations and Inuit Tobacco Control Strategy was released by Health Canada to the First Nations and Inuit Health Branch's regional offices. Also, portions of the released $39 million were not spent on the First Nations and Inuit Tobacco Control Strategy due either to:
  - Funding sometimes arriving too late in some regions for planned activities to be completed within the fiscal year, resulting in the requirement to reallocate the unspent funds at year's end; or
  - Portions of the First Nations and Inuit Tobacco Control Strategy funding sent to the regions were reallocated by regional staff to address priorities and funding shortages within other First Nations and Inuit Health Branch programs and initiatives.

  Note: The gaps in financial information did not allow for the identification of the percentage of the $39 million budget that was eventually spent on the First Nations and Inuit Tobacco Control Strategy.
- Community participants have been informed about the First Nations and Inuit Tobacco Control Strategy objectives and approaches through proposal guidelines and reporting tools.

- Based on the results of the telephone survey, community participants have a general, but not comprehensive, knowledge of the First Nations and Inuit Tobacco Control Strategy objectives.
- Human resource foundations were established at the national, regional and community levels.
- The full-time national training coordinator position was not staffed; the responsibilities were assigned to other staff.
- Some communities had difficulty identifying knowledgeable tobacco control resources to work within their communities.
- More than 30% of the respondents reported they had not received training or training materials related to developing and maintaining partnership or community development strategies. Ongoing training is a continuing requirement.
- The interviewees noted that most educational resources produced nationally and regionally were appropriate for use within the communities since most had been adapted or developed for use in First Nations and Inuit communities.
- Many of the interviewed community-based project holders stated that the most readily available training resources, such as those available on the Internet, are generally not culturally appropriate for direct use within First Nations and Inuit communities.
- According to the project holders, appropriate criteria were established to define project eligibility.
- The First Nations and Inuit Health Branch has established and maintains appropriate national and regional funding approval processes, however there were significant delays in funding allocations to the regional and community levels.
- The effectiveness of the initiative has been limited by the delays in the release of First Nations and Inuit Tobacco Control Strategy funds by headquarters to the regions.
- Developing individual project plans and reporting to the First Nations and Inuit Health Branch consumes too much of the total effort dedicated to the project. Some interviewees stated that writing the project proposal and the end-of-project report took more time than what was spent to deliver the project.
- Finally, in some instances the regional processes for contribution agreements can cause delays.

6.2.3 Recommendations (EQ 1.2)

As part of its ongoing management and administration practices, and its desire to improve program delivery, it is recommended that the First Nations and Inuit Health Branch and its First Nations and Inuit Tobacco Control Strategy undertake a management review to:

- Identify training needs at the regional and community levels and develop a strategy that will ensure effective training at all levels and at a frequency which will address high staff and employee turnover rates; and.
- Identify the structural barriers and impediments that are causing funding delays at both the national and regional levels.

6.3 Evaluation Question 1.3: Community Delivery

Question
Was the First Nations and Inuit Tobacco Control Strategy successful in delivering community programming?

6.3.1 Discussions (EQ 1.3)

6.3.1.1 Project Creation

National Project Creation: At the national level, First Nations and Inuit Tobacco Control Strategy contribution funding has supported the demonstration projects and a number of training and resource development initiatives, most undertaken by national Aboriginal organizations. The funds have also been allocated to support:

- Partnerships with national Aboriginal organizations;
- The development of culturally appropriate training tools and processes; and
- The design and distribution of community-oriented education and awareness tools and products.

Regional Project Creation: In addition to supporting project development and managing the contribution funds allocated for community projects and activities, First Nations and Inuit Tobacco Control Strategy resources have supported regional initiatives. The majority of these initiatives have focused on capacity building (training, networking, information sharing, etc.) and the development and distribution of culturally appropriate social-marketing products, educational and awareness materials and similar resources.

Community Project Creation: Based on project lists and other information provided by the First Nations and Inuit Health Branch's regional offices, it appears that:

- All of the First Nations and Inuit communities in Quebec, Manitoba, Saskatchewan and Alberta have received direct funding through the First Nations and Inuit Tobacco Control Strategy, or they are the beneficiaries of tobacco activities delivered by their Tribal Councils or regional governments;
- In the Atlantic region, the Inuit communities of Labrador are the beneficiaries of a project sponsored by the Labrador Inuit Health Commission (LIHC) and all but one of the First Nations have participated in the First Nations and Inuit Tobacco Control Strategy;
- Fifty (50) of the 139 communities in Ontario have received direct First Nations and Inuit Tobacco Control Strategy funding and an additional 23 communities have benefited from services delivered by four Tribal Councils;
- In British Columbia, about a third of First Nations have been involved in tobacco activities as individual communities or through coalitions;
- In the Yukon, 11 tobacco projects were funded in 2005-2006; and
- The delivery of the First Nations and Inuit Tobacco Control Strategy in Nunavut and the Northwest Territory is managed through local governments which target all communities.

The evaluation's survey of First Nations and Inuit Tobacco Control Strategy community projects reached about 260 First Nations communities and 15 Inuit communities and found that the activities identified as most "important" by respondents included those that addressed the Strategy's objectives.

Table 6
Ranking of Project Activities

Activities	Rank		
	1nd	2nd	3rd
Preventing tobacco misuse by youth	95	23	22
Promoting smoke-free homes and/or public spaces	26	33	26
Educating people on dangers of smoking for children	16	36	41
Promoting anti-smoking attitudes in the community	17	30	36
Delivering cessation programs and services	15	25	19
Information about or referrals to cessation programs	2	14	15
Encouraging enforcement of by-laws/regulations	5	11	6
Training teachers, health care staff and others	4	5	9
Research on tobacco control and/or tobacco misuse	0	3	5
Other	0	0	1

6.3.1.2 Integration and Coordination

During the in-person interviews and the Sharing Circles, more than 75% of the project representatives described service delivery models that emphasized the pursuit of the First Nations and Inuit Tobacco Control Strategy's education, prevention and awareness objectives through activities that linked tobacco use reduction with general health promotion. There were, for example, frequent references to the advantages of making links to the importance of reducing tobacco misuse in programs designed to reduce or mitigate respiratory, cardiac and diabetes risks.

The respondents also described a variety of efforts to educate parents, particularly expectant and new mothers, about the negative health impacts of tobacco use for infants and children by integrating anti-tobacco information and education in prenatal and parenting programs and the Canadian Prenatal and Nutrition Program.

Based on the information gathered during the telephone survey, projects were most likely to work in partnerships with health services and schools that contributed staff time to deliver activities.

6.3.1.3 Project Barriers

The project representatives participating in the telephone survey were asked to describe the challenges that they and others encountered in trying to implement the First Nations and Inuit Tobacco Control Strategy in their communities. The most common challenges reported were associated with community attitudes and resistence to change (Table 7). Responding to an open question, 79 of 167 interviewees identified one or more of the following barriers:

- Apathy, lack of interest;
- Community denial of tobacco as an addiction, plus a focus on other addictions (alcohol, drugs, etc.);
- Community perception;
- Low attendance rates,
- Lack of interest from older people;
- Smoking is 'normal';
- People not interested to change behaviour;
- Elders who smoke may not be considered role models;
- Everybody smokes, thus low turnout from adults;
- Getting people to participate in the project;
- Getting the people involved;
- Getting young people involved;
- Hard to get people to the workshops;
- Not enough support from the community; and
- (it seems that) Everyone in the community smokes.

