

Women Warriors Survey & Interview Results on Concurrent Use Commercial Tobacco
& Cannabis Interventions

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SOCIOLOGY 366 Research Methods in the Social Sciences

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Preface

This research paper is original, unpublished, independent work by the author, Shelley Wiart. The research outlined in this paper is covered by ethics under Athabasca University for the course Sociology 366 Research Methods in the Social Sciences, January 2018 to July 2018.

Positioning

Before I begin sharing my findings about Indigenous women's concurrent use commercial tobacco & cannabis and how this decolonized research contributes to culturally appropriate and harm reduction approaches to interventions, I first need to position myself in this pursuit. As an Indigenous researcher, my positioning honours the "Indigenous ideological understanding of the world predicated on relationality and agency" (Martin, 2017). I accept the responsibility to respectfully locate myself within this research process and in relation to the communities and women that I worked with co-creating digital stories. I am Métis and a board member of the North Slave Métis Alliance, Yellowknife, Northwest Territories (NT). I have long-term community relationships and ties to both Treaty Six (Lloydminster, on the border of Alberta and Saskatchewan) and Treaty Eight (Yellowknife, Northwest Territories) through our health promotions program, Women Warriors and as a member of the North Slave Métis Alliance.

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Introduction

Indigenous peoples experience greater health disparities than the general population of Canada, including an overrepresentation of morbidity and mortality rates related to commercial tobacco use (Ontario Tobacco Research Unit, 2018). In Canada, Indigenous women have double the smoking rates - 39.1% of First Nations women, 34.2% of Metis women, and 48.9% of Inuit women (Hemsing, Greaves & Poole, 2015, p. 268) - in comparison to the general population, 16% (Bougie & Kohen 2018). Indigenous women's health must be understood in relation to racism, sexism and colonialism (Bourassa, McKay-McNabb & Hampton, 2004, p. 24) and their economic and social determinates of health. Hemsing, et al (2015) highlights the need for tailored smoking interventions with women that face health disparities (p. 269). With the upcoming legalization of cannabis, scheduled by the federal government for August 2018, this need also applies to cannabis, as concurrent use is common. These research findings serve as baseline data before the implementation of the Women Warriors concurrent use commercial tobacco and cannabis health promotions unit for our manual.

Purpose

This exploratory study gathered preliminary information on smoking and cannabis behaviours, attitudes about upcoming legalization, opinions on community driven tobacco interventions, and characteristics of the population, composed of participants from Women Warriors. The target users of Women Warriors, an Indigenous focused women's health promotions program that offers free fitness classes and nutrition education, are First Nations, Metis, and Caucasian women between the ages of 18-65. The exploratory study in the form of a survey, analyses the commercial tobacco smoking and cannabis behaviours of Women Warriors participants. The definition of smoking for the purpose of this survey is consuming commercial tobacco in the form of cigarettes. The definition of cannabis use for the purpose of this study is the inhalation methods of smoking or vaporization. Also, cannabis use includes both medicinal and recreational marijuana.

Literature Review

The main research question in the academic article, *Tobacco Cessation Interventions for Underserved Women* (2015) by Hemsing, et al was how to tailor tobacco cessation interventions to meet the needs of marginalized women, such as “Aboriginal and ethnic minority women, women living on a low income, women who use other substances, and women who have experienced violence, abuse, or trauma” (p. 267). To address the high rates of tobacco use amongst this underserved population, Hemsing, et al (2015) completed a literature review of “women-specific tobacco control approaches, tobacco use and cessation among socially disadvantaged women, and sex and gender differences in tobacco use, cessation, and intervention response were located through online and academic database searches, as well as searches of the collected literature databases at the British Columbia Centre of Excellence for Women’s Health” (p. 270). Upon completion, the authors collaborated to refine their cessation strategy with twenty-four key informant interviews with relative researchers in the field of health care and community based organizations from Canada, the United States, and Australia (ibid). The following four recommendations were made when creating interventions for women: (a) should be tailored or individualized; (b) should build confidence and increase motivation; (c) should integrate social justice issues; and (d) should be holistic and comprehensive (Hemsing, et, al, 2015, p. 270). This research relied heavily on the researchers’ interpretation of the qualitative data calling into question the ability to generalize findings for worldwide consensus on cessation interventions for their defined unit of analysis – low-income and marginalized women.

In their cross-sectional analysis using the 2012 Aboriginal People’s Survey (APS), Ryan, Leatherdale, and Cook (2015) examine off-reserve First Nation and Metis adult’s associations between smoking and culturally specific, demographic, geographic, socioeconomic, and health-related variables (p. 75). Their sample size was selected starting with a total of 14,540 off-reserve single identity First Nations or Métis aged 18 years and older, followed by the exclusion of 450 people because they were pregnant or were currently attending school and therefore had missing BMI or educational attainment measures. Once excluded and missing cases were deleted they included 12,720 First Nations and Métis (Ryan et al., 2015, p. 76). Their findings include the

bivariate associations of an increased risk of smoking for those respondents that were engaged in cultural practice. It includes, those that spoke an Indigenous language (as opposed to those that did not); were exposed to an Indigenous language at home; attended residential school or had a family member attend; participated in traditional activities like hunting, fishing or trapping; made traditional arts and crafts in the last year (p. 78). In relation to bivariate associations of socioeconomic and health, the odds of smoking increased with being unmarried, unemployed, low income household, low education, drank heavily, had poor perceived health and had lower BMI (p. 78). In terms of geography and smoking, two significant associations were found - people in small populations centers were more likely to smoke and those living in British Columbia were less likely to smoke than those living in Ontario (p. 80). This finding demonstrates the need for research between geographic area level factors and smoking behavior in order to create effective smoking interventions.

Bougie and Kohen (2018) used the data from the 2012 Aboriginal People's Survey (APS) to compose a gender-based analysis of the Inuit smokers living in the four regions collectively known as Inuit Nunangat. They identify a gap of empirical research in smoking in this area, and highlight the high prevalence of Inuit smokers, men (75%) and women (74%) in comparison to the general population (16%) in Canada. The sample size, composed of self-identified Inuit aged 18 or older living in the region at the time of data collection was 2,614 Inuit—1,263 men (mean age 36.7) and 1,351 women (mean age 38.8). Their method of analysis was multivariate logistic regression analysis. The findings of the Bivariate analyses include: low levels of food security and low income increased the odds smoking; men had significantly lower rates of smoking with increased education, specifically a high school diploma; the odds of smoking were significantly higher for both sexes if they experienced overcrowding in their home, lived with a regular smoker, were unemployed, or engaged in heavy drinking. In relation to residential school, the odds of smoking for Inuit women were significantly higher if their parents attended. The authors recommend more research be done on the relationship between overcrowding in homes and smoking, noting that living with a regular smoker should be taken into account. Also highlighted were two associations for Inuit women and increased odds of smoking; food

insecurity and having personally attended residential school. The authors identify future research must include Inuit history, such as residential school as factor(s) to explain smoking behaviors.

Due to the fact that both these studies were done using the APS, they share several flaws including response bias (self-reporting to proxy interviewers), the lack of culturally specific questions pertaining to Inuit and First Nations culture, a lack of questions pertaining to availability of health services, such as access to doctor for cessation aides or medication. Furthermore, this analysis did not include the examination of mental health, mental health resources, and addiction services for Inuit or First Nations living in these remote communities. Ryan, et al (2015) connection between traditional tobacco, Indigenous peoples culture, and increased odds of smoking could not prove causality due to the fact this survey was cross-sectional; a longitudinal study should examine this association.

