EXECUTIVE SUMMARY:

Studies have shown that the use of tobacco (cigarette, chewing) for non-traditional use among First Nations and Inuit people is more than double the national rate. Exposure to nicotine generated through first and second hand smoke has placed many families at high risk for serious health problems such as heart disease and cancer. In trying to address this risk, the federal government (First Nations and Inuit Health Branch) coordinated the development of a national plan entitled "The First Nations and Inuit Tobacco Control Strategy (2002)". The national plan is aimed at developing alternative choices for the misuse of tobacco products through a comprehensive tobacco control program built upon the principles of the "Building Best Practices with Community" model. The principles help guide the development of a national process which respects and works with First Nation and Inuit communities in developing culturally appropriate and sustainable tobacco control programs and practices aimed at prevention, promotion, protection and de-normalization.

The "Building Best Practices with Community" model is based upon the traditional values of respect for others, building trust in relationships, responsibility of the individual and community, freedom of the individual, holism, kindness, compassion and humility. These values form the base upon which participatory models can be developed and they bridge a gap between science and community action by striving to build upon existing information and scientific studies on tobacco control and working with the community to raise the level of awareness regarding that knowledge.

The model stresses the importance of facilitating participatory policies which provide access, ownership and resource supports to individuals and communities who are working on their tobacco cessation strategies from research, identification of needs, planning and designing programs, delivery and evaluation. It respects First Nation and 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 use. 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. It offers opportunities for joint funding of innovative projects which are affordable, practical and accountable.

INTRODUCTION

Misuse of tobacco is placing at high risk the health, quality of life and even life expectancy of a very large number of adults and children in First Nations and Inuit communities (First Nations and Inuit Tobacco Control Strategy, 2002). Tobacco use is the single most preventable cause of death and disease in our society (Fiore, Bailey, Cohen et al, 2000). It has been suggested that the prevalence of non-traditional tobacco use among First Nations and Inuit people is more than double the rate for the rest of Canada (Statistics Canada, 1991).

GUIDING VALUES OF BUILDING BEST PRACTICES WITH COMMUNITY

Based on the First Nations and Inuit Tobacco Control Strategy (2002), the following core values will guide the way that "Building Best Practices with Community" will unfold across Canada.

1. ***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.
2. ***Trust*** Just as the First Nations and Inuit Tobacco Control Strategy (2002) will be based upon capacity-building processes and training materials that build and enhance

trusting relationships between tobacco control facilitators, leaders, administrators, human services providers and community members, so also will be building of best practices reflect these same parameters.

3. ***Responsibility*** rests with individuals and the communities in which they reside to support the tobacco control strategies [prevention, promotion of cessation, eliminating exposure to environmental tobacco smoke (ETS)] and to serve as role models by making personal choices to practice lifestyles free of tobacco misuse.
4. ***Freedom*** of the individual in making choices regarding tobacco use will be honoured, as will the basic right of all people to live in a smoke-free environment.
5. ***Holism*** in prevention and intervention will play a major influence in program development and service implementation decisions. A holistic perspective implies that everyone in the community has not only a role to play in every aspect of the implementation of the tobacco control strategy but also in building best practices.
6. ***Kindness and compassion*** will be critical in both the presentation of information and in the provision of support and encouragement as the community moves towards a sustainable smoke-free environment.
7. ***Humility*** will define the orientation to community leadership, community members and to those in receipt of services as the community moves towards building best practices.

CONTEXT

Health is a basic human right and essential for social and economic development (WHO, 1997). Health is described as the state of complete physical, mental and social well-being and not merely the absence of disease (WHO, 1948). The Ottawa Charter for Health Promotion (WHO, 1986) indicated that "health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as, physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond health lifestyles to well-being. Health promotion strategies and programs should develop personal skills through the provision of information, education about health and enhancing life skills and by so doing, increase the opportunities for individuals to exercise more control over their own health and well-being (WHO, 1986).