A similar range of challenges was identified by project representatives in personal interviews, although funding issues and political resistance, rather than attitudes, were the challenges more commonly identified.

Table 7
Implementation Barriers

Implementation Challenges (Personal Interviews)	Frequency
Funding issues, particularly levels of funding and timing of allocations	10
Political resistance	8
Community attitudes and ignorance about the effects of tobacco misuse	8
Human resources (availability and qualification)	6
Commercial interests	5
Isolation of some communities	4
Other priorities (e.g., drug abuse)	4

6.3.1.4 Consistency

The First Nations and Inuit Tobacco Control Strategy Program Framework identified four principal areas of activity for the Tobacco Control Strategy projects to focus on:

- *activities that influence behaviour and attitudes, whether directly as an activity or set of activities dedicated solely to tobacco control or as part of a more multi-dimensional healthy lifestyle program that engages the time, energy and use of physical space in ways that promote health and divert adults and youth from smoking and smokeless tobacco use;*
- *activities which build capacity, such as developing and distributing culturally appropriate community tobacco control strategies with curriculum guides, information packages and training the trainers and training the counsellors who will provide prevention and cessation programs within communities and facilitate community support;*
- *activities which ensure provider compliance, such as education programs for vendors inside and near First Nations and Inuit communities or enforced community by-laws regulating the sales and promotion of commercial tobacco products;*
- *activities which involve coordination and development, such as curriculum development, preparation of training-the-trainer sessions, the coordination and hosting of seminars of several communities or regional or age group-specific conferences and which attempt to engage community support for the tobacco control strategies. Examples of community support activities include leadership consultations and seminars and the formation of local tobacco control advocacy and education groups.*

National Consistency: The national office, with the advice of the National Advisory Circle, approved contracts and contributions in the following areas:

- Planning: Consultants were hired to assist with the development of the Framework and the production of the resource guide *Building and Sustaining Partnerships* and similar resources.
- National Demonstration Projects: Eight National Demonstration Projects were initially funded to help develop knowledge regarding effective culturally sensitive tobacco control approaches (best practices). Seven of the eight projects remained operational in 2005-06.
- Capacity Building: National organizations, such as Pauktuutit Inuit Women of Canada, Nechi Training Institute and the National Indian and Inuit Community Health Representatives Organization (NIICHRO) have sponsored national training events or developed training tools for use by communities.

- Tools: Projects have been undertaken to develop resources, such as the *Tobacco Cessation Workers Tool Kit*, for use by health care and other staff at the community level.

Regional Consistency: The regions have supported projects and activities that have focused on:

- Capacity Building: Training events and capacity-building activities included: (i) training events; (ii) development of training materials and retailer guides; and (iii) less frequently experience-sharing events were held.
- Awareness Tools: Projects and activities to design and produce materials and products for regional and local education and social-marketing efforts. The products of these efforts include posters, brochures, handbooks and other tools that feature First Nations and Inuit images, languages and traditions.
- Other: Projects supporting First Nations and Inuit Tobacco Control Strategy planning such as: environmental scans and evaluation plans, and policy development; and surveys and programs to recognize communities that have established smoke-free public spaces.

Community Consistency: The First Nations and Inuit Tobacco Control Strategy has funded 236 community projects as well as territorial programs in the Northwest Territories and Nunavut, reaching all of the communities in these two regions. The projects reach about 75% of the communities outside of the Northwest Territories and Nunavut.

Based on the telephone survey responses, the funded projects tend to target children and youth and pregnant women, the groups who were identified as priority targets for the First Nations and Inuit Tobacco Control Strategy.

Table 8
Target Populations Addressed Within (by) Projects

Target Populations Addressed Within Projects	Frequency
Youth 13 to 21 years old	130
Children 12 years and younger	90
Pregnant women	73
Adults	52
Mothers of infants and young children	48
Elders/seniors	17
Teachers, health and other community workers	11
Community leaders	5
Other	11

6.3.2 Findings (EQ 1.3)

The primary findings developed from Evaluation Question 1.3 are as follows:

- The First Nations and Inuit Tobacco Control Strategy delivered tobacco control projects which fell within the objectives of the First Nations and Inuit Tobacco Control Strategy.
- The large majority of project holders are coordinating and integrating the planning and delivery of projects/activities with other related community programs and initiatives.
- The four most commonly identified challenges are: (i) community attitudes; (ii) funding issues, particularly levels of funding and timing of allocations; (iii) lack of First Nations and Inuit Tobacco Control Strategy support by community leadership; and (iv) human resources (availability and qualifications).
- The types and volume of projects are consistent with the First Nations and Inuit Tobacco Control Strategy's objectives.
- The project activities are consistent with the range of activities identified for the First Nations and Inuit Tobacco Control Strategy and are relevant to its objectives and priorities.

6.3.3 Recommendations (EQ 1.3)

It is concluded that the First Nations and Inuit Tobacco Control Strategy is delivering tobacco control projects that are within the scope and objectives described within the Program Framework.

As part of its ongoing management and administration practices, and the desire to improve program delivery, it is recommended that the First Nations and Inuit Health Branch and its First Nations and Inuit Tobacco Control Strategy partners undertake a management review of barriers and challenges faced at the national, regional, and community levels with a view to facilitating the implementation, management and administration of tobacco control projects.

6.4 Issue #1: Implementation

Issue: Was the First Nations and Inuit Tobacco Control Strategy implemented as proposed in the First Nations and Inuit Tobacco Control Strategy Program Framework?

6.4.1 Conclusions: Issue #1

In summary, the conclusions for Issue #1 are:

- The First Nations and Inuit Tobacco Control Strategy has an established and functioning planning process, organizational structures have been established, operational and reporting processes and requirements have been established, and partnerships had been initiated.
- The First Nations and Inuit Tobacco Control Strategy has communicated its objectives, established human resource foundations, developed and delivered training and educational resources, established an effective selection criteria or process, and has delivered project funding to the communities.
- Inconsistent funding levels and significant delays in funding practices have had a significant negative impact upon community resources.
- The First Nations and Inuit Tobacco Control Strategy is delivering tobacco control projects that are within the scope and objectives described within the Program Framework. A future summative evaluation will determine if these projects are successful and if they are producing the expected results identified within the Program Framework.

6.4.2 Recommendations: Issue #1

In summary, the recommendation for Issue #1 is that the First Nations and Inuit Health Branch and its First Nations and Inuit Tobacco Control Strategy partners undertake a management review of where the Strategy is today and where it should be in the next three to five years. The management review should include, but not be limited to:

- Producing an update of all strategic documents, including the First Nations and Inuit Tobacco Control Strategy Program Framework, so that the strategic documents:
  - Reflect the experience and knowledge gained to date;
  - Address the new issues that have been identified, such as the production of commercial tobacco on reserves and the economic impact it has upon the community; and
  - Are more relevant to the community.