Context Research Ltd. (2015) was hired by the First Nations Health Authority (FNHA) of British Columbia (BC) to assist in the development of their “Respecting Tobacco” initiative on commercial tobacco use in Indigenous populations. Between November 2014 and January 2015 this research firm used the methods, world-wide literature review of peer-reviewed journal articles, environmental scan, and key informant interviews, to generate preliminary recommendations on three key areas of tobacco strategies: prevention, cessation, and protection. This report gave a bird’s eye view of culturally relevant tobacco programs and policies worldwide, identified the gaps in research, and made recommendations on how to adapt the interventions to meet the cultural needs and values of Indigenous peoples in Canada. It would have been helpful to include their key informant interview questions and transcripts as an appendix and a section dedicated to decolonizing evaluation methods - a more culturally appropriate way to evaluate these programs than Western methodologies.

The recommendations for delivering prevention program and policy, based on six peer-reviewed articles, and government/community policy analysis include: culturally tailored messaging, point of sale interventions including retailer’s education, training and enforcement of policy/laws pertaining to tobacco products, online education tools for youth, decrease the affordability of tobacco (while being aware of the disposable income of

those that smoke), the implementation of a tobacco tax on reserve, an implementation of smoke-free school(s) policy, and the assessment of Indigenous youth access and exposure to tobacco in retail outlets and the outcomes of tobacco taxes to community revenue (p. 37). The recommendations of tobacco cessation programs and policy, based on eighteen relevant peer reviewed articles and tax policy include: Culturally relevant and proven interventions such as counselling (in-person or by telephone), quit contests, pharmaceutical interventions such as nicotine replacement therapy and cessation medication - all of which need high levels of community awareness, and accessibility of these program. While the main policy driver for cessation was increasing the price of tobacco, the researchers caution it should be in line with disposable income and earning power (p. 37). Finally, tobacco protection programs have a gap in research. The protection policy recommendations include: focusing on adequate housing to address overcrowding (allowing for non-smokers to live in a smoke-free environment), smoke free spaces legislation and the assessment of the existing smoke-free policies in First Nations communities (p. 38).

There is a lack of tailored smoking interventions for marginalized women, especially ones that take into account social determinates of health and the complexity of women's smoking context (Hemsing, et al, 2015, p. 280). Moreover, there needs to be more comprehensive research data on Indigenous populations smoking behaviours and interventions in Canada (Ontario Tobacco Research Unit, 2018, p. 4). Bougie, et al (2018) APS research on the remote region of Inuit Nunangat found increased odds of smoking with overcrowding, residential school attendance, and food insecure households. While focused on urban Indigenous populations Ryan, et al (2015) made an association between increased rates of smoking and daily cultural practices such as speaking an Indigenous language, hunting/fishing and/or making traditional arts/crafts. Finally, Context Research (2015) highlights the need for more qualitative and quantitative research on reserve. These factors all point to the need for more community-driven research in tobacco interventions for Indigenous populations (Ontario Tobacco Research Unit, 2018, p. 4).

This exploratory survey will contribute to the overall goal of creating a Women Warriors tobacco and cannabis harm reduction strategy.¹

Context of Study

Onion Lake Cree Nation has obtained funding to run two, twelve-week Women Warriors programs on-reserve starting September 2018. The reserve is located approximately fifty kilometers north of Lloydminster, on the Alberta/Saskatchewan border. The total membership of this reserve is approximately four thousand, with two thousand five hundred on-reserve members. Also, an important consideration for the cannabis research is the fact that Onion Lake Cree Nation has been issued two permits to sell cannabis after it becomes federally legalized in August 2018.

Study Population

The study population is former Women Warrior participants from years 2016-2018 $n = 173$. The participants, my units of analysis, are Indigenous and non-Indigenous women from Lloydminster, Onion Lake, other surrounding rural areas, and Calgary. The 2016 population (Lloydminster): $n = 92$ women, mean age was 37.3 years old, 42% of the newcomers were First Nations. The 2017 population (Lloydminster): $n = 64$ women, mean age was 38.2 years old, 79% of the newcomers were First Nations. The 2018 population (Calgary) $n = 17$ 100% self-identify as Indigenous, and completed their first pilot group from April 4th-May 30th, 2018. I do not know the mean age.

Sampling

Ideal: I would use the purposive sample technique to include the entire target population - Women Warriors participants, $n = 189$. This technique is appropriate for my study because this is the population that can provide answers to the question for this study and assist in the creation of a community driven concurrent use tobacco and cannabis interventions for Women Warriors.

Pilot: I contacted the target population of participants that are on the Facebook Lloydminster and Calgary group. Not every participant was on our social media Facebook meaning they did not all have an equal

¹ My original intention of only focusing on tobacco has evolved to include cannabis due to legalization this coming summer.

opportunity to participate in the study, therefore these findings cannot be generalized to all of the Women Warriors participants. After the voluntary respondents $n = 27$ read **Appendix C: Informed Consent Letter**, and filled out the survey they messaged me to have their names entered for the gift certificate draw. It allowed me to clarify any issues with the consent form and reassure them their answers are anonymous.

Methods & Data Collection

Before I sent out the questionnaire I interviewed a gatekeeper of the community, an Elder from Onion Lake Cree Nation. Please review **Appendix A Interview Questions** and **Appendix B Elder Interview Transcript**. Within Indigenous communities research it is important to approach the Elder first, to get their blessing before proceeding with data collection.

The survey, dispersed using Survey Monkey, consisted of 37 questions of quantitative data regarding self-reported smoking and cannabis behaviors with two open-ended questions, #21 and #37 that required coding. The self-administered questionnaire was composed of validated and reliable questions from the Aboriginal People's Survey: 2012 Concepts and Methods Guides Appendix A, Global Adult Tobacco Survey Collaborative Group, and Statistics Canada National Cannabis Survey. A weakness of this research methodology was its top-down approach, but it did assist me in the collection of baseline data before the creation of a commercial tobacco and cannabis health promotions unit. The data provided by $n = 27$ respondents was analyzed with the Survey Monkey software with the ability to cross-tabulate data across the survey.

Appendix D: Data Results WW Tobacco & Cannabis Survey.

Ethics

The informed consent letter instant messaged to each of the respondents highlighted the following ethical considerations: voluntary participation, free and informed consent, ability to withdraw by contacting me, and due to the fact that cannabis is not legal yet I guaranteed anonymity on the survey. Through anonymity there was no risk of criminal charges for using cannabis before the legalization date. I did not ask my key informant about her cannabis behavior/ usage, and opinions about legalization in person. A material incentive in the form of a \$100 Superstore gift card was offered to increase the rate of nonresponse error. The respondents

messed me to confirm the completion of the survey and confirm their understanding of the consent letter. I input their names into a random name picker website to choose the winner. The benefit to the community from this research is a planned Unit in the Women Warriors manual on culturally relevant, harm reduction approaches to concurrent use commercial tobacco and cannabis interventions.

Demographics

There was $n = 27$ respondents. First Nation on-reserve, 12 (46%); First Nation off-reserve, 8 (30%); Metis 2 (7%); and Caucasian 4 (15%) (Figure 1). The age range was 18 years (no one under 18 is allowed in our Facebook group) to 65 years plus with majority in the age group 35-44 years old, 11 (42%); equal number of 25-34 and 45-54, 5 (19%); equal numbers of 15-25 & 65+, 2 (7.6%); and 55-64, 1 (3.8%) (Figure 2). The geographic locations of the respondents was 20 (80%) Saskatchewan, and 5 (20%) Alberta. The Onion Lake Cree Nation respondents included 11 (44%); followed by Lloydminster, Saskatchewan (SK) 6 (24%); Lloydminster, Alberta (AB) 3 (12%); Calgary, AB 2 (8%); Loon Lake, SK 1 (4%); North Battleford, SK 1 (4%); and Meadow Lake, SK 1 (4%) (Described by postal code Q. 36).

