The Strategic Counsel

POR-408-06
Contract # H1011-060068/001/CY
Contract Award Date: 2007-02-19

Final Report
HEALTH DIRECTORS' PERCEPTIONS OF CURRENT TOBACCO CONTROL ACTIVITIES IN FIRST NATIONS COMMUNITIES (HC POR 06-90)

Prepared for
First Nations and Inuit Health Branch
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February 2008

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The Strategic Counsel

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Executive Summary

The Strategic Counsel is pleased to present this report to the First Nations and Inuit Health Branch (FNIHB) of Health Canada on findings from the result of a survey of First Nations Health Directors. The research was undertaken in order to better understand and quantify current tobacco control initiatives in place in First Nations communities.

The survey focused on non-traditional use and consumption of commercial tobacco products rather than on traditional, medicinal or ceremonial uses. Specific research objectives included:

- Gathering data on current tobacco control activities underway in First Nations communities;
- Measuring the degree of awareness of resources in place and information available to community members;
- Assessing the current state of policies, bylaws and other restrictions on the use of tobacco in workplaces and public spaces;
- Gathering views on the factors which are perceived to be contributing to high smoking rates in First Nations communities; and
- Determining whether community members see a clear link between tobacco cessation activities and other health related initiatives or programs.

A total of 223 First Nations Health Directors completed a 20-minute survey by telephone.

The survey was conducted from mid-July through mid-August 2007. The list of Health Directors, including contact information, was provided by Health Canada and included a total of 373 contacts. As such, the results are accurate to within +/- 4.17%, based on a finite population of 373 First Nations Health Directors.

The final sample represents a response rate of 65% and a refusal rate of just one per cent (1%), based on the total eligible contacts (i.e. less numbers not in service, etc.) of 345.

The final sample distribution by region closely reflects the distribution of the population, with slight over-representation in British Columbia and under-representation in Ontario.

The majority of Health Directors surveyed provide services to one community only. Their tenure as Health Director varies, with a slightly higher proportion of Health Directors having served for just under five years as compared to those with five years or more service (about a 3:2 ratio).

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A. Key Findings

The main findings are detailed below. Note that these findings reflect the perception of Health Directors' views of their communities and not the views of residents or community members themselves.

Health Directors assess their community members' knowledge both of the dangers associated with non-traditional tobacco and tobacco misuse, and of the existing resources available to those wishing to quit, as moderate but not high.

- Perceived knowledge of the dangers associated with smoking among children and youth, as well as those stemming from second-hand smoke, is fairly good although not particularly strong.

- From Health Directors' vantage point, communities are much less intimately knowledgeable of the dangers of recreational smoking, the resources and information available to assist smokers to quit smoking as well as of the dangers of chewing or spit tobacco.

- The majority of Health Directors (55%) feel that there is insufficient information and materials about tobacco cessation in their community.

By contrast, Health Directors rate themselves as being fairly familiar with the available information and materials about tobacco cessation. At the same time, there is an opportunity to further educate Health Directors given that only a bare majority assessed themselves as being "very familiar" with the materials. In particular, longer serving Health Directors should be a specific target for refresher courses/seminars and for up to date tobacco cessation information kits.

- Over nine-in-ten (94%) Health Directors said they were familiar with the available information and materials.

- Just over half (52%) claimed to be "very familiar" which suggests there is a significant opportunity to educate Health Directors so that they are better able to provide leadership and bridge the information gap (as perceived by the Directors) among members of their community.

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- While levels of overall familiarity were roughly the same regardless of tenure, there was a slight drop in the percentage of those who have served as a Health Director for 10 years or more indicating they were "very familiar" (48%) as compared to those who have served as a Health Director for less than three years (55%).

The average perceived cost of a package of cigarettes is $8.17. Health Directors are divided as to whether retailers would support or oppose an increase in the price, but believe that opposition from residents would be much more strenuous.

- A majority of Health Directors were uncertain or unaware of the price of a carton of cigarettes (56%).

- Almost as many Health Directors say that retailers in their community would support (45%) as oppose (40%) an increase in the price of a package of cigarettes.

- A significantly higher percentage of Health Directors predict that residents would oppose such an increase (79%).