- Conducting an organizational review of the entire First Nations and Inuit Tobacco Control Strategy organizational structure, including national, regional and community organizations. The review should include an examination of the roles and responsibilities of each of the organizations and the interfaces and dependencies that exist between the organizations;
- Examining regional planning and reporting format and content requirements as to the levels of detail and levels of effort that would be appropriate at the national, regional and community levels. The relatively small size of tobacco control projects should be a major consideration when developing community planning and reporting requirements and guidelines;
- Examining partnership processes in order to identify how more effective and longer-term partnerships can be established to support the First Nations and Inuit Tobacco Control Strategy at the community level;
- Identifying training needs at the regional and community levels and developing a strategy that will deliver effective training at all levels and in a manner that addresses high staff and employee turnover rates;
- Identifying the structural barriers and impediments that are causing funding delays at both the national and regional levels; and
- Reviewing barriers and challenges faced at the national, regional and community levels regarding the implementation, management and administration of tobacco control projects.

SECTION 7.0 EVAL FINDINGS, ISSUE #2: SUCCESS AND PERFORMANCE

This section of the report addresses Evaluation Issue #2.

> *Were success targets, performance measurement indicators and a performance measurement system established that will allow for the evidence-based measurement of the First Nations and Inuit Tobacco Control Strategy's results?*

An important element of this formative evaluation is to determine if the structures, processes and information exist for the upcoming summative evaluation that will identify and measure the successes and results of the First Nations and Inuit Tobacco Control Strategy.

7.1 Evaluation Question 2.1: Success Targets

Question
Were success targets established at the national, regional and community levels?

7.1.1 Discussions (EQ 2.1)

The First Nations and Inuit Tobacco Control Strategy's success targets were identified as five objectives within the Program Framework: [48]

1. *To build the capacity within First Nations and Inuit communities to develop and deliver comprehensive, culturally sensitive and effective tobacco control programs at a pace acceptable to those communities.*

2. *To promote the health of First Nations and Inuit people by decreasing the prevalence of tobacco smoking and spit tobacco use among all age groups, but in particular among youth and pregnant women.*

[48] First Nations and Inuit Tobacco Control Strategy Program Framework, August 6, 2002, page 4, First Nations and Inuit Health Branch.

3. *To decrease the uptake of smoking among youth. As smoking in First Nations and Inuit communities starts at a younger age, youth is considered to include children.*

4. *To decrease the impacts of environmental tobacco smoke on the health of First Nations and Inuit communities.*

5. *To engage the leadership of First Nations and Inuit in learning about, voicing opinions and supporting tobacco control strategies. This program includes Elders as leaders as they are holders of traditional knowledge and their opinions and support will be an important component in developing and building community capacity in First Nations and Inuit Tobacco Control strategies.*

7.1.2 Findings (EQ 2.1)

The First Nations and Inuit Tobacco Control Strategy expressed its success targets as either increasing or decreasing trends, whereas the Federal Tobacco Control Strategy took a different approach and identified its success targets in quantitative terms and provided dates by which it hoped to achieve its expected results:

The ten-year objectives of the Federal Tobacco Control Strategy, to be reached by 2011, are:

- *to reduce the national smoking prevalence from 25% to 20%;*
- *to reduce the number of cigarettes sold in Canada by 30%;*
- *to increase retailer compliance with youth access laws from 69% to 80%*
- *to reduce the number of people exposed to second-hand smoke in enclosed public places; and*
- *to explore how to mandate changes to tobacco products to reduce health hazards.*

If the First Nations and Inuit Tobacco Control Strategy were to adopt the approach taken by the Federal Tobacco Control Strategy to identify quantitative success targets,one result would be having the potential to provide more precise and detailed information to measure and demonstrate the results achieved by the First Nations and Inuit Tobacco Control Strategy. That information could also be used to deliver the First Nations and Inuit Tobacco Control Strategy more effectively.

7.1.3 Recommendations (EQ 2.1)

It is recommend that the First Nations and Inuit Tobacco Control Strategy adopt quantitative success targets complete with target dates by which the identified results should be achieved.

7.2 Evaluation Question 2.2: Performance Measurement Systems

Question
Were performance measurement systems established for the evidence-based measurement of results?

7.2.1 Discussions (EQ 2.2)

Performance measurement systems are management and evaluation tools that can be used to quantifiably determine if programs and projects are achieving their success targets within the specified time. Furthermore, performance measurement systems are dependent upon the identification of performance indicators that, when used in conjunction with a reliable and accurate information baseline designed to provide evidence-based information, will provide evidence-based proof that the program is or is not achieving its success targets and objectives.

7.2.2 Findings (EQ 2.2)

The First Nations and Inuit Tobacco Control Strategy Program Framework does not contain or describe the need for the development of a performance measurement strategy. Interviews conducted at the national level confirmed that neither a performance measurement strategy nor a performance measurement system had been approved for the First Nations and Inuit Tobacco Control Strategy.

During the Sharing Circles and in-person interviews, between 10 and 25% of the participants stated that their communities had attempted to undertake various surveys and studies related to smoking habits in their community and/or to measure the results that they may be achieving with their tobacco control projects. Some reported success with their surveys, but most stated that they lacked statistical and other information from a large enough portion of their community to be able to draw conclusions from their results. Others reported that their surveys were based on individuals they met and talked to, and that that information was used to measure community acceptance of their tobacco projects.

The participants in Sharing Circles and regional interviews generally did not disagree with the statement that quantitative success targets are good measures of project success. However, they also observed that success must also be measured in qualitative terms addressing quality of life

and the wellness of individuals, their families and the community as a whole. They also stated that the quantitative success targets need to be complemented by qualitative, culturally sensitive success targets that are appreciated and understood by community members in First Nations and Inuit communities.

7.2.3 Recommendations (EQ 2.2)

It is recommend that the First Nations and Inuit Health Branch and its First Nations and Inuit Tobacco Control Strategy partners establish a performance measurement system.

7.3 Evaluation Question 2.3: Information Baselines

Question

Have information baselines been established to ensure that the data and information required to measure performance will be available?

7.3.1 Discussions (EQ 2.3)

Information baselines include information gathered over the life of a program that can be used for the effective management and evaluation of the program.

Establishing and maintaining an information baseline is both time-consuming and costly. The design of an information baseline should be determined in part by the performance measurement strategy and system that have been developed for the program. The performance measurement system and its performance measurement indicators facilitate the task of identifying which information should be gathered and placed within the information baseline, thus avoiding the gathering of transactional information that is not required for the effective management and evaluation of the program.

Information baselines should contain outcomes-based information and not only outputs-based information.

7.3.2 Findings (EQ 2.3)

At the national level, a February 2006 study entitled 'Analysis of the Information from the Tobacco Control Program Evaluation Forms' gathered and presented information on the projects being delivered at the community level. This report, which produced outputs-based information, will be useful in providing an historical overview of the First Nations and Inuit Tobacco Control Strategy.

The Canadian Tobacco Use Monitoring Survey (CTUMS) was developed to provide Health Canada and its partners with timely, reliable and continual data on tobacco use and related issues. The survey's primary objective is to track changes in smoking status and amounts smoked, especially for 15-24-year-olds, those who are most at risk for taking up smoking. [49] The Canadian Tobacco Use Monitoring Survey's methodology did not track the number of respondents who were First Nations or Inuit when they conducted their smoking surveys, thus eliminating the possibility of using the Canadian Tobacco Use Monitoring Survey as part or all of the required information baseline to support the First Nations and Inuit Tobacco Control Strategy.