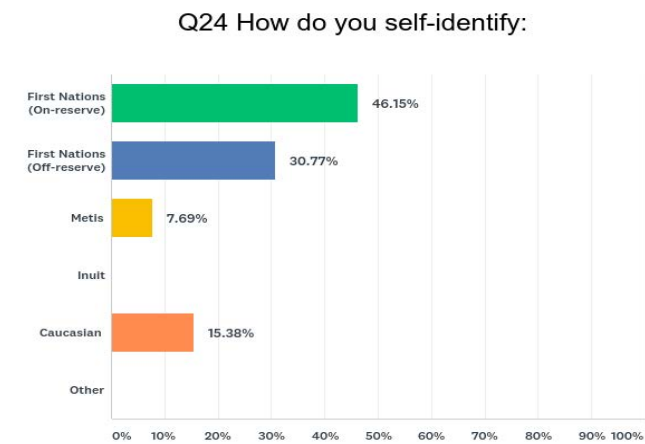


Figure 1

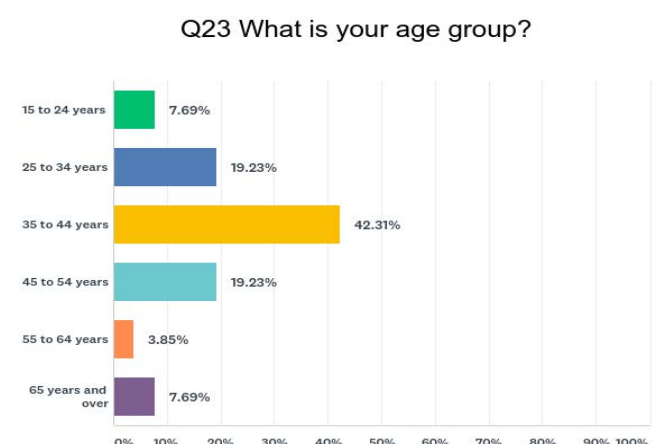


Figure 2

Those that personally attended residential school were, 5 (19%) and those that did not attend, 21 (80%) (Figure 3). Parental attendance of residential school was mother and/or father, 16 (62%); both attended 1 (4%); and no attendance 9 (34%) (Figure 4).

Q25 Did you attend residential school?

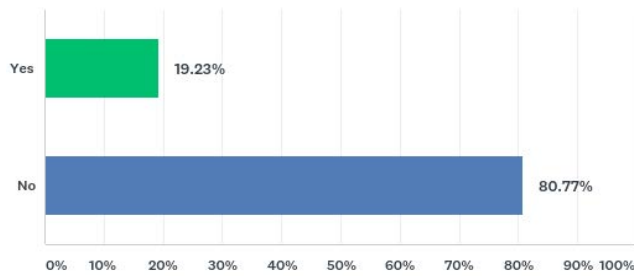


Figure 3

Q26 Did your mother and/or father attend residential school?

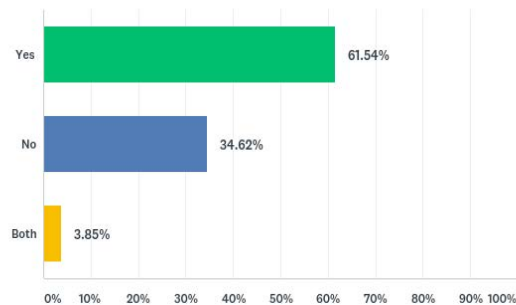


Figure 4

In terms of income the majority of respondents made \$40,000 to less than \$50,000, 8 (32%); \$30,000 to less than \$40,000, 4 (16%); followed equally by 3 (12%) in the categories of \$50,000 to less than \$60,000 & \$20,000 to less than \$30,000 & less than \$20,000; \$70,000 to less than \$80,000, 2 (8%); equal number of 1 (4%) \$60,000 to less than \$70,000 and \$90,000 to less than \$100,000 (Figure 5). The majority of respondents were employed working at a paid job or business, 15 (57%); followed by caring for children and household work, 3 (11.5%); going to school, 2 (7%); and equal number of 1 (3.8%) on maternity leave, volunteering or caregiving and retired (Figure 6).

Q33 What was your total personal income during the year ending December 31, 2018? Q31 Last week, what was your main activity? Main activity means the activity on which you spend most of your time.

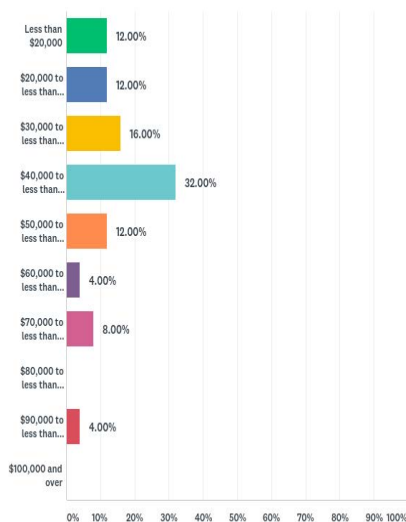


Figure 5

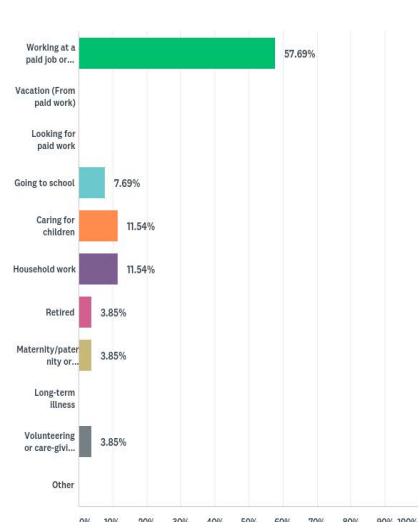


Figure 6

The education levels were majority trade certificate or diploma, 6 (23%); equal number of 5 (19%) of College, CEGEP or other non-university certificate or diploma & some university; bachelor's degree 4 (15%),

high school diploma 3 (11.5%); university certificate, degree or diploma above a bachelor’s level 2 (7.6%); and less than a high school diploma 1 (3.8%) (Figure 7).

Q32 What is the highest certificate, diploma or degree that you have completed?

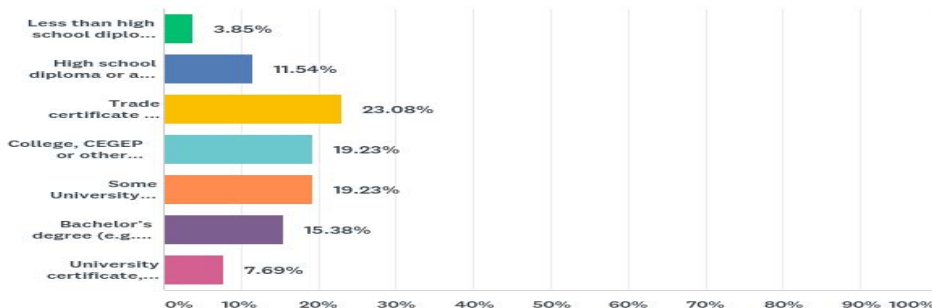


Figure 7

Those respondents that spoke their traditional language, 9 (36%) and did not speak a traditional language, 16 (64%) (Figure 8). The cultural activities most participated in were hunting, fishing or trapping, 5 (19%), gathering wild plants for example berries or sweet grass, 4 (15%), followed equally by making clothing or footwear and making arts/crafts and/or jewellery, 2 (7.6%); no participation in traditional activities, 13 (50%) (Figure 9).