There is wide variability in Health Directors' sense of the degree to which cigarettes and tobacco are sold in their communities to those under the age of 18, with the plurality suggesting it occurs, at least sometimes, if not frequently.

- Over three-quarters of Health Directors indicated that broad-based and targeted youth educational and community awareness raising programs were in place to prohibit or discourage the sale of tobacco products to youth. Just over half, but less than two-thirds, of Health Directors said that information sessions with parents and mandatory retailer ID checks were undertaken. Fewer than one-in-five indicated that educational programs aimed at retailers were in effect in their community.

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Just under one-quarter of Directors indicated that their community collects the First Nations Tax (FNT) on tobacco products. Many believe that there is minimal to no understanding of the purpose and administration of the tax

- On average, half of all Health Directors (50%) claimed their community had a limited or no understanding of the tax. One-quarter of Health Directors (26%) indicated there was absolutely no understanding at all.

- It appears that a lack of information or interest in the FNT rather than fundamental opposition is at the root of low levels of understanding of the tax.

According to Health Directors, most communities have policies, by-laws or restrictions in place regarding smoking in public spaces or work places. Of these, a complete ban is more likely the case as compared to a partial ban, by a ratio of about two to one.

- Far and away, the most perceived prevalent impact has been in the institution of more smoke-free public spaces.

- The measures currently in place could be described as "soft" or informal (i.e. verbal warnings rather than penalties and fines for non-compliance).

- For those communities which did not have such policies or by-laws in place, a variety of reasons were given. Many Health Directors offered that self-regulating mechanisms were in place (i.e. the community effectively monitors itself or that residents simply don't smoke in public places).

- A smaller percentage of Health Directors indicated that the absence of such by-laws was due to difficulties in instituting them or a lack of leadership within the community to address the issue.

Communities implement or support other activities such as recreational or sports programs, health and community nursing or youth programming as a means of encouraging members of all ages to stay or become smoke-free. Moreover, many Health Directors noted that tobacco control activities are linked to other community-based programs such as maternal child health programs, chronic disease prevention and healthy living initiatives. At the same time, a lack of federal funding is the single most commonly cited barrier communities face, according to Health Directors, in initiating additional activities of this nature.

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- Communities partner with other organizations and individuals to leverage the smoke-free/tobacco cessation message, including most frequently elders, the federal government and to some extent national or regional Aboriginal organizations, other First Nations communities and provincial or territorial governments. Non-governmental organizations are less frequently cited as partners.

- One-third of Health Directors (32%) indicated that a lack of funding from the federal government was among the principal barriers to developing and implementing smoking awareness and tobacco cessation programming.

B. Overview and Suggestions for Future Considerations – Addressing Informational and Structural Issues

The findings from the Health Directors painted a consistent and interesting picture of tobacco control activities in First Nations communities. Overall, Health Directors rated themselves as possessing a reasonable level of knowledge on the issue and the relevant resources. By contrast, the findings suggest that Health Directors see considerable room for improvement in raising levels of awareness and understanding amongst the people in their communities.

The findings clearly indicated areas of strength that could be built upon, and identified barriers to further progress. On the positive side, community-based health programs such as maternal child health, chronic disease prevention and healthy living initiatives appear to have effectively delivered tobacco control messages.

- A first possible path forward for improved tobacco control activities would be to reinforce messaging and resources delivered through existing initiatives focused on related health issues, instead of trying to deliver a separate program through already heavily tasked Health Directors. There is definitely a need for continued efforts to raise the level of awareness and understanding of the dangers of smoking generally and specifically among children and youth. Messaging on the dangers of chewing or spit tobacco and of recreational smoking as well as on available resources and supports for those wishing to quit would be important elements of such a campaign.

In their responses to the survey Health Directors clearly identified two sets of barriers to tobacco control in their communities: informational and structural.

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The Health Directors described themselves as having reasonable levels of knowledge about tobacco issues and about the relevant materials available to use in their communities. However, only half rated themselves as being "very familiar" and a substantially high number did not know the price of cigarettes in their communities (one of the key deterrents to increased usage). In addition, levels of those Health Directors who described themselves as "very familiar" with materials dropped from 55 per cent for those who had been in their position for less than three years to 48 per cent for those with more than ten years in their position, another indication of a requirement for additional communications activities focused on the Health Directors.