Attempts were made at the regional and community levels to establish information baselines to support their particular needs. Given that a performance measurement system has not been established, it could not be determined if the information that has been gathered would be useful to, and incorporated within, a national information baseline.

It is concluded that an accepted national information baseline upon an agreed upon performance measurement strategy has not been established.

7.3.3 Recommendations (EQ 2.3)

It is recommend that First Nations and Inuit Health Branch establish and populate an information baseline based upon outcomes that will support the management and ongoing evaluation of the First Nations and Inuit Tobacco Control Strategy.

[49] Health Canada Website; http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/ stat/ctums-esutc/index_e.html.

7.4 Issue # 2: Success and Performance Measurement

Question

Were success targets, performance measurement indicators and a performance measurement system established that will allow for the evidence-based measurement of the First Nations and Inuit Tobacco Control Strategy's results?

7.4.1 Conclusions: Issue #2

It was found that quantifiable success targets, a performance measurement system, and an information baseline have not been established.

It is also concluded that the summative evaluation to be conducted in the future would not be successful in measuring success and results if quantifiable success targets, a performance measurement system and an information baseline are not established.

7.4.2 Recommendations: Issue #2

It is recommend that the national and regional First Nations and Inuit Health Branch offices, assisted by the National and Regional Advisory Circles:

- establish quantitative success targets;
- develop a performance measurement strategy and system; and
- develop and maintain a national information baseline.

It is also recommend that the First Nations and Inuit Health Branch establish and populate an information baseline based upon outcomes that will support the management and ongoing evaluation of the First Nations and Inuit Tobacco Control Strategy.

SECTION 8.0 EVAL FINDINGS, ISSUE #3: EFFECTIVENESS AND EFFICIENCY

This section of the report addresses Evaluation Issue #3:

> *Are there ways to improve the delivery of the* [First Nations and Inuit] *Tobacco Control Strategy from the perspective of its effectiveness and/or its efficiency?*

The third evaluation issue examines ways to improve the efficiency and effectiveness of the First Nations and Inuit Tobacco Control Strategy at the national, regional and community levels.

8.1 Evaluation Question 3.1: Program Improvements

Question
Are there ways to improve the efficiency and effectiveness of the national and regional components in carrying out their responsibilities for delivery of the First Nations and Inuit Tobacco Control Strategy?

8.1.1 Discussions (EQ 3.1)

8.1.1.1 National and Regional Components

When asked about ways that the First Nations and Inuit Health Branch could improve how it administers the First Nations and Inuit Tobacco Control Strategy, the telephone survey respondents tended to emphasize funding levels and stability as matters that could improve the administration of the issues (Table 9 next page). However, they also identified a number of non-funding opportunities for improvements:

- **Improvements in Program Management:** The majority of the suggestions in this area addressed the reduction of administrative burdens (less paperwork; clearer and better structured work plans).

- **Project Support:** A number of the respondents called for the First Nations and Inuit Health Branch to provide more services to help community members plan and deliver services.
- **Training:** A significant proportion of those surveyed called for: continuing and increased training (e.g., more training for communities so we can do our jobs, especially with new trends, theories and information; keeping us up to date; and providing on-line training manuals we can download when we need them).

Table 9
Improvement Administration

Improvement Areas	Suggestions	Frequency
Funding - Levels	More funding to create full-time positions	38
Training	More training, especially with new trends/theories.	30
Program management	Less paper work; integrate with other programs; etc	27
Funding - Stability	Longer commitment; ongoing program; guarantees	22
Project support	More information on the programs and new avenues to explore.	31
Funding - Timing	Get money out at beginning of fiscal year	11
Information sharing	Networking between projects; Website to share experience	10
Other		19
Total	Suggestions Identified	188

8.1.1.2 Administrative Efficiencies

The First Nations and Inuit Tobacco Control Strategy is administered in accordance with the planning, funding approval and reporting practices and procedures established for all First Nations and Inuit Health Branch programs and initiatives.

The comments offered by survey respondents and the people participating in the Sharing Circles and in-person interviews indicated that the most common and important administrative challenges are:

- the number of separate work plans/proposals that have to be developed;

- the requirement for separate progress reports for each initiative even when the health promotion or wellness program in the community is trying to integrate its services and activities; and
- the level of detail required for progress reports.

A number of people participating in in-person interviews suggested the "cost" of the work they had to do to complete the administrative tasks for the First Nations and Inuit Tobacco Control Strategy seemed greater than the dollar value of the funding. In this regard, it was noted that about 90% of the participants that participated in the survey provided service to a single community. The average value of the contributions to single communities is less than $10,000, and can be as low as $3000.

The telephone survey asked for suggestions "about ways that the First Nations and Inuit Health Branch could improve how it administers the First Nations and Inuit Tobacco Control Strategy" (Table 10). About 14% of the suggestions concerned the need to reduce, or ways to reduce, the administrative burden associated with the management of the program.

Table 10
Community Administration

Improvement Areas	Suggestions	Frequency
Funding - Levels	More funding to create full-time positions	38
Training	More training, especially with new trends/theories.	30
Program management	Less paper work; integrate with other programs; etc	27
Funding - Stability	Longer commitment; ongoing program; guarantees	22
Project support	More information on the programs and new avenues to explore.	31
Funding - Timing	Get money out at beginning of fiscal year	11
Information sharing	Networking between projects; Website to share experience	10
No comment		9
Other		19
Total	Suggestions Identified	197

8.1.2 Findings (EQ 3.1)

The findings in response to Evaluation Question #3.1 are as follows:

- A more effective and efficient delivery of the First Nations and Inuit Tobacco Control Strategy could be achieved by addressing: (i) funding levels; (ii) training; (iii) program management; (iv) funding stability; (v) project support; (vi) funding timing; and (vii) information sharing.

- According to survey respondents, community administrative and reporting costs are not proportionate to the size and complexity of a majority of the projects.

It is concluded that the barriers to increasing efficiency and effectiveness at the national and regional levels are mostly structural in nature and are caused by the administrative and operational procedures established by the First Nations and Inuit Health Branch.

8.1.3 Recommendations (EQ 3.1)

It is recommend that the First Nations and Inuit Health Branch and its First Nations and Inuit Tobacco Control Strategy partners conduct a management review with the objective of making structural and other changes required to reduce and/or eliminate the barriers to increased efficiency and effectiveness.

8.2 Evaluation Question 3.2: Lessons Learned

Are there lessons learned and best practices that could be used to improve the efficiency and effectiveness of the First Nations and Inuit Tobacco Control Strategy?

8.2.1 What Areas are Working Well?

The interviewees and Sharing Circle participants identified three areas where national and regional operations were working well:

- Advisory Circles in their various forms;
- training initiatives; and
- support, where it exists, for sharing information and networking among projects.

In the telephone survey, the respondents expressed a variety of views about what has been successful. About half of them stated that success lay in the Strategy's very existence and that it had made money available to communities. Interestingly, given that community attitudes present the most common challenge faced by projects, at least a few project representatives see the positive community responses to the First Nations and Inuit Tobacco Control Strategy as success.