Q27 Do you speak your traditional language?

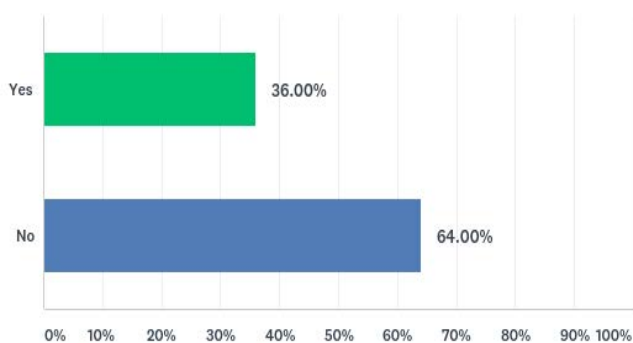


Figure 8

Q28 Do you participate in any of the following traditional activities? (If you participate in more than one activity please pick the one you spend the most time on).

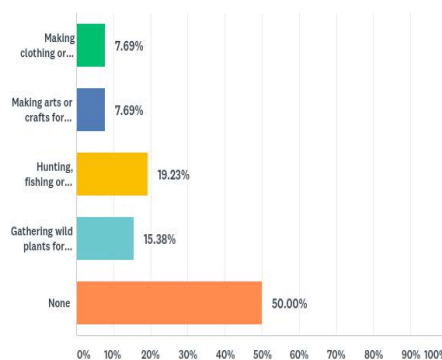


Figure 9

Physical health was described as good, 12 (46%); equal numbers of excellent and very good, 5 (19%); and fair & poor, 2 (7.6%). The majority of respondents stated their mental health was excellent, 9 (34%); equal numbers of very good & good, 6 (23%); fair 4 (15%); and poor 1 (3.8%).

Q29 In general, how would you rate your health?

Q30 In general, how would you rate your mental health?

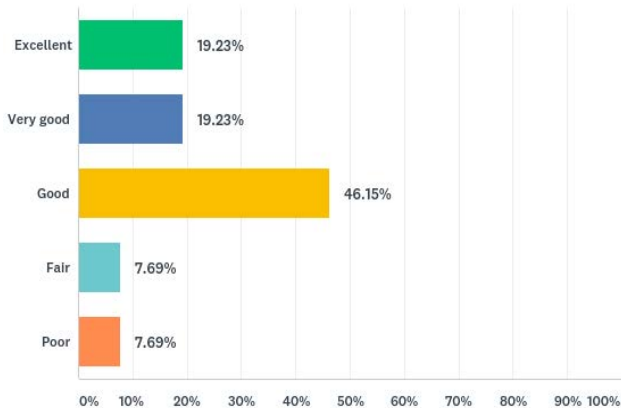


Figure 10

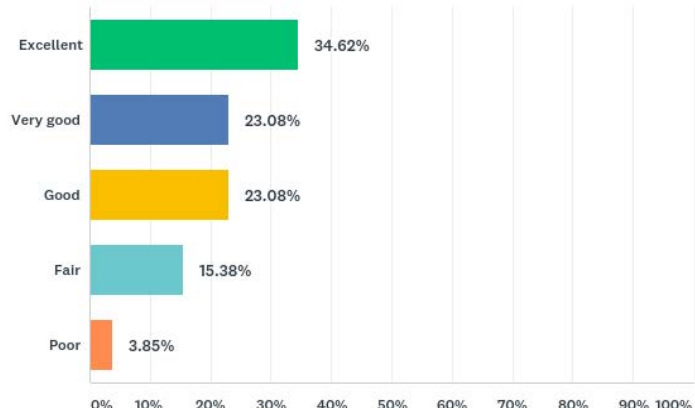


Figure 11

Tobacco Behaviour & Interventions

Tobacco behaviour includes current daily smokers, 7 (26.9%), less than daily, 5 (19%) and not at all, 14 (53%) (Figure 12). Daily past smokers include, 15 (57%) and non-smokers, 11 (42%) (Figure 13). In order to estimate the First Nations smokers, the filters daily smokers and First Nations on and off reserve were applied resulting in, 4 (16%) and 3 (12%) have smoked daily in the past.

Q1 Do you currently smoke tobacco on a daily basis, less than daily, or not at all? (Daily means smoking at least one tobacco product every day or nearly every day over a period of a month or more).

Q2 Have you smoked tobacco daily in the past?

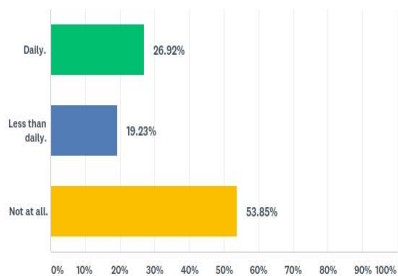


Figure 12

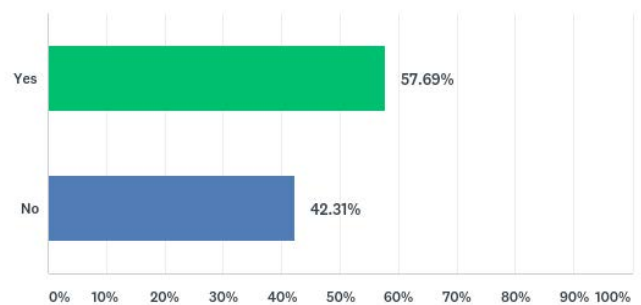


Figure 13

The commercial tobacco intervention that respondents would like to participate in were equal numbers of a traditional sharing circle with Elders & a group quit smoking challenge with prizes, 7 (25.9%); a workshop with healthcare professionals on cessation aides, 5 (18.5%); and a multi-generational photo project explaining traditional tobacco vs. commercial tobacco, 4 (14.8%) (Figure 14). Other, 4 (14.8%) open-ended answers that include: all of the above; I would participate in a sharing circle with those who have quit smoking and can share how they did so; I do not smoke; and encourage the health benefits of not smoking.

Q8 The commercial tobacco intervention you would most like to participate in:

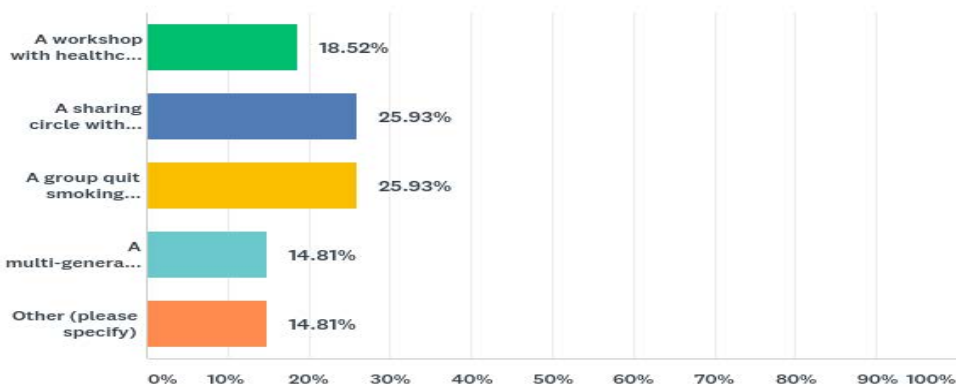


Figure 14

Cannabis Behaviour & Education

All of the respondents, 22 (100%) started using cannabis more than three months ago (Figure 16)>

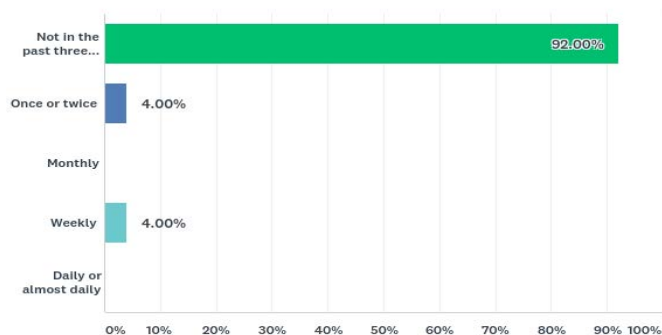


Figure 15

Q10 Did you start using cannabis in the past three months?