- The second consideration is that a communications campaign on tobacco control activities be targeted at the Health Directors, particularly those who have been engaged in the position for more than three years, to refresh and update their knowledge and familiarity with materials and information on tobacco cessation messaging and programming.

Health Directors also singled out retailers in their communities as an important constituency for targeted educational programs and information. In addition, Health Directors indicated that the sale of tobacco to minors occurs at least occasionally, if not more frequently.

- The third consideration would be for Health Canada to target retailers with appropriate messaging and educational materials on tobacco use among minors.

The second set of barriers to tobacco control that emerged from the interviews is more structural: specifically, price, taxation and regulatory enforcement of identification checks to restrict sales to minor and smoking bans in public areas. These issues are outside the strict purview of the Health Directors, but are proven and effective tobacco control policy instruments.

- The fourth consideration for Health Canada would be to work through its federal partners and First Nations leaders to introduce regulatory capacity building in First Nations communities in order to enforce identification checks when selling tobacco, develop and enforce smoking bans in public areas and increase awareness of the First Nations Tax on tobacco products. This could be complemented by Health Canada working directly to encourage Health Directors to mobilize community efforts against non-traditional uses and consumption of tobacco in partnership with other groups such as elders, other Aboriginal organizations and various levels of government.

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Finally, many of the communities represented by those Health Directors who participated in the survey have a partial or complete smoking ban in place. However, it is not evident based on the survey results how effective Health Directors believe the various approaches, ranging from the softer/informal measures to harder/formal measures are perceived to be.

- The final consideration would be to undertake further assessments of the perceived/actual effectiveness of various policy approaches, including informal self-regulation as well as partial and complete bans on smoking in public spaces and work places.

MORE INFORMATION

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Award Date:	2007-02-19

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II. Sommaire

Sommaire

The Strategic Counsel est heureuse de présenter ce rapport des résultats de l'étude auprès des directeurs et directrices de la santé des Premières nations à la Direction générale de la santé des Premières nations et des Inuits (DGSPNI) de Santé Canada. Cette étude a été menée afin de mieux comprendre et de quantifier les initiatives de lutte contre le tabagisme en cours au sein des communautés des Premières nations.

L'étude s'est concentrée sur l'utilisation non traditionnelle et sur la consommation des produits commerciaux du tabac, plutôt que sur ses usages traditionnels, médicinaux ou cérémoniaux. Les objectifs précis de l'étude étaient de :

- recueillir des données sur les activités de lutte contre le tabagisme en cours au sein des communautés des Premières nations;
- mesurer le degré de connaissance des ressources en place et de l'information disponible aux membres de la communauté;
- évaluer l'état actuel des politiques, règlements et autres restrictions sur l'utilisation du tabac dans les lieux de travail et les espaces publics;
- Recueillir des points de vue quant aux facteurs qui sont perçus comme contribuant aux taux élevés de tabagisme au sein des communautés des Premières nations; et
- déterminer si les membres de la communauté voient un lien évident entre les activités d'abandon du tabagisme et les autres initiatives ou programmes liés à la santé.

Au total, 223 directeurs et directrices de la santé des Premières nations ont répondu au sondage téléphonique qui durait une vingtaine de minutes.

Le sondage a été mené de la mi-juillet à la mi-août 2007. La liste des directeurs et directrices de la santé, y compris leurs coordonnées, a été fournie par Santé Canada et comprenait un total de 373 noms. Par conséquent, les résultats sont considérés précis selon une marge d'erreur de +/- 4,17 % en fonction d'une population finie de 373 directeurs et directrices de la santé des Premières nations.

L'échantillon final affiche un taux de réponse de 65 %, et un taux de refus de seulement un pour cent (1 %) si on se fie au nombre total de contacts admissibles (c'est-à-dire l'échantillon moins les numéros hors service), soit 345.

La répartition de l'échantillon final par région reflète étroitement la répartition de la population, avec une légère surreprésentation en Colombie-Britannique et une légère sous-représentation en Ontario.