Table 11
Success

FNITCS Success Areas	Reasons Identified	Frequency
Funding	Funding for tobacco control only; Funding! What else?	39
Initiative in general	The very existence of the program	24
Community response	Good levels of participation	15
Flexibility	Ability to develop our own approaches	10
Training	The training was very effective	9
Program management	The coordinator's help; the funding process	4
Tradition	Maintaining tradition through ceremonies	1
Other		18
Total	Reasons Identified	120

8.2.2 What is Success?

Project representatives participating in the telephone survey were asked to identify the activities they thought are most likely to be successful in these four areas:

- Preventing children and youth from starting to use tobacco;
- Helping people quit misusing tobacco;
- Establishing smoke-free environments; and
- Helping pregnant women and mothers of infants avoid the use of tobacco and the effects of second-hand smoke.

The great majority of the activities identified were those that focused on engaging children and youth in learning activities in their schools and in the larger community (Table 12 below). Many of the approaches described by respondents incorporated activities that drew on the participants' skills (poster contests) or more immediate interests (recreational opportunities). Others focused on integrating age-appropriate teaching about the effects of smoking as part of ongoing learning (health course, reading/writing, science, etc.).

Just as education and awareness were the preferred activities for addressing prevention goals, the survey respondents favoured education and awareness activities, including community workshops, for helping people quit smoking. Cessation support groups, counselling and similar interventions were seen as successful strategies by few respondents (Table 13, next page).

Table 12
Youth and Prevention

Youth and Prevention	Examples of Activities	Frequency
School programs	Presentations in schools; resources and visual aids in schools	39
Events/Contests	Camps; poster contests; smoke-free dances	35
Education awareness	Workshops; giving them accurate information	33
Tools	Visual aids; videos and films; colouring books	15
Parents	Parent education; promoting smoke-free homes	12
Role models	Role models; personal examples	9
Culture/Tradition	Elders' teachings; teaching traditional knowledge	7
Social marketing	Mass media campaign	3
Other		14
Total	Activities Identified	167

Table 13
Cessation Activities

Support Activities	Examples of Activities	Frequency
Awareness and education	Presentations; visual aids; information on health effects	49
Community workshops	Lots of integrated workshops (diabetes, etc)	19
Cessation programs	Cessation programs; cessation kits	17
Social marketing	Radio campaign; billboard in the community	12
Tradition	Elders teachings; respect for traditional use	12
Incentives	Quit to win challenges; draws; door prizes	9
Youth focus	Prevention with youth	9
Smoke-free environments	More smoke-free spaces; smoke-free meetings	8
Support groups	Healthy Circle strategies; support groups; peer pressure	8
Policy	Reducing the availability of cigarettes; increasing prices	5
Nicotine substitutes	Patches; nicotine gum	4
Parents	Convincing moms	2
Other		23
Total	Activities Identified	179

When asked what activities would help pregnant women and mothers of infants to avoid the use of tobacco and the effects of second-hand smoke, a large majority of the activities identified by respondents indicated a preference for either or both of: awareness activities (workshops, meetings, promotion at events such a health fairs or well-baby clinics); and by integrating tobacco presentations into prenatal and postnatal programs and services (Table 14).

Table 14
Mothers

Helping Pregnant Women and Mothers of Infants	Activities/Support Areas	Frequency
Prenatal classes	Presentations at prenatal classes; CPNP presentations	60
Awareness activities	Workshops; discussion groups	36
Tools	Visual aids; videos; posters; brochures	17
Staff training	Tobacco training for nurses/ family workers	2
Culture/Tradition	Traditional teachings	2
Parenting programs	Parenting courses	2
Other		17
Total	Activities/Support Areas Identified	136

While education and awareness were seen as the most successful approaches in other areas, when it comes to promoting and achieving smoke-free environments the survey respondents reported that activities that would lead directly to the adoption and/or enforcement of Band Council resolutions, by-laws and formally approved policies were most successful (Table 15).

Table 15
Smoke-Free Environments

Smoke-Free Environments	Examples	Frequency
By-laws/Policies	By-laws; community policies; enforcing policies	75
Smoke-free home campaigns	Blue light campaigns	25
Awareness/Education	Workshops; posters; pamphlets; stickers	23
Consensus	Getting the cooperation of all the community	9
Signage	Non-smoking signs	5
Social marketing	Media; local radio spots	2
Other		11
Total		150

The views about successful tobacco control projects and activities identified through the survey were echoed in the discussions in the Sharing Circle and the comments and observations offered by the participants in regional interviews.

8.2.3 Findings (EQ 3.2)

The findings in response to Evaluation Question #3.2 are:

- The four areas most often identified as working well were: (i) the regional Advisory Circles; (ii) training initiatives; (iii) support for the program; and (iv) community support.
- Activities and practices are deemed by the interviewees as being most successful when they are matched to the participants. Overall, success is achieved using: (i) school programs; (ii) events and contests; (iii) education awareness; (iv) by-laws and policies; and (v) smoke-free home campaigns.

It was concluded that the Advisory Circles and the training initiatives were the two best working areas of the First Nations and Inuit Tobacco Control Strategy.

8.2.4 Recommendations (EQ 3.2)

No recommendations are provided for Evaluation Question #3.2.

8.3 Issue #3: Effectiveness and Efficiency

Issue #3: Are there ways to improve the delivery of the First Nations and Inuit Tobacco Control Strategy from the perspective of its effectiveness and/or its efficiency?

8.3.1 Conclusions: Issue #3

It is concluded that the regional Advisory Circles and the training initiatives were the two best working areas of the First Nations and Inuit Tobacco Control Strategy.

Furthermore, increases in effectiveness and efficiency could best be achieved by:

- having consistent project funding levels provided in a timely manner;

- providing ongoing training at all levels; and
- promoting information sharing at all levels.

8.3.2 Recommendations: Issue #3

It is recommend that the national First Nations and Inuit Health Branch office conduct a review to reduce the funding delays caused by internal funding allocation practices and controls.

SECTION 9.0 EVALUATION OBJECTIVES

This section of the report addresses each of the *six specific objectives of this evaluation* as specified within the request for proposals issued for this evaluation.

9.1 Evaluation Objective #1: Assess Participatory Approaches

First Objective: *To assess how the participatory approach of the FNITCS has been adopted nationally, regionally and at the community level.*

The First Nations and Inuit Health Branch national office and the National Advisory Circle have promoted a participatory philosophy at all levels of the First Nations and Inuit Tobacco Control Strategy.

The Program Framework, which sets out the fundamental goals and approaches for the First Nations and Inuit Tobacco Control Strategy and has guided its implementation, makes no reference to "participatory" processes. The concept, however, is introduced in *Building Best Practices with Community*, which was completed in the fall of 2002 and published sometime later. Among other things, the paper says that the building of a best practices model *stresses the importance of facilitating participatory policies that provide access, ownership and resource supports to individuals and communities who are working on their tobacco cessation strategies from research, the identification of needs, planning and designing programs, delivery and evaluation*.[50]

This statement suggests that a particpatory process is one that includes 'partnerships' as they are described in Building and Sustaining Partnerships, A Resource Guide to Address Non-Traditional Tobacco Use. It states that a partnership is:

[50] Building Best Practices With Community. V. Ramsden, B. Beatty. First Nations and Inuit Health Branch, Health Canada, October 2002.