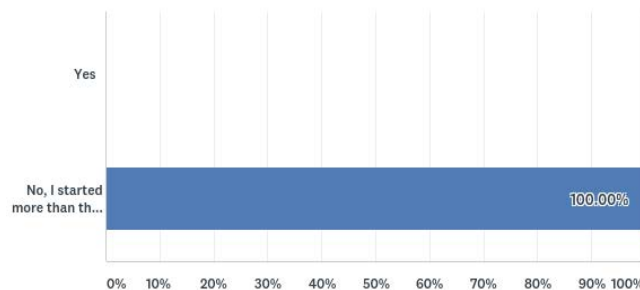


Figure 16

The intention to use non-medical cannabis once it is legalized were No, 19 (70%); equal numbers Yes & Don't know, 4 (14.8%) (Figure 17). The use of cannabis for medical purposes were No, 23 (88%); and Yes, 3 (11.5%) (Figure 18).

Q12 The use of cannabis for non-medical purposes is not yet legal. Do you intend to use cannabis for non-medical purposes once it is legalized?

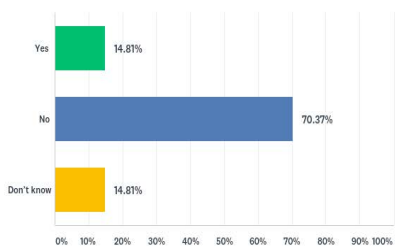


Figure 17

Q13 In the past 12 months, have you used cannabis for medical purposes (used to treat disease or improve symptoms)?

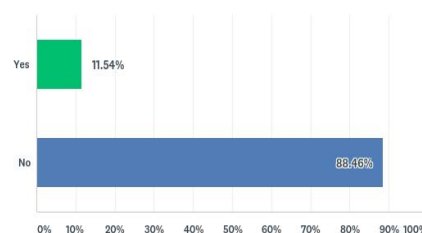


Figure 18

The social acceptance of recreational cannabis include somewhat acceptable, 8 (29%); somewhat unacceptable, 6 (18%); equal numbers of completely unacceptable & no opinion, 5 (18%); and completely

acceptable 3 (11%) (Figure 19). The social acceptance of the use of cannabis for medical purposes include completely acceptable, 14 (51%); somewhat acceptable, 6 (22%); somewhat unacceptable, 4 (14%); and no opinion, 3 (11%) (Figure 20).

Q14 How socially acceptable do you think it is for a person to use cannabis for non-medical purposes? Q15 How socially acceptable do you think it is for a person to use cannabis for medical purposes?

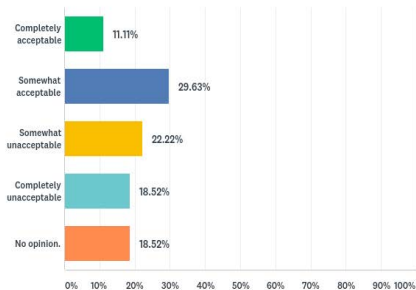


Figure 19

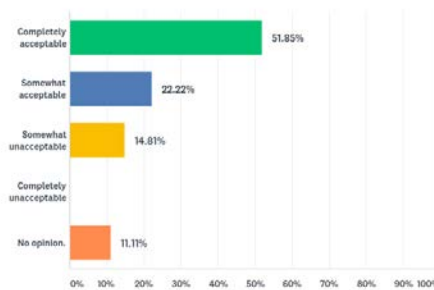


Figure 20

The most significant concern associated with cannabis use include addiction, 6 (23%); equal numbers of leads to other drugs/social stigma/increased risk of minors having access, 4 (15%); equal number of no significant concerns & long-term effects, 3 (11.5%); and impairment of senses, 2 (7%) (Figure 21).

Q16 In your opinion, what is the most significant concern associated with the use of cannabis?

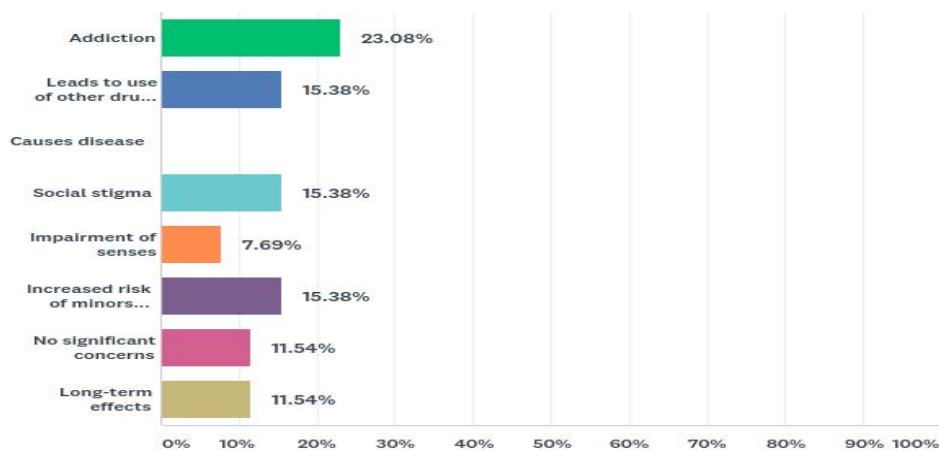


Figure 21

Medical marijuana education for the treatment of chronic illnesses and mental health issues include the same amount of responses on Yes, 19 (70%) and No, 8 (29%) (Figure 22 & Figure 23).

Q17 I would like to learn about medicinal marijuana for the treatment of chronic illness like multiple sclerosis, lupus, and diabetes? Q18 I would like to learn about medicinal marijuana for the treatment of mental health issues such as depression, anxiety, and post-traumatic stress disorder?

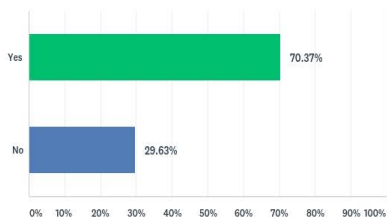


Figure 22

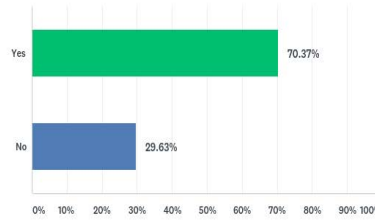


Figure 23

Education of the impact of cannabis in the health of individuals includes Yes, 20 (74%); and No 7 (25%) (Figure 24). The opinion on Onion Lake Cree Nation opening an on-reserve dispensary includes No, 8 (40%); Yes, 7 (35%), and Other, 5 (25%) that stated: I'm undecided about this question. Maybe I would if I knew the facts about marijuana; n/a; I am unsure how to answer. Not enough information to provide an answer; depends on for what purpose (Figure 25).