The World Health Organization (1997) indicated that pre-requisites for health are peace, shelter, education, social security, social relations, food, income, empowerment of women, a stable eco-system, sustainable resource use, social justice, respect for human rights and equity. Health promotion can made a difference but the five strategies outlined in the Ottawa Charter (WHO, 1986) are essential for success: building healthy public policy, creating supportive environments, strengthening community action, developing

personal skills and re-orienting health services. Comprehensive approaches to health promotion are the most effective and any combination of the five strategies has been demonstrated to be more effective than any one strategy (WHO, 1997). In addition to this, participation by individuals and communities is critical if the effects of the health promotion strategies undertaken are to be sustainable (Kahssay & Oakley, 1999).

GOALS OF A COMPREHENSIVE TOBACCO CONTROL PROGRAM

The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by:

- Preventing the initiation of tobacco use [prevention].
- Promoting smoke-free behaviour and smoking cessation [promotion].
- Eliminating exposure to environmental tobacco smoke (ETS) [protection].
- Identifying and eliminating the disparities related to tobacco misuse and its effects among different population groups [de-normalization] (CDC, 1999; WHO, 1999).

BUILDING BEST PRACTICES WITH COMMUNITY: EVIDENCE-BASED INTERVENTIONS

Facilitating the healing process and building best practices with community, needs to build on the evidence that is known within the global context. The elements of this systems approach as outlined by the World Health Organization (1999) are to:

1. promote healing from tobacco dependence [within the individual and within the community] as a public health priority.

2. provide accessible, practical, scientifically based and proven interventions to all individuals that misuse tobacco.

   Relationships and traditions unique to a community can provide a framework for a comprehensive tobacco control program and in some cases reduce the need for formal treatment. First Nations and Inuit peoples should be encouraged to develop their own programs considering the unique traditions that could empower the individual who uses tobacco to change; enhance change by working with healers [elders] and/or community leaders; consider the relationship between health promotion and cultural values; and not expecting or demanding early change (Groth-Marnat, Leslie & Renneker, 1996).

3. Assess tobacco misuse and offer appropriate interventions

   Health care workers and practitioners are asked to assess the smoking status of individuals at every opportunity; to encourage individuals to become smoke-free; to assist individuals in doing so; to provide support and encouragement to individuals, families and communities working towards becoming smoke-free; to facilitate follow-up; and to refer individuals to tobacco control experts if necessary. Becoming smoke-free must not be a privilege only for those who can afford to do so, but must be accessible, practical and based on scientific evidence (WHO, 1999). Community-based tobacco control strategies and interventions must be implemented with collaboration from elders, individuals, communities, health care workers, health care practitioners and government.

The desire to quit appears to be similar across all racial and ethnic groups (US Dept of Health and Human Services, 1998; Orleans, Schoenback, Salmon et al, 1989; Stotts, Glynn & Baquet, 1991; Royce, Hymowitz, Corbett et al, 1993; Ramsden, White, Butt et al, 2001).

Changing a health habit is not a simple action that is undertaken once a decision has been made but a process that may occur over time (Prochaska, Norcross & DiClemente, 1994). Many of the models of behaviour change do not take into account the natural history of how people modify health behaviours, or for that matter any behaviour. In the Stages of Change or the Transtheoretical Model by Prochaska, Norcross & DiClemente (1994), both health care practitioners and individuals move through six discrete stages in changing behaviour: pre-contemplation, contemplation, preparation, action, maintenance and termination. Each stage represents a set of tasks needed for movement to the next stage. Linear progression may be possible but is a relatively rare phenomenon. The individual that successfully changes a behaviour re-cycles through the process several times prior to achieving the desired outcome, thus, it is felt that education of the individual and community, environment modification and healthy public policy reinforces individual lifestyle changes. A key to successful change is in recognizing the stage of readiness the individual and/or the health care practitioner is at on the continuum of change. Relapse remains the rule rather than the exception. The feelings that relapse evokes are not pleasant but it provides the individual and the health care practitioner with

an opportunity to learn about what worked and what did not work in the previous attempt at becoming smoke-free.