La majorité des directeurs et directrices de la santé sondés n'offrent des services qu'à une communauté. Leur ancienneté à titre de directeur ou directrice de la santé varie, mais la proportion de directeurs et de directrices de la santé en poste depuis un peu moins de cinq ans est légèrement plus élevée que celle de ceux en poste depuis cinq ans ou plus (un ratio d'environ 3 pour 2).

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A. Principales constatations

Les principales constatations sont détaillées par la suite. Il est important de garder à l'esprit que ces résultats reflètent la perception des directeurs et directrices de la santé de leurs communautés, et non le point de vue des résidents ou des membres des communautés eux-mêmes.

Les directeurs et directrices de la santé évaluent la connaissance des membres de leur communauté des dangers associés à l'usage non traditionnel ou au mauvais usage du tabac et des ressources existantes disponibles pour ceux qui désirent cesser de fumer comme modérée, mais pas élevée.

- La connaissance perçue des dangers associés à l'usage du tabac chez les enfants et les jeunes, de même que ceux émanant de la fumée secondaire, semble plutôt bonne même si elle n'est pas particulièrement forte.

- Du point de vue des directeurs et directrices de la santé, les communautés connaissent beaucoup moins bien les dangers du tabagisme récréatif, les ressources et l'information disponibles pour aider les fumeurs à cesser de fumer, ainsi que les dangers de mâcher ou de priser du tabac.

- La majorité des directeurs et directrices de la santé (55 %) croient qu'il n'y a pas suffisamment d'information et de documents au sujet de l'abandon du tabagisme au sein de leur communauté.

En contrepartie, les directeurs et directrices de la santé jugent qu'ils sont plutôt familiers avec l'information et les documents au sujet de l'abandon du tabagisme disponibles. En même temps, il y a là une occasion de mieux sensibiliser les directeurs et directrices de la santé, puisqu'à peine la majorité se considèrent « très familiarisé-e » avec les documents. Plus particulièrement, les directeurs et directrices de la santé en poste depuis plus longtemps devraient être une cible privilégiée pour les cours ou séminaires de recyclage et pour recevoir des trousses d'information sur l'abandon du tabagisme à jour.

- Plus de neuf directeurs et directrices de la santé sur dix (64 %) affirment être familiarisés avec l'information et les documents disponibles.

- Seulement un peu plus de la moitié des répondants (52 %) affirment être « très familiarisés », ce qui indique qu'il y a là une occasion importante de sensibiliser les directeurs et directrices de la santé afin qu'ils soient davantage en mesure de faire preuve de leadership et de combler le manque d'information (perçu par les directeurs) auprès des membres de leur communauté.

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- Si le degré de familiarité global est à peu près le même, peu importe l'ancienneté, on remarque une légère baisse du pourcentage des répondants qui ont indiqué « Très familiarisé » (48 %) chez les directeurs et directrices qui sont en poste depuis 10 ans ou plus, comparativement à ceux et celles qui sont en poste depuis moins de trois ans (55 %).

Selon les directeurs et directrices de la santé, *le prix approximatif moyen d'un paquet de cigarettes est 8,17$.* ***Les directeurs et directrices de la santé sont divisés quant à dire si les détaillants soutiendraient une hausse du prix ou s'y opposeraient, mais croient que l'opposition de la part des résidents serait beaucoup plus grande.***

- Une majorité de directeurs et de directrices de la santé sont incertains du prix d'une cartouche de cigarettes ou ne le connaissent pas (56 %).

- Presque autant de directeurs et de directrices de la santé affirment que les détaillants de leur communauté soutiendraient (45 %) une hausse du prix d'une cartouche de cigarettes ou s'opposeraient (40 %).

- Un pourcentage nettement plus élevé de directeurs et de directrices de la santé prévoient que les résidents s'opposeraient à une telle hausse (79 %).

Le perception de la mesure dans laquelle des cigarettes et des produits du tabac sont vendus à des mineurs de moins de 18 ans dans la communauté varie beaucoup d'un directeur ou d'une directrice à l'autre. La plupart s'entendent toutefois pour dire que cela se produit, du moins parfois et peut-être même fréquemment.