Q20 I would like to learn about the impact of cannabis on the health of individuals? Q22 The following question is for Onion Lake Cree Nation members only. I support Onion Lake Cree Nation opening a dispensary to sell legal cannabis on reserve?

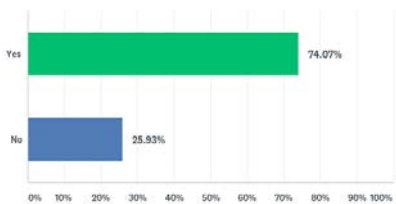


Figure 24

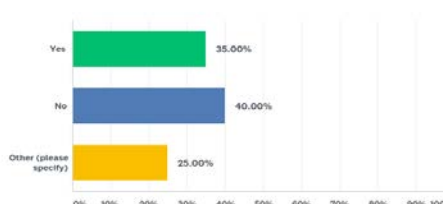


Figure 25

Second-hand smoke (tobacco) exposure inside the home includes never, 18 (69%); daily, 6 (23%); equal number of weekly & less than monthly 1 (3.8%) (Figure 26). The second hand smoke (marijuana) exposure inside the home includes never, 23 (88%); equal number of daily/weekly/less than monthly, 1 (3.8%) (Figure 27).

Q4 How often does anyone smoke (tobacco) inside your home? (This only includes enclosed areas of the home – the respondent should not include areas outside of the home including patios, porches, etc. that are not fully enclosed). Q11 How often does anyone smoke (cannabis) inside your home? This only includes enclosed areas of the home – the respondent should not include areas outside of the home including patios, porches, etc. that are not fully enclosed.

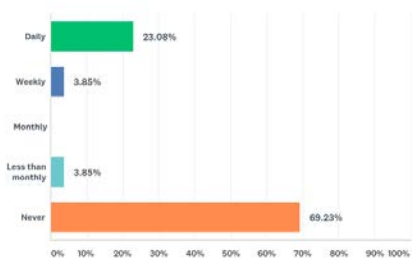


Figure 26

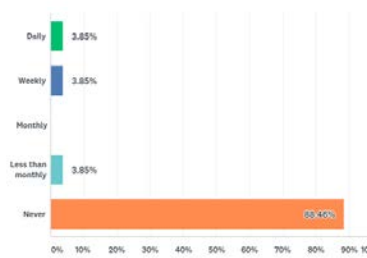


Figure 27

Interest in learning about the different forms of usage of marijuana include Yes, 16 (61%); and No, 10 (38%) (Figure 28).

Q19 I would like to learn about the different forms of usage of marijuana?

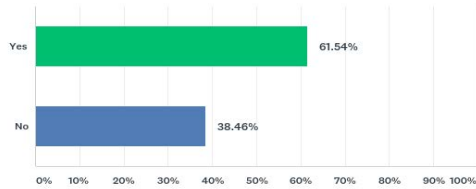


Figure 28

The open-ended responses for the specific information to be included in a cannabis workshop as it relates to the impact of cannabis use on the health of individuals include (Figure 29):

| # | RESPONSES | DATE |
|----|--|--------------------|
| 1 | Pain reduction | 6/13/2018 2:08 PM |
| 2 | Just basic info not to familiar with it | 6/12/2018 3:53 PM |
| 3 | Just the difference between street cannabis and medical cannabis | 6/12/2018 10:20 AM |
| 4 | Safer than other hard core drugs | 6/11/2018 9:36 PM |
| 5 | Thorough details of work related topics. How it helps the user be effective and productive during work hours. Ask why worker is allowed to work while in this particular medication. | 6/11/2018 8:39 PM |
| 6 | I would like statistics on susccess rates for medical uses of Canibis & what diseases and things it's helped with | 6/11/2018 7:52 PM |
| 7 | Specific health effects on long term chronic users | 6/11/2018 3:46 PM |
| 8 | Benefits of using medicinal marijuana | 6/11/2018 3:02 PM |
| 9 | cannabis and Teens the impacts of use | 6/11/2018 9:28 AM |
| 10 | The affects and side side effects of its use to an individual | 6/11/2018 8:30 AM |
| 11 | marijuana induced psychosis in youth, youth mental health issues, youth suicide related to drug use (solvents, marijuana, cocaine, etc.) | 6/10/2018 4:51 PM |
| 12 | none | 6/10/2018 3:44 PM |
| 13 | can you overdose on marijuana | 6/10/2018 1:40 PM |
| 14 | That the use of medicinal marijuana will lead to addictions and it it not a cure to health problems. | 6/10/2018 11:52 AM |
| 15 | Marijuana effects people differently. Some people can smoke and have no effects while some smoke it and have panic attacks. | 6/10/2018 10:42 AM |
| 16 | Possibly having proof available & visible on the negative & positive impacts on a person's health. | 6/10/2018 10:32 AM |
| 17 | How does it help diabetics? | 6/10/2018 10:20 AM |
| 18 | Side effects, long term effect of use | 6/10/2018 10:09 AM |
| 19 | Just want people who are against medicinal marijuana... to see the benefits of it over pharmaceutical pills... | 6/10/2018 9:38 AM |
| 20 | The effectiveness of cannabis and epilepsy | 6/9/2018 11:38 AM |

Figure 29

Analysis

Tobacco Quantitative

It is important to reiterate that these findings cannot be generalized to all of the Women Warriors participants due to the fact that there were only $n = 27$ voluntary participants of the survey. It is an exploratory and descriptive survey to gather data about the best way to approach a community tobacco intervention and cannabis behavior and education.

In relation to Ryan, Leatherdale, and Cook (2015) I also found an increased risk of daily smoking between First Nations (on & off reserve), and mother and/or father residential school attendance. This finding also aligns with Bougie and Kohen (2018) that the odds of smoking for Inuit women were significantly higher if their parents attended.

| | Parents attended residential school | No residential school | Total |
|-------------------------|-------------------------------------|-----------------------|-------|
| Smoking Daily | 4 (67%) | 0 (0%) | 4 |
| Smoking Less than daily | 2 (33%) | 3 (100%) | 5 |
| Total | 6 (100%) | 3 (100%) | 9 |

Unlike Bougie and Kohen (2018) findings of an association for Inuit women and increased odds of smoking with having personally attended residential school, there were 0 First Nations (on and off reserve) respondents in the survey that attended residential school and smoked daily or less than daily.

Also, in relations to Ryan et.al (2015) there was bivariate associations of an increased risk of daily smoking for those respondents that identified as First Nations (on/off reserve) and were engaged in cultural practices such as traditional activities like hunting, fishing, and trapping/making arts and crafts/making traditional clothing.

| | Cultural Activities | No Cultural Activities | Total |
|-------------------------|---------------------|------------------------|-------|
| Smoking Daily | 3 (75%) | 1 (20%) | 4 |
| Smoking Less than daily | 1 (25%) | 4 (80%) | 5 |
| Total | 4 (100%) | 5 (100%) | 9 |

There was no association between increased smoking between those that spoke an Indigenous language as opposed to those that did not, unlike the findings of Ryan et. al (2015).

| | Speak traditional language | No traditional language | Total |
|-------------------------|----------------------------|-------------------------|-------|
| Smoking Daily | 2 (50%) | 2 (40%) | 4 |
| Smoking Less than daily | 2 (50%) | 3 (60%) | 5 |
| Total | 4 (100%) | 5 (100%) | 9 |

In terms of household income and smoking there was an indication of higher rates of smoking in higher income households (\$30,000-\$100,000) than lower income (less than \$30,000), which contradicts Ryan, et. al. (2015) bivariate associations of low income and high rates of smoking.