The challenge of developing best practices with communities is to move from knowledge and evidence-based strategies to action rather than building new knowledge within a vacuum. Meta-analyses of hundreds of controlled scientific studies have provided a road map from which to build best practices with First Nations and Inuit communities. The recommendations promoted in various guidelines around the world are similar and evidence-based in that their recommendations are based on statistical findings of treatment efficacy, published evidence and expert opinion (Fiore et al, 2000; WHO, 1999; Raw, McNeill, & West, 1998; American Psychiatric Association, 1996). The treatments endorsed include brief advice, behavioral counseling, nicotine replacement [chewing pieces and patches] and bupropion (Fiore et al, 2000; Raw, McNeill, & West, 1998; American Psychiatric Association, 1996).

> Recommendation: Smoking cessation treatments have been shown to be effective across different racial and ethnic minorities. Therefore, members of racial and ethnic minorities should be provided treatments shown to be effective (Fiore MC, Bailey WC, Cohen SJ, et al, 2000).

Recommendation: Whenever possible, tobacco dependence treatments should be modified or tailored to be appropriate for the ethnic or racial populations with which they are to be used (Fiore MC, Bailey WC, Cohen SJ, et al, 2000).

Studies have demonstrated the efficacy of a variety of smoking cessation interventions in minority populations (Fiore MC, Bailey WC, Cohen SJ, et al, 2000). Screening for tobacco use, advice, reinforcement/support of the health care worker, and follow-up materials have been shown to be effective for American Indian populations (Johnson, Lando, Schmid, Solberg, 1997). Smoking cessation interventions developed for the general population have been effective with various ethnic groups (Fiore MC, Bailey WC, Cohen SJ, et al, 2000). To optimize the effectiveness of smoking cessation counseling or self-help materials they must be available in a language and at an appropriate reading level so as to be understandable by the individuals currently smoking and the communities in which the individuals reside. Culturally appropriate interventions and/or stories may increase the acceptance of the intervention.

One of the most important steps in addressing tobacco misuse and dependence has been identified as asking individuals whether or not they currently smoke or utilize smokeless tobacco. After the health care worker and/or practitioner has established whether or not an individual misuses tobacco and has identified the readiness to change, the provision of appropriate interventions can occur utilizing a systematic approach such as is outlined by

MC Fiore, WC Bailey, SJ Cohen et al (2000) and is more commonly known as the 5 A's which are:

- Ask – Systematically identify individuals that currently smoke.
- Advise – Strongly encourage the individuals that are currently smoking to become smoke-free.
- Assess – Determine the willingness of the individual to consider becoming smoke-free.
- Assist – If the individual agrees that he/she is interested in becoming smoke-free, support the individual on the journey/process of becoming smoke-free. Fiore MC, Bailey WC, Cohen SJ, et al (2000) in the clinical practice guideline entitled, *Treating tobacco use and dependence* outlined the evidenced-based practices for assisting individuals to become smoke-free. These are:

  "There is a strong dose-response relation between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact)."

  "Three types of counseling and behavioral therapies were found to be specially effective and should be used with all patients attempting tobacco cessation:
  (1) Provision of practical counseling (problemsolving/skills training);
  (2) Provision of social support as part of treatment (intra-treatment social support); and
  (3) Help in securing social support outside of treatment (extra-treatment social support)."

  "Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all individuals attempting to quit smoking."

"Five first-line pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
(1) Bupropion SR;
(2) Nicotine gum;
(3) Nicotine inhaler;
(4) Nicotine nasal spray; and
(5) Nicotine patch."

Two second-line pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:
(1) Clonidine; and
(2) Nortriptyline."

? Arrange – Follow-up which provides encouragement and support even when relapse is encountered is probably the most critical. Small successes and working together to facilitate and achieve the outcome of becoming smoke-free provides the support for continuation even when the vision grows dim. By taking advantage of teachable moments and opportunities for prevention and intervention, the collaboration and relationship between the individual who currently smokes and the facilitator [health care practitioner, elder, community member, friend] is strengthened. Facilitators should remain sensitive to individual differences and health beliefs that may affect treatment acceptance and success in all populations (Fiore, Bailey, Cohen et al, 2000).

4. Set an example – Modeling of smoke-free behaviour

In some areas of the world, health care practitioners continue to misuse tobacco. Health workers and/or practitioners function as exemplars [role-models] and educators for others, and consequently should set an example by abstaining from the misuse of tobacco.