- Plus des trois-quarts des directeurs et directrices de la santé ont indiqué que des programmes de sensibilisation de la communauté et d'éducation des jeunes à grande portée et ciblés étaient en place pour interdire ou décourager la vente de produits du tabac aux jeunes. Un peu plus de la moitié, mais moins des deux-tiers, des directeurs et directrices de la santé affirment que des séances d'information pour les parents ont lieu et que les détaillants ont l'obligation de vérifier l'âge. Moins

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d'un répondant sur cinq a indiqué que des programmes éducatifs destinés aux détaillants étaient en cours dans leur communauté.

Un peu moins du quart des directeurs et directrices ont indiqué que leur communauté perçoit une taxe des Premières nations (TPN) sur les produits du tabac. Beaucoup croient qu'il y a peu ou pas de compréhension du but et de la gestion de cette taxe.

- En moyenne, la moitié de tous les directeurs et directrices de la santé (50 %) ont affirmé que leur communauté a peu ou pas de compréhension de la taxe. Un quart des directeurs et directrices de la santé (26 %) ont indiqué qu'il n'y avait absolument aucune compréhension.

- Un manque d'information ou d'intérêt à propos de la TPN semble à la base de ce faible degré de compréhension de la taxe, plutôt qu'une opposition fondamentale.

Selon les directeurs et directrices de la santé, la plupart des communautés ont des politiques, des règlements ou des restrictions en vigueur au sujet de l'usage du tabac dans les lieux publics ou de travail. Parmi ceux-ci, une interdiction complète est plus probable qu'une interdiction partielle dans un ratio d'environ deux pour un.

- Les mesures actuellement en vigueur pourraient être décrites comme « légères » ou informelles (p.ex. avertissement verbal plutôt qu'amendes ou sanctions en cas de non-respect).

- Dans les communautés qui n'ont pas de telles politiques ou règlements en vigueur, diverses raisons ont été données pour justifier la situation. Plusieurs directeurs et directrices de la santé ont déclaré que des mécanismes d'autorégulation étaient en place (p.ex. la communauté surveille ses membres ou les résidents ne fument tout simplement pas dans les lieux publics).

- Un pourcentage plus faible de directeurs et directrices de la santé ont indiqué que l'absence de tels règlements était dû aux difficultés de les mettre en œuvre ou au manque de leadership au sein de la communauté pour s'attaquer à ce problème.

Les communautés mettent en vigueur ou soutiennent d'autres activités, comme des programmes de sports ou récréatifs, de promotion de la santé ou de soins infirmiers communautaires ou encore des programmes

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destinés aux jeunes, comme moyens d'encourager leurs membres de tous âges à cesser de fumer ou à ne pas commencer. De plus, beaucoup de directeurs et directrices de la santé ont souligné que les activités de lutte contre le tabagisme sont liées à d'autres programmes communautaires, comme les programmes de santé maternelle et infantile, les programmes visant la prévention des maladies chroniques et les initiatives de vie saine. En même temps, un manque de financement fédéral est l'obstacle le plus souvent cité par les directeurs et directrices de la santé à ce que les communautés mettent d'autres activités du genre sur pied.

- Les communautés s'associent à d'autres organismes ou personnes pour tirer profit du message d'abandon du tabagisme ou de vivre sans fumée, surtout aux aînés, au gouvernement fédéral et, dans une certaine mesure, à des organismes autochtones nationaux ou régionaux, à d'autres communautés de Premières nations et à des gouvernements provinciaux ou territoriaux. Les organismes non-gouvernementaux sont moins souvent cités comme partenaires.

- Un tiers des directeurs et directrices de la santé (32 %) ont indiqué que le manque de financement de la part du gouvernement fédéral est un des principaux obstacles au développement et à la mise sur pied de programmes de sensibilisation aux dangers du tabac et d'abandon du tabagisme.