| | Low Income (less than \$30,000) | Income (\$30,000 - \$100,000) | Total |
|-------------------------|---------------------------------|-------------------------------|-------|
| Smoking Daily | 1 (50%) | 5 (56%) | 6 |
| Smoking Less than daily | 1 (50%) | 4 (44%) | 5 |
| Total | 2 (100%) | 9 (100%) | 11 |

In terms of educational attainment and smoking there was an indication of higher rates of smoking in higher levels of education than lower levels of education (high school diploma and less), which contradicts Ryan, et. al. (2015) bivariate associations of low education and high rates of smoking.

| | High School Diploma & Less | Trade Certificate to Master’s Degree | Total |
|-------------------------|----------------------------|--------------------------------------|-------|
| Smoking Daily | 0 (0%) | 7 (70%) | 7 |
| Smoking Less than daily | 2 (100%) | 3 (30%) | 5 |
| Total | 2 (100%) | 10 (100%) | 12 |

The employment status of respondents contradicts Ryan, et. al. (2015) findings of bivariate associations between unpaid work and increased smoking rates. The respondents in paid employment had a higher rate of smoking.

| | Employed Paid Work | Unpaid Work | Total |
|-------------------------|--------------------|-------------|-------|
| Smoking Daily | 4 (50%) | 3 (75%) | 7 |
| Smoking Less than daily | 4 (50%) | 1 (25%) | 5 |
| Total | 8 (100%) | 4 (100%) | 12 |

The tobacco cessations interventions recommended in the Context Research Ltd. (2015) report, “Respecting Tobacco” such as counselling (in-person or by telephone), quit contests, pharmaceutical interventions such as nicotine replacement therapy and cessation medication were the foundation of the survey question about the commercial tobacco intervention that respondent’s would most like to participate in. First Nations on & off reserve that smoked daily or less than daily indicated their top two tobacco interventions as the sharing circle with Elders 3(50%) and quit smoking contest with prizes 3 (50%).

An important consideration for the delivery of the tobacco intervention is the fact that 5 (50%) of the 10 total First Nations (on & off reserve) that smoked daily or less than daily had not visited a health care provider in the past twelve months (Figure 30). It is worth exploring why they have not visited their healthcare provider and/or what other point of health care service delivery they may receive tobacco cessation/education.

Furthermore, the same number of respondents identified as trying to quit smoking in the past twelve month, and it needs to be identified how they attempted to quit and if a health care providers guidance would have increased success rates (Figure 31).

Q6 Have you visited a doctor or other healthcare provider in the past 12 months? Q5 In the past 12 months, have you tried to stop smoking?

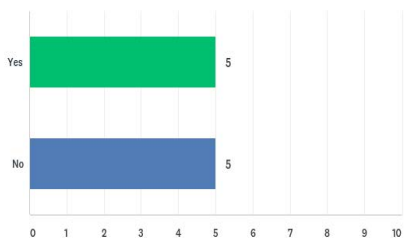


Figure 30

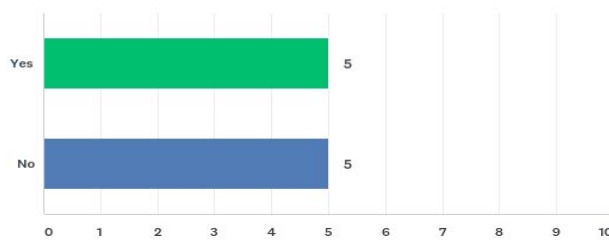


Figure 31

Ryan et. al (2015) findings of a bivariate association of low socioeconomic status, poor perceived health and daily or less than daily smoking were not confirmed by this survey. Only 1 respondent identified with these criteria.

A question to further explore is the fact that 8 (66%) daily/less than daily smokers identified as having “good” health. How do smokers perceive “good” health (Figure 32)? Would education on the health effects of commercial tobacco use lower their perceived health score from “good” to “fair” or “poor?” Would helping them quit increase their scores to “very good” or “excellent?”

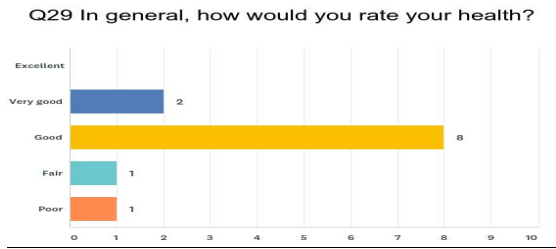


Figure 32

In addition, the findings, when filtered to First Nations (on/off reserve) and Metis revealed that 12 (54%) of respondents have visited their healthcare provider in the past 12 months and 10 (45%) have not (Figure 33). This question needs further clarification on reasons for not visiting, including an exploration of systemic barriers or institutional racism within the health care system that prevents visits. This is a question that I will suggest be used on all further Women Warriors research questionnaires. It could lead to a better understanding of the most effective way to deliver tobacco interventions and cannabis education (ie) community events vs. health care appointments. Moreover, we could create another appendix on suggested yearly examinations and tests to prevent chronic illness and disease.

Q6 Have you visited a doctor or other healthcare provider in the past 12 months?

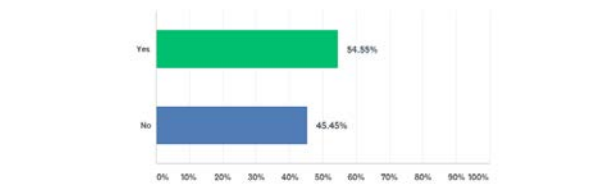


Figure 33

The exposure of second-hand tobacco smoke, daily 6 (23%) (Figure 26) suggest the need for education on the impacts of second-hand smoke in homes. I will include in the tobacco intervention the affects of second – hand smoke on the respiratory health of children (i.e.) increased likelihood of asthma. Furthermore, the numbers of cannabis smokers inside the home may likely increase upon legalization. It will be important to also educate on the effects second-hand cannabis smoke.

Tobacco – Qualitative Interview with Elder

The Elder I interviewed was the program manager at Ekweskeet Healing Lodge, a drug and alcohol treatment centre located on reserve at Onion Lake Cree Nation. Her interview highlighted the fact that there are no tobacco programs or interventions offered on reserve, “Nobody’s helping” (p. 10) and “I think it’s so serious, we need a program like for alcohol, they have a place for that. But smoking, there’s nothing” (p. 11). The Elder identified high rates of smoking within the community, “When I first go to Onion Lake, that’s what I noticed – parents smoked, grandparents smoke, the teenagers and grandchildren smoke. Like I see a lot of smoking and I was like - - everybody smokes here?” (p. 2). She reinforced the acceptance of tobacco as an intergenerational occurrence by using the example of a young girl that chews snuff telling her, “it’s bought for me - - she said. My dad makes sure to have a supply all the time. I did see her again. She’s still doing it.” (p. 9).

She also stated that the root cause of tobacco use in her community is linked to pain and smoking is a coping mechanism, “Maybe they don’t want to feel anything. Some kind of pain. That’s what I think - because all of life is about pain. You do addiction so you don’t have to feel, feel those feelings.” (p. 7). She stated she used smoking to deal with her own grief over the loss of her brother, “The only way I could get through the funeral is to smoke. But after the funeral, I’m good. I don’t smoke. But during those, you know, before the funeral, wake and then funeral, like all three days, I’ll smoke” (p. 14). This finding is significant and I would include a question on the next survey about reasons for smoking. The assumption behind this question is if you know the source of health behaviours it is more likely to find long-term solutions.