5. Provide resources for effective interventions

   Governments, health care organizations, professional associations and communities should ensure that evidence-based interventions are easily accessible and accessible. The development of resources [human, space, materials, programs, technology], the updating of resources [continuing education for human resources, materials, programs, technology] so that they reflect current trends and interventions, and collaboration with the community will help to build "best practices" within the community that are sustainable over time and are framed within the context of the community.

6. De-normalization of tobacco

   If smoke-free behaviour becomes normalized, it is likely that only the most dependent smokers will continue to misuse tobacco (Tunstall, Ginsberg & Hall, 1985).

   Addictive behaviour is often rewarded in our society. These indirect rewards often create the environment in which a variety of addictions are enabled – (1) silence is encouraged; (2) feelings should not be expressed openly; (3) communication is indirect and less than transparent; (4) being strong, good, right and perfect is optimal; (5) behaviour is to make someone else proud; (6) being selfish is inappropriate; (7) do as I say and not as I do; (8) having fun or engaging in playful activity is frowned upon; and (9) whatever you do, don't rock the boat – challenge the status quo (adapted from Killinger, 1991). In attempting to be all of these things each and every minute, people seek ways to fill the voids in their lives. One of the ways that people

over the years have found to do this is through the misuse of nicotine which is found in tobacco products.

> "The cigarette was my best friend – it was always there when I needed and/or wanted it; it provided me with some sense of control – I could take it or leave it; it made me feel good; it was acceptable within society and easily available regardless of the price; it provided me with an opportunity to have a break during the day which my colleagues were less likely to achieve; and there was always a person to smoke with." [Anonymous]

BUILDING BEST PRACTICES WITH COMMUNITY: APPLICATIONS AND LEARNINGS

P Friere (1973) indicated that the mark of successful education is not skill in persuasion – but the ability to dialogue with individuals in a way that empowers them to become the best that they can be. However, this is usually built on trust and over time (Friere, 1973). Each moment spent in dialogue, which prepares men and women to emerge from their state of numbness or submersion, is time gained. Conversely, all is lost, in spite of glittering appearances, if natural objects or social structures are formally altered but individuals are left powerless. Freire's (1973) concern for individuals is so central that it rules out policies, programs or projects, which do not become truly theirs. The oppressed/marginalized individuals in every society have no difficulty recognizing the need for voice in their efforts to overcome their silence (Freire, 1973). Building best practices with community should facilitate learning together by both the teacher/facilitator which in this case is the health care workers and/or practitioners and the individuals engaged in learning. All individuals are important and merit respect.

P Freire (1972) indicated that learners need to be active participants in the learning program; the learning experience needs to be meaningful; and the learner needs to have an opportunity to reflect upon the experience. In the process of learning, meaningfulness is a matter of negotiation between the learner and facilitator/teacher from the outset of the educational experience (Grundy, 1987). Empowerment becomes the act of finding one's voice which can occur only in conditions of justice and equality (Grundy, 1987). Authentic participation is based on trust - trust in one's self, in others and in the purpose of the group. In turn, trust builds a stronger foundation for participation. To truly participate in a process in which the goal is to become smoke-free means to be actively involved; to be actively involved in the decision-making process, taking actions, accessing resources and obtaining information.

Health care workers and practitioners who are promoting transformative learning recognize the importance of certain elements: people's readiness to learn; the formation of a strong team; knowing people's context and needs very well; the improvement of abilities to reflect and act (think and do); and the opportunity to experience an increased level of awareness and personal growth (Ramsden, White, Butt et al, 2002). Transformative learning is not for the weak at heart as it requires courage to be transparent, facilitate appropriate risk-taking behaviour and to remain patient with others, as well as, yourself. Vulnerability, risk-taking, trust, cooperation, openness and patience are the spiritual dimensions in a process of change, and are as important as the steps of program planning: needs assessment, development, implementation and evaluation (Smith & Dickson, 1997).