B. Aperçu et suggestions pour considérations futures – Comment résoudre les problèmes d'information et de structure

Les déclarations des directeurs et directrices de la santé dressent un portrait cohérent et intéressant des activités de lutte contre le tabagisme au sein des communautés de Premières nations. Dans l'ensemble, les directeurs et directrices de la santé jugent qu'ils possèdent un degré raisonnable de connaissances en la matière et des ressources pertinentes. En contrepartie, les résultats suggèrent que les directeurs et directrices de la santé perçoivent énormément de place à l'amélioration pour ce qui est de la sensibilisation et de la compréhension des membres de leurs communautés.

Les résultats indiquent clairement les points forts dont on peut tirer partie, et les obstacles aux progrès. D'un point de vue positif, les programmes de santé communautaires, comme ceux de santé maternelle et infantile, de prévention des maladies chroniques et d'initiatives de vie saine, semblent livrer le message de lutte contre le tabagisme de façon efficace.

- Une première voie possible pour améliorer les activités de lutte contre le tabagisme serait de renforcer le message transmis par les initiatives existantes portant sur les problèmes de santé connexes, et les ressources qu'elles offrent, plutôt que d'essayer d'instaurer un programme distinct par l'entremise des directeurs et directrices de la santé déjà surchargés. De toute évidence, des

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efforts continus sont nécessaires pour améliorer le degré de sensibilisation et de compréhension des dangers du tabac en général, et plus particulièrement pour les enfants et les jeunes. Orienter le message sur les dangers de mâcher ou de priser du tabac et le tabagisme récréatif, ainsi que sur les ressources et le soutien disponibles pour ceux qui désirent cesser de fumer, serait des éléments importants d'une telle campagne.

Dans leurs réponses au sondage, les directeurs et directrices de la santé ont clairement identifié deux ensembles d'obstacles à la lutte contre le tabagisme dans leurs communautés (obstacles au niveau de l'information et de la structure).

Les directeurs et directrices de la santé se décrivent comme ayant un degré de connaissances raisonnable des problèmes liés au tabagisme et des documents pertinents disponibles dans leurs communautés. Cependant, seulement la moitié jugent qu'ils sont « Très familiarisés », et un nombre plutôt élevé ne connaissent pas le prix d'un paquet de cigarettes dans leur communauté (un des éléments dissuasifs clés à un plus grand usage). De plus, la proportion de directeurs et de directrices de la santé qui se décrivent comme « Très familiarisés » avec les documents chute de 55 pour cent chez ceux qui sont en poste depuis moins de trois ans à 48 pour cent chez ceux qui comptent plus de dix ans d'ancienneté; un autre indicateur du besoin d'activités de communications supplémentaires destinées aux directeurs et directrices de la santé.

- La deuxième considération est qu'une campagne de communications portant sur les activités de lutte contre le tabagisme cible les directeurs et directrices de la santé, surtout ceux et celles qui sont en poste depuis plus de trois ans, afin de rafraîchir leurs connaissances et les mettre à jour quant aux documents et à l'information disponibles sur les messages et les programmes d'abandon du tabagisme.

Les directeurs et directrices de la santé ont aussi pointé les détaillants de leurs communautés comme cibles importantes pour des programmes éducatifs et d'information ciblés. De plus, les directeurs et directrices de la santé ont indiqué que la vente de produits du tabac à des mineurs se produit au moins à l'occasion, sinon fréquemment.

- La troisième considération serait pour Santé Canada de cibler les détaillants avec un message et des documents de sensibilisation appropriés sur l'usage du tabac chez les mineurs.

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Le deuxième ensemble d'obstacles à la lutte contre le tabagisme révélé par les interviews se situe davantage au niveau des structures, plus précisément le prix, les impositions et l'exécution de la réglementation obligeant à vérifier l'âge afin de réduire les ventes à des mineurs, ainsi que l'interdiction de fumer dans les lieux publics. Ces aspects ne sont pas du ressort des directeurs et directrices de la santé, mais il s'agit de mesures éprouvées et efficaces de lutte contre le tabagisme.