She reinforced the findings that both of the interventions of sharing circle. She states, “We have done that...when we had that big circle one time. During addictions week, we had one at the hall and it was a big turnout” (p. 16). She also supported the quit smoking contest, “Whenever there’s a big prize, they all go for it” (p. 5). She stated, “there could be interest” (p. 6) in growing traditional tobacco on reserve. She did not support the suggestion of raising taxes, point of sales interventions at the gas stations, or the use of scare tactics like diseased lung pictures on packaging to help people quit, “Trying to scare people to quit, don’t work,” (p. 3).

She identifies a lot of second hand smoking happening in homes and wants the messaging to be “don’t smoke in the house” and “no smoking in vehicles” (p. 13). She identified chewing snuff as a popular form of commercial tobacco consumption, “there’s a lot of them out there. Even the old ladies – they chew snuff. Some of them real sneaky” (p. 8). Her next challenge, as a community addictions resource person, is to educate women on the dangers of chewing snuff and pregnancy (p. 8).

Analysis – Cannabis

Based on the open-ended answers in Figure 29, the general themes of the cannabis education will be:

1. Basic information on how it affects the health of the individual including the chronic long-term effects, safety of usage, difference between medical and recreational, and positive and negative impacts on health, and the different ways to consume it.
2. Teens and cannabis usage – long-term effects, is it a gateway drug, the safety issues of cannabis use for youth including psychosis and its link to mental illnesses such as schizophrenia.
3. Medical cannabis – effectiveness in the treatment of health issues such as epilepsy, diabetes, and pain reductions. It’s important to note respondents want information on medical cannabis and its use in the treatment of chronic illness and mental health (Figure 22 and 23).

It is common for smokers to have concurrent use of tobacco and cannabis. The survey results revealed the 2 respondents that used cannabis (Figure 34) identified as less than daily smokers of tobacco (Figure 33).

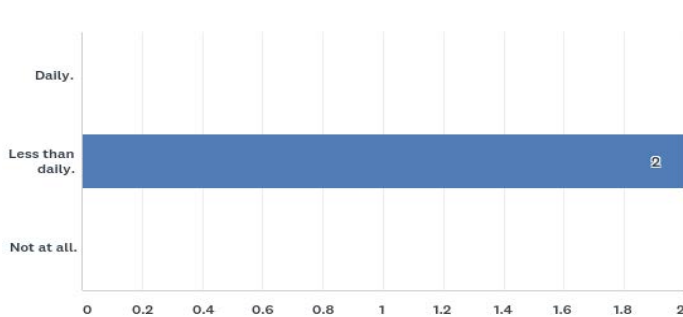


Figure 34

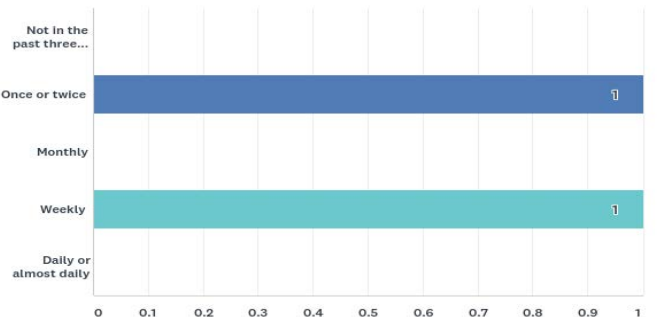


Figure 35

The survey results revealed that respondents find it more acceptable to use medicinal cannabis, 51% than recreational cannabis, 11% (Figure 19 & 20). It would be interesting to track social acceptance of cannabis usage as legalization and subsequent education of cannabis occurs. The data also reveals that the most

significant worry of cannabis legalization is addiction (Figure 21) and it will be important to include statistics on the capture rate of cannabis addiction and the long-term addiction rates.

The support for Onion Lake Cree Nation opening an on-reserve dispensary for cannabis was filtered to include only First Nations (on reserve). The results were No, 5 (41%); Yes, 4 (33%) and other, 3 (25%) stating they need more information before answering the question (Figure 35). It would be important to ask this question again, with more contexts. This would require speaking with community leaders about the details of opening a dispensary, which requires community input.

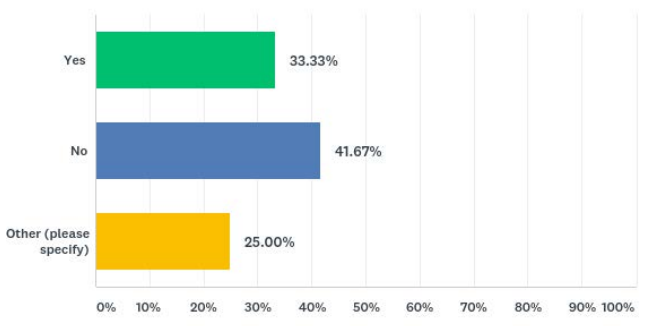


Figure 36

Project Analysis

There were several flaws in format of the survey, which I can remedy by becoming familiar with how to format contingency and matrix questions. For example, Q1 I only wanted those respondents that answered yes to daily or less than daily smoking to answer Q5 (attempts to quit), Q7 (healthcare provider advised to quit smoking), Q8 (what type of intervention would be best). It skewed the results of the survey by allowing all respondents to answer these questions. Q9 (cannabis use) should have been a contingency question for users to go onto Q10 (started in the past three months). Again, all respondents skewed the results, 100% of respondents stated they started more than three months ago, which also included the people that don't use cannabis. Q12 (nonmedical use of cannabis upon legalization) should have included the category, Other: Explain. Q's 17-20 which had a YES or NO answer would have been better formatted as a matrix style question – take up less space and quicker to scan for the respondents. Q12 should be edited to state, “In general, how would you rate your physical health?” Respondents did not provided valuable feedback under the general comments section, instead using it for responses like thank you and no comment.

The challenge of this survey was getting Women Warriors to participate. I initially posted it on the secret Facebook group and waited two days for a response and nothing. I had to individually message them to explain the survey and I attached the informed consent letter. Next time, I would send the survey to their personal emails and follow up on Facebook instant message feature. After I clarified that the survey was anonymous they felt more comfortable participating.

I missed the opportunity to explore overcrowding on reserve and how living with a smoker influences behaviours, as Bougie and Kohen (2018) found that the odds of smoking were significantly higher for both sexes if they experienced overcrowding in their home, and/or lived with a regular smoker. In the next iteration of the survey I would create two questions to capture those variables. I would define overcrowding, which I would first have to research what the markers of overcrowding are and ask if respondents experience it. Living with a smoker would be defined as someone that daily consumes commercial tobacco and how that behavior impacts his or her lives.

A flaw of this research is its top down approach. Now that I have some baseline data to create the manual, I would enact a participatory action research approach. I would ask community how they want to approach tobacco interventions and cannabis education and involve the community health centre, and the participants of Women Warriors groups. Once I'm done writing the unit for the concurrent use commercial tobacco and cannabis intervention I would host an event and then do an evaluative survey to capture if it served the community needs.

A positive outcome from doing this survey is recycling some of the questions for our health questionnaire for Women Warriors OLCN and Calgary. Such as, the parental attendance of residential school, which we were not asking, but I now know it's an important health indicator. Also, visiting the health care provider offered surprising results, which need more exploration. As well, how do cultural activities impact the overall health of respondents – according to my findings they are more likely to smoke – Why?

Finally, I understand the complexity of doing research on reserve with meeting the regulations of First Nations OCAP: Ownership, Control, Access and Possession. I would be careful to approach the community

well in advance of the data collection so that everything is in place before beginning. I also understand that there is community fear surrounding cannabis legalization and I would be weary of providing my own thoughts and advice to community members meaning all the literature I provide and the messaging needs to be thoroughly researched and referenced.

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