Any relationship between two individuals takes time to develop and the relationship between a health care worker and/or practitioner and an individual is no different. In establishing readiness to learn, both the health care worker and/or practitioner and the individual need to reflect on the various extraneous issues that may impact on the encounter prior to engaging in dialogue. The formation of a strong team between the health care worker and/or practitioner and the individual is critical if both are to be involved in shared decision-making, negotiating outcomes and reflecting on what worked and what was less than helpful in working towards becoming smoke-free. In learning about people's context and their needs, a non-judgemental and unconditional approach must be demonstrated. This does not mean that health care workers and/or practitioners would necessarily approve of the behaviour but they would need to learn how to share that respectfully and not blame the individual for continuing the behaviour. Dialogue will facilitate the process, enhance the relationship and build a strong team, whereas, lack of dialogue will block the process, minimize the relationship and weaken the ability of both the health care worker and/or practitioner and the individual to hear what is being said. Celebration of small successes build sustainable behaviour changes because it starts with something that the individual is willing and able to do in working toward the desired outcome which in this case is smoke-free behaviour and results in enhanced self-esteem, as well as, sustainable behaviour changes. If building best practices with community is facilitated respectfully, both the individuals and the health care workers and/or practitioners will be able identify the strengths and opportunities for change in the four dimensions (physical, mental,

psychological and spiritual) based on their own experience and wisdom in working towards building best practices.

BUILDING BEST PRACTICES: EVALUATING WHAT WORKS AND WHAT DOES NOT

The challenge of developing best practices with communities is to move from knowledge and evidence-based strategies to action rather than building new knowledge within a vacuum. In doing so, appropriate evaluation strategies must be put into place to facilitate knowing what works and what does not within the community. Criteria used to evaluate the success of a program needs to be developed in collaboration with the community and should reflect the objectives of the program. The principles for promoting participatory development which is the basis for building best practices with community as outlined by P Oakley, W Bichmann & S Rifkin (1999) are:

1. Primacy of people – people's knowledge and skills must be seen as a potential contribution to the learnings.
2. People's participation includes women – enormous social and cultural barriers hinder women's participation and these must be acknowledged.
3. Autonomy as opposed to control – it is important to seek to optimize the roles of community members and as such build community-based capacity.
4. Community action as opposed to community response – it is important to reflect upon how to facilitate shared decision-making rather than responding to initiatives proposed by others.

5. Allowing for some spontaneity in project direction – participatory projects often take longer but the learnings are greater and subsequently more sustainable.

SUMMARY

If we consider, where we are as individuals within our own context are we then able to consider community-based strategies that work with individuals, organizations and communities that would build self-esteem, provide support and encouragement, focus on the strengths and consider the opportunities, begin building teams to replace the hierarchy (adherence and not compliance, begin working with the individual and not telling them what to do and how to do it when we ourselves are not able to make the many changes that we expect of others, empower ourselves and the individuals that we work with - transformation).

N Branden (1994) identified six pillars of self-esteem. These are: (1) the practice of living consciously; (2) the practice of self-acceptance; (3) the practice of self-responsibility; (4) the practice of self-assertiveness; (5) the practice of living purposefully; and (6) the practice of personal integrity. The focus of building best practices with community must focus on balance with each of the aspects [physical, mental, emotional and spiritual] being equally developed (Four World International Institute, 1984) and on the processes rather than on outcomes (eg the number of individuals that stop smoking in any given twelve months) as this would impact not only the number of individuals that become smoke-free but it would also increase the health and well-being of individuals, communities and organizations.

Such an approach does however challenge the status quo and as such escalates the presence of the usual coping strategies which are denial which prevents us from coming to terms with what is actually happening; confusion which prevents us from taking responsibility; the "I" phenomenon; manipulation – to achieve the desired outcomes regardless of the cost to the individual or the organization; perfection; omnipotence; the illusion or perception of control; and as such the lack of ethical behaviours and processes. These characteristics were identified as the characteristics of an addictive organization by A Schaef & D Fassel (1998) but are seen everyday within the environments which we live and work. If we are to consider how best to facilitate the development of "best practices with community" within a new paradigm then we need to consider fully participatory methods, action research and true collaboration with individuals, communities and organizations with whom we are working to impact on the health and well-being in Canada and subsequently reduce the misuse of tobacco.

These strategies will be less than optimal if the focus is only on changing behaviour of others. Building best practices with community needs to be linked with the transformation of individuals, health care workers and practitioners working within such realities and health care systems (McVea, Crabtree, Medder et al).

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