> *. . . a coming together of concerned individuals and organizations to address an issue within a community. Successful partnerships will identify common interests, create and implement a project, and ultimately achieve positive results to improve the quality of life in a community.*[51]

Further, the Program Framework states: *In the communities, partnerships are envisioned among Chief and Council, Community Health Nurses, Community Health Representatives, Community Health Boards, Principals and teachers, Parent and School Boards/Committees, Youth workers, Addictions workers, and community police.*

9.1.1 Seeking and Achieving Higher Participation Levels

A stated objective by the National Advisory Circle, which was included within the Framework and some other of their documents, was that National Advisory Circle would promote increased levels of participatory processes within the First Nations and Inuit Tobacco Control Strategy. For the purposes of the evaluation, the emphasis was placed upon determining if levels of participation within the First Nations and Inuit Tobacco Control Strategy are higher than those being achieved in other First Nations and Inuit Health Branch programs and initiatives where there is no stated objective to increase participatory practices and processes.

In many respects, the factors that characterize a participatory process are situational and subjective:

- Did people have a 'real' opportunity to present their ideas?
- Were those ideas heard and respected, even when they may not have been accepted?

Given this, the challenge of assessing a participatory process lies in identifying the type of 'after-the-fact evidence' that can be used to determine if the process was participatory or not.

The National Advisory Circle described participatory processes, as it pertains to research and evaluation, in this way: [52]

> *Participatory processes frame the work within the context of "working with" individuals and communities. In addition to this, participatory processes facilitate individuals and communities being a part of the decision-making team regarding: the questions to be asked; the processes to be undertaken; the analysis (if*

---

[51] Building and Sustaining Partnerships, A Resource Guide to Address Non-Traditional Tobacco Use, First Nations and Inuit Health Branch, page 15, October 2003.

[52] The description of participatory practices was provided by Vivian R Ramsden, RN, PhD, Co-chair of the National Advisory Circle's Evaluation Sub-committee, First Nations and Inuit Tobacco National Strategy.

appropriate) and interpretation of the results; and the information contained within the Final Report with any disagreements being clearly delineated.[53]

Based on this description, the criteria that were applied here to determine if more extensive participatory processes were used in the implementation of the First Nations and Inuit Tobacco Control Strategy are as follows:

- Were there significant meetings and other forums and opportunities for an exchange of ideas between the participants at different levels?
- Were decisions taken and, if so, were the decisions about matters of substance, or were they of little consequence to program implementation or delivery?

9.1.2 Seven Participatory Interfaces

Three organizational levels are employed within the First Nations and Inuit Tobacco Control Strategy:

- National level;[54]
- Regional level; and
- Community level.

However, it is also necessary to address the overlaps among the three levels, resulting in the examination of participation from seven different perspectives;

- Within the national level;
- Between the national and regional levels;
- Between the national and community levels;
- Within the regional level;
- Between the regional and community levels;
- Within the community level; and

---

53 Who are the question-makers? A participatory evaluation handbook, Capeling-Alakija S, Lopes C, Benbouali A, Diallo D, New York, NY: OESP Handbook Series. 1997.

54 For the purposes of this evaluation, the national level is presented first, rather than the community level, as it is at the national level that program policy and criteria are established.

- Among the national, regional and community levels.

9.1.3 Within the National Level

The national level organizations include the First Nations and Inuit Health Branch's national office, the National Advisory Circle and national Aboriginal organizations.

National level participants stated during interviews, work sessions and at their Sharing Circle that participatory processes are a key component of their work and of the First Nations and Inuit Tobacco Control Strategy. The First Nations and Inuit Tobacco Control Strategy written in August 2002 promotes participation. Evaluators found no other documents, guidelines, procedures or written practices that specifically promoted or encouraged participatory processes.

There were frequent meetings and telephone discussions between the First Nations and Inuit Health Branch's national office and the National Advisory Circle. The interviews and a review of the minutes of meetings demonstrated an open dialogue and sharing of information. It was not possible to determine the level of participation in decision-making.

The national level Aboriginal organizations participated as members of the National Advisory Circle and through other mechanisms established by the First Nations and Inuit Health Branch and the national Aboriginal organizations' national leadership. A high level of participation is seen at this level.

9.1.4 Between the National and Regional Levels

The regional organizations included the First Nations and Inuit Health Branch's regional offices, Regional Advisory Circles, regional Aboriginal organizations, and other regional governments and organizations that have been selected as partners within the region.

The First Nations and Inuit Health Branch's national and regional offices had monthly teleconferences and annual meetings to discuss the overall management and administration of the First Nations and Inuit Tobacco Control Strategy as well as any new issues that may have emerged. There are also regular exchanges of e-mails and telephone discussions addressing region-specific operational matters. This process is similar to that used by the First Nations and Inuit Health Branch's other programs and initiatives.

The National and Regional Advisory Circles operated relatively independently of each other, with no formal mechanism in place to have Regional Advisory Circle members participate as members of the National Advisory Circle. Representatives of the Regional Advisory Circles are invited to attend an annual meeting with the National Advisory Circle. A review of the minutes

of the annual meetings and interviews with Circle members suggest that the primary focus is to update one another on what had been accomplished during the last year. While information was shared, few decisions were taken at these annual meetings other than those addressing management and administrative issues.

9.1.5 Between the National and Community Levels

Community organizations delivered tobacco control projects directly within the communities. This was done either by members of the community, by coalitions of communities working together, or by a regional organization such as a tribal council.

The First Nations and Inuit Health Branch's organizational philosophy was that the national office is responsible for obtaining funds, establishing national policies and guidelines, and conducting national-level reviews and evaluations. The regional offices were responsible for working with the communities and their regional organizations to help ensure that projects were delivered in communities. As such, the First Nations and Inuit Health Branch's national office had little contact with Aboriginal communities.

The National Advisory Circle's terms of reference did not include working with the communities, other than what may be required to conduct national and regional evaluations of the First Nations and Inuit Tobacco Control Strategy.

Participatory processes between national and community organizations were not found.

9.1.6 Within the Regional Level

The First Nations and Inuit Health Branch's regional offices' management, administration, and financial control operations and practices vary from region to region. These differences developed over time through a series of discussions and negotiations with Aboriginal organizations and communities, all working together to find mutually acceptable solutions.

The roles and relationships among the Regional Advisory Circles, regional Aboriginal organizations and the First Nations and Inuit Health Branch's regional offices varied from region to region. In some regions, the Advisory Circles played an active role, sometimes including assisting in the selection of projects for funding, assisting with regional projects, and/or facilitating the delivery of projects within the communities. In other regions, Advisory Circles played a relatively minor role.

A review of a sample of the minutes of meetings and other project-related documents did not identify any participatory processes or activities that would not be found in other programs and initiatives funded by the First Nations and Inuit Health Branch.

9.1.7 Between the Regional and Community Levels

The majority of activities, dialogues and communications related to the First Nations and Inuit Tobacco Control Strategy were between the regional and community level organizations, and this is typical for the majority, if not all, of the First Nations and Inuit Health Branch's programs and initiatives that receive their funding through contribution agreements. A large portion of these activities related to management, administration, funding and reporting requirements, most of which were guided and/or prescribed by the First Nations and Inuit Health Branch's policies, guidelines and practices.

Participatory processes between the First Nations and Inuit Health Branch's regions and First Nations and Inuit communities, groups and organizations tended to occur: at the start of a new program or initiative; when an ongoing program or initiative needed to be updated; or when a major issue had been identified. Few tobacco control project participatory processes were observed except on an exceptional basis, such as when the First Nations and Inuit Health Branch's Atlantic office worked closely with the communities in developing their project funding proposals.