- La quatrième considération pour Santé Canada serait de travailler, par le biais de ses partenaires fédéraux et des chefs des Premières nations, à instaurer un pouvoir réglementaire dans les communautés des Premières nations afin d'appliquer la vérification d'identité lors de la vente de tabac, de mettre sur pied et en œuvre des interdictions de fumer dans les lieux publics et d'augmenter la conscience d'une taxe des Premières nations sur les produits du tabac. Cette mesure pourrait être complétée en demandant à Santé Canada de travailler directement à encourager les directeurs et directrices de la santé à mobiliser les efforts de la communauté contre l'usage non traditionnel et la consommation de produits du tabac, en partenariat avec d'autres groupes comme les aînés, d'autres organismes autochtones et divers niveaux gouvernementaux.

Finalement, plusieurs des communautés représentées par les directeurs et directrices de la santé qui ont participé au sondage ont une interdiction partielle ou complète de fumer en vigueur. Cependant, il est moins évident, si on se fie aux résultats du sondage, de savoir à quel point les directeurs et directrices de la santé croient que ces diverses approches sont efficaces, qu'il s'agisse de mesures douces et informelles ou de mesures plus strictes et officielles.

- La dernière considération serait de procéder à d'autres évaluations de l'efficacité perçue et réelle de diverses approches, y compris l'autosurveillance informelle et les interdictions partielles et complètes de fumer dans les lieux publics et de travail.

POUR PLUS D'INFORMATION

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Date d'octroi :	2007-02-19

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III. Research Objectives and Methodology

Research Objectives and Methodology

A. Research Objectives

The First Nations and Inuit Tobacco Control Strategy (FNITCS) was established in April 2001 with the intention of promoting healthier First Nations and Inuit communities across Canada, free of tobacco misuse and addiction. The Strategy was developed and implemented by the First Nations and Inuit Health Branch (FNIHB) of Health Canada.

Funding for the Strategy was eliminated as part of a 2006 expenditure review process. Nevertheless, the Government of Canada remains committed to protecting First Nations communities from the harmful effects of tobacco use. Health Canada/FNIHB continues to work with the Assembly of First Nations (AFN) to address the issue of tobacco control on-reserve and to better ascertain the receptivity of community leaders on-reserve to tobacco control strategies.

As a result, the FNIHB and the AFN jointly initiated this survey of First Nations Health Directors. The survey is aimed at developing a better understanding of current tobacco control initiatives in place in First Nations communities. The findings also serve to establish benchmark measures that will be used in the development and design of a new approach to tobacco control in First Nations communities across the country.

Specific objectives for the research included:

- Gathering data on current tobacco control activities underway in First Nations communities;
- Measuring the degree of awareness of resources in place and information available to community members;
- Assessing the current state of policies, bylaws and other restrictions on the use of tobacco in workplaces and public spaces;
- Gathering views on the factors which are perceived to be contributing to high smoking rates in First Nations communities; and
- Determining whether community members see a clear link between tobacco cessation activities and other health related initiatives or programs.

Research Objectives and Methodology

B. Methodology

The Strategic Counsel conducted a telephone survey of 223 First Nations Health Directors from across the country between July 12, 2007 and August 10, 2007. It is assumed that there are in the order of 300 to 400 Health Directors in total. The results which follow have an associated margin of error of +/-4.17 per cent. This means that an identical survey of First Nations Health Directors could be expected to produce results that are within plus or minus 4.17 percentage points of the current findings, 19 times out of 20.

The average interview was about 20 minutes in length and was completed by a small group of experienced, bilingual interviewers. The use of a smaller team of more experienced telephone interviewers is typical for studies of this nature where the level of the discussion between the interviewer and the interviewee is somewhat more sophisticated and detailed than is usually the case for surveys among the general population. These interviewers are highly trained and experienced in the use of appropriate probing techniques to ensure that responses to open-ended questions are thoroughly explained and understood.

The original sample of Health Directors was provided by Health Canada. A communication from Health Canada and the Assembly of First Nations was sent to all First Nations Health Directors (see Appendix A) in advance of the survey.

As is typical of elite interviews, the survey was conducted in two stages:

- A first contact was made to:
  - Ensure that the contact name provided by Health Canada was indeed the appropriate person to complete the survey; and
  - Schedule an appropriate date and time to conduct the survey.
- A second contact was made at an agreed-upon date/time to conduct and complete the actual interview.

Research Objectives and Methodology

The following table illustrates the regional breakdown from the final sample as compared to the list provided by Health Canada.