Participatory processes between the Regional Advisory Circles and the First Nations and Inuit Health Branch's regions were evident at the start of the First Nations and Inuit Tobacco Control Strategy in 2002 and 2003, but a review of the minutes of more recent meetings suggested that the dialogue at those meetings became less participatory and more administrative in nature.

The major exception, where participatory processes were evident in many of the regions, was when regional training initiatives were undertaken. In these instances, the First Nations and Inuit Health Branch's regional offices tended to seek input from community organizations in the design of the content for regional training exercises. The level of participation varied from region to region, from high to low, depending on the role and effectiveness of the Advisory Circle within each region.

There was insufficient information to determine whether the Regional Advisory Circles and community organizations had shared participatory processes other than for regional training initiatives.

9.1.8 Within Community Organizations

For the most part, First Nations and Inuit communities employed participatory and integrated processes in their community wellness and health programming activities and projects.

Assuming that the development and maintenance of partnerships are an expression of a participatory process, the data suggested that most of the First Nations and Inuit Tobacco Control Strategy projects incorporate elements of that process.

In the telephone survey, for example, all but three of the interviewees reported that their projects had established partnerships with one or more organizations or groups, with the mean average being four to six partners. The most common partnerships were with health services, Band Councils, schools and the National Native Alcohol and Drug Abuse Program.

The relatively small size of the tobacco control projects was also a contributing factor to reducing or preventing participatory processes. For the majority of the First Nations and Inuit Health Branch's regions that fund tobacco control projects to most or all of the First Nations and Inuit communities within their region, the average project size is about $7000. Participatory processes tend to be time-consuming and expensive to implement and operate.

No evidence was found that community participatory processes had changed as a direct result of the First Nations and Inuit Tobacco Control Strategy.

9.1.9 Among the National, Regional and Community Levels

Excluding national training initiatives, no participatory practices were identified as including national, regional and community organizations.

9.1.10 Findings

Participatory processes are not employed at all organizational levels.

9.1.11 Recommendations: Objective #1

No recommendations provided.

9.2 Evaluation Objective #2: Assess National Framework Strategy

Second Objective: *To identify the strengths and challenges of a flexible national framework strategy that is intended to allow the regions and the communities to assess and determine how it promoted the incorporation of best practices.*

The second objective was reformulated into two questions: [55]

- What are the strengths and challenges of a flexible national framework strategy?
- How does a flexible national framework strategy promote the incorporation of best practices?

9.2.1 Findings

9.2.1.1 Strengths and Challenges?

The flexibility of the First Nations and Inuit Tobacco Control Strategy, though not specifically identified within the Framework, has generally been interpreted to mean that:

- the program is both community-based and community-paced;
- the communities have the ability to identify, plan and implement the tobacco control projects which they believe will be most appropriate and effective within their community; and
- the regions can decide, if they choose, to establish Advisory Circles and employ facilitators, or to employ other approaches that will assist with the implementation of the First Nations and Inuit Tobacco Control Strategy.

Communities with strong project design, planning and implementation capabilities and who have access to tobacco control expertise are advantaged by a flexible program that allows them to develop projects specific to the needs of the community, as well as to employ approaches that meet the expectations of community members.

Challenges exist with flexible programs when some or many of the participating communities do not have a strong project design and planning capacities, or have little available affordable tobacco control expertise.

Little evidence was found to suggest there was any national strategy to support those communities that require external resources and expertise to design, plan and implement effective tobacco control projects. Within regions, communities had different levels of expertise and assistance available to them. In some regions, the First Nations and Inuit Health Branch staff assisted the communities in writing their proposal; in other regions, the facilitators assisted some communities; while in others, little or no assistance was provided.

[55] The question was reformulated during the project initiation meeting in Vancouver in January 2006.

Within those regions that employ a project selection process whereby only those communities with the best proposals receive project funding, flexible programming can become a major barrier to those communities that lack the capacity to design, plan and implement tobacco control projects. These communities are disadvantaged because, while their communities require tobacco control assistance as much as their neighbouring communities, they will not receive the funding because they lack the necessary resources. For these communities, this can result in a widening of the gap between the levels of health services available to their members.

9.2.1.2 Promote Incorporation of Best Practices?

Best practices are those practices which consistently produce better results in both an effective and efficient manner. Best practices must first be identified and then, through a rigorous evaluation process, be proven to be better than other currently employed practices.

The community-based projects and the demonstration projects were examined to see if they had identified best practices. A review of the project reports and related documents revealed that:

- a performance measurement system was not established to determine if the projects consistently produced better results; and
- the projects were not compared against other projects to determine if the selected projects were actually best practices or contained best practices.

It is concluded that while flexible programming is an advantage to some communities, it is a disadvantage to communities that do not possess some or all of the design, planning and implementation capabilities required for effective tobacco control projects. Flexible programming is probably even more of a disadvantage to those communities which lack design, planning and implementation capabilities when the First Nations and Inuit Health Branch regional office funds only the best of the submitted project funding proposals.

9.2.2 Recommendations: Objective #2

It is recommended that a strategy be developed to identify best practices.

It is also recommended that a strategy be developed to assist those communities that do not possess some or all of the design, planning and implementation capabilities required for effective tobacco control projects.

9.3 Evaluation Objective #3: Implementation Methodologies

Third Objective: *To examine specific implementation opportunities and considerations which are different or similar among First Nations and Inuit communities.*

9.3.1 Findings

Tobacco control projects implemented within Inuit communities in Quebec and Labrador were essentially the same as those implemented in First Nations communities, with the exception of considerations that were specific to cultural and traditional practices and beliefs.

Tobacco control projects implemented in Inuit communities in Nunavut and the Northwest Territories were designed and implemented by the local governmental authorities. On the surface, they do not seem significantly different from those projects implemented by Tribal Councils. The contribution agreements that were signed with these governmental authorities have limited reporting requirements; this seriously limits the identification of implementation opportunities and considerations that are different or similar among First Nations and Inuit communities.

It is summarily concluded that the only differences between First Nations and Inuit Tobacco Control Strategy projects lie in considerations that are specific to cultural and traditional practices and beliefs.

9.3.2 Recommendations: Objective #3

No recommendations are presented for Objective #3.

9.4 Evaluation Objective #4: Best Practices

Fourth Objective: *Identify and document various models of delivery and best practices nationally, regionally and at the community level.*

9.4.1 Discussions

A best practice is one which has been demonstrated and proven to work better than other practices employed in the delivery of projects and programs. The identification of best practices is a process which includes:

- Identifying models of delivery that seem to perform better than other models of delivery;
- Establishing criteria that can be used to determine if the identified model of delivery is truly a best practice;
- Testing and evaluating the identified model of delivery to see if it truly performs better than other models; and
- Reporting on the results of testing and evaluating the best practice, including identifying those parameters, conditions and constraints that form the environment within which the model of delivery has been identified as a best practice.

9.4.2 Findings

Interviews at the national and regional levels did not result in the identification of best practices. Some individuals identified practices which 'seemed' to work better, but none of these practices were formally evaluated to determine if they were best practices.

It is concluded that best practices were not identified by the use of an analytical and evaluative process.

9.4.3 Recommendations: Objective #4

It is recommend that a methodology be developed for the identification of best practices, and once identified, that the best practices be communicated at the national, regional and community levels.

9.5 Evaluation Objective #5: Characteristics and Types

Fifth Objective: *To determine the extent to which regional characteristics and/or the community type have influenced the development, planning and implementation of the FNITCS and how these developments differ or are consistent with FNITCS's original program framework, and were the intended outputs stated in the logic model achieved.*

9.5.1 Findings

The telephone survey included 189 individuals who participated in the delivery of tobacco control projects within their communities. The results of the survey were placed into an SPSS database and the analysis was conducted using criteria such as: location; degree of remoteness;

project dollar value; project delivery methodology; and the type of projects being delivered. Remote communities differ from other communities in that they have higher travel costs, have less access to the on-site assistance of tobacco specialists and have more difficulty in establishing partnerships outside of their community.

The in-person interviews generally confirmed that remote communities are disadvantaged when compared to other communities. There was also a consensus that this is true for all First Nations and Inuit Health Branch funded projects and programs.

The logic model produced for the draft Results-based Management Accountability Framework is incomplete and did not allow for a determination of whether the outputs in the logic model had been achieved.

It is concluded that community remoteness and size are the characteristic that most influenced the design and implementation of tobacco control projects.

9.5.2 Recommendations: Objective #5

It is recommended that the logic model be completed and formally approved.

9.6 Evaluation Objective #6: Data Collection and Reporting

Sixth Objective: *To assist in the data collection and reporting for the program's five-year comprehensive evaluation by collecting baseline data to enable the creation of a longitudinal design.*

9.6.1 Findings

This objective was addressed prior to the signature of the contract for the evaluation and, subsequently, at the first meeting with the National Advisory Circle's Evaluation Sub-committee held in Vancouver on Tuesday 24 January 2006. On both occasions it was agreed that the interpretation of the sixth objective was to ensure that the information gathered during the evaluation would be of the quality and accuracy needed for that information to be included and potentially used during a future summative evaluation.

The information gathered was reviewed by FNIHB, the National Advisory Circle and the evaluation team to ensure the usefulness, accuracy and quality of the information that was gathered. Upon completion of the Evaluation Report, the evaluation team submitted their electronic databases in SPSS format, excluding personal identifiers, to the First Nations and Inuit

Health Branch. Electronic versions of the Evaluation Report, working papers, reports and other documents provided as references were submitted/returned to the First Nations and Inuit Health Branch.

9.6.2 Recommendations: Objective #6

No recommendations are provided for Objective #6.

SECTION 10.0 CONCLUSIONS AND RECOMMENDATIONS

This section presents an integrated set of conclusions and recommendations drawn from the evaluation's issue-specific conclusions and recommendations presented in Sections 6, 7, and 8; as well as the conclusions developed in response to the objectives of the evaluation presented in Section 9 of this report.

10.1 Conclusions

The conclusions for the three issues and evaluation objectives are summarized as follows:

Issue 1: Was the Strategy implemented as proposed in the First Nations and Inuit Tobacco Control Strategy Program Framework?

It was found that the First Nations and Inuit Tobacco Control Strategy was implemented as proposed. Community-based organizations and some partnerships were successfully established to deliver the First Nations and Inuit Tobacco Control Strategy within First Nations and Inuit communities.

It is also concluded that the Program Framework and the terms of reference and/or objectives for the Advisory Circles and First Nations and Inuit Health Branch staff need to be updated to focus more on program improvement and delivery now that the program implementation phase has been completed.

Issue 2: Were success targets, performance measurement indicators and a performance measurement system established that will allow for the evidence-based measurement of the Tobacco Control Strategy's results?

The First Nations and Inuit Tobacco Control Strategy Program Framework identified success targets as general trends and not as specific quantitative targets to be achieved by a specified date.

For the most part, the performance measurement system and a national information baseline that focuses on outcomes were not established; this will make it very difficult to quantifiably measure program results and successes.

Issue 3: Are there ways to improve the delivery of the [First Nations and Inuit] Tobacco Control Strategy from the perspective of its effectiveness and/or its efficiency?

It is concluded that increases in effectiveness and efficiency would best be achieved by: (i) having consistent project funding levels provided in a timely manner; (ii) providing ongoing training at all levels; and (iii) supporting information sharing at all levels.

Evaluation Objectives: For the six evaluation objectives, it is concluded that:

- Participatory practices were not employed at all levels;
- Flexible programming was more suitable for communities with greater readiness and infrastructure for tobacco control programming;
- Addressing different cultural and traditional beliefs and practices was the major defining characteristic that distinguishes First Nations and Inuit tobacco control projects;
- A best practices process has not been developed; and
- Based upon survey information, community remoteness was the variable that most impacted project costs and implementation effectiveness.

10.2 Recommendations

The recommendations for the three issues and evaluation objectives are summarized as follows:

- Produce and communicate an updated Program Framework and/or other documents that will: (i) define success targets; (ii) present a performance measurement strategy; (iii) present a logic model; (iv) outline an evaluation strategy that will allow for the measurement of program results and success; and (v) update the terms of reference and/or objectives for the Advisory Circles and First Nations and Inuit Health Branch staff.
- Conduct a management review to address and resolve the funding and structural barriers to efficient and effective implementation of tobacco control strategy projects.
- Establish and populate an information baseline based upon outcomes that will support the management and ongoing evaluation of the First Nations and Inuit Tobacco Control Strategy.

APPENDIX 1. Evaluation Participants

1.1 National Partners

Stirbys, Cynthia
Assembly of First Nations

Okalik, Looee
Inuit Tapiriit Kanatami

1.2 National Aboriginal Organizations

Carry, Catherine
National Aboriginal Health Organization

Dedam-Montour, Debbie
National Indian and Inuit Community Health Representatives Organization

Deranger, Sue
National Native Addictions Partnership Foundation

Brown, Lynda
Pauktuutit Inuit Women of Canada

Roberts, Ada
Aboriginal Nurses Association of Canada

1.3 National Advisory Circle Members

Angnatok, Heather
National Inuit Youth Council

Carry, Catherine*
Ajunnginiq Centre, National Aboriginal Health Organization

Dedam-Montour, Debbie
National Indian and Inuit Community Health Representatives Organization

Deranger, Sue*
National Native Addictions Partnership Foundation

Brown, Lynda
Pauktuutit Inuit Women of Canada

Hachey, Dawn
Healthy Environments, Consumer Safety Branch, Health Canada

Hardy, Sheila*
Laurentian University

Head, Jordan
Nechi Training, Research and Health Promotions

Fox, Mikah
Youth Representative, Assembly of First Nations

Okalik, Looee *
Inuit Tapiriit Kanatami (ITK)

Ramsden, Vivian*
University of Saskatchewan

Roberts, Ada
Aboriginal Nurses Association of Canada

Roberts, Lynda*
First Nations and Inuit Health Branch

Ryan, Kevin
First Nations and Inuit Health Branch

Schwartz, Deborah
Aboriginal Tobacco Control Expert

Selby, Peter*
Centre for Addictions and Mental Health

Stirbys, Cynthia*
Assembly of First Nations

Wardman, Dennis
First Nations and Inuit Health Branch

* Denotes members of the Evaluation Sub-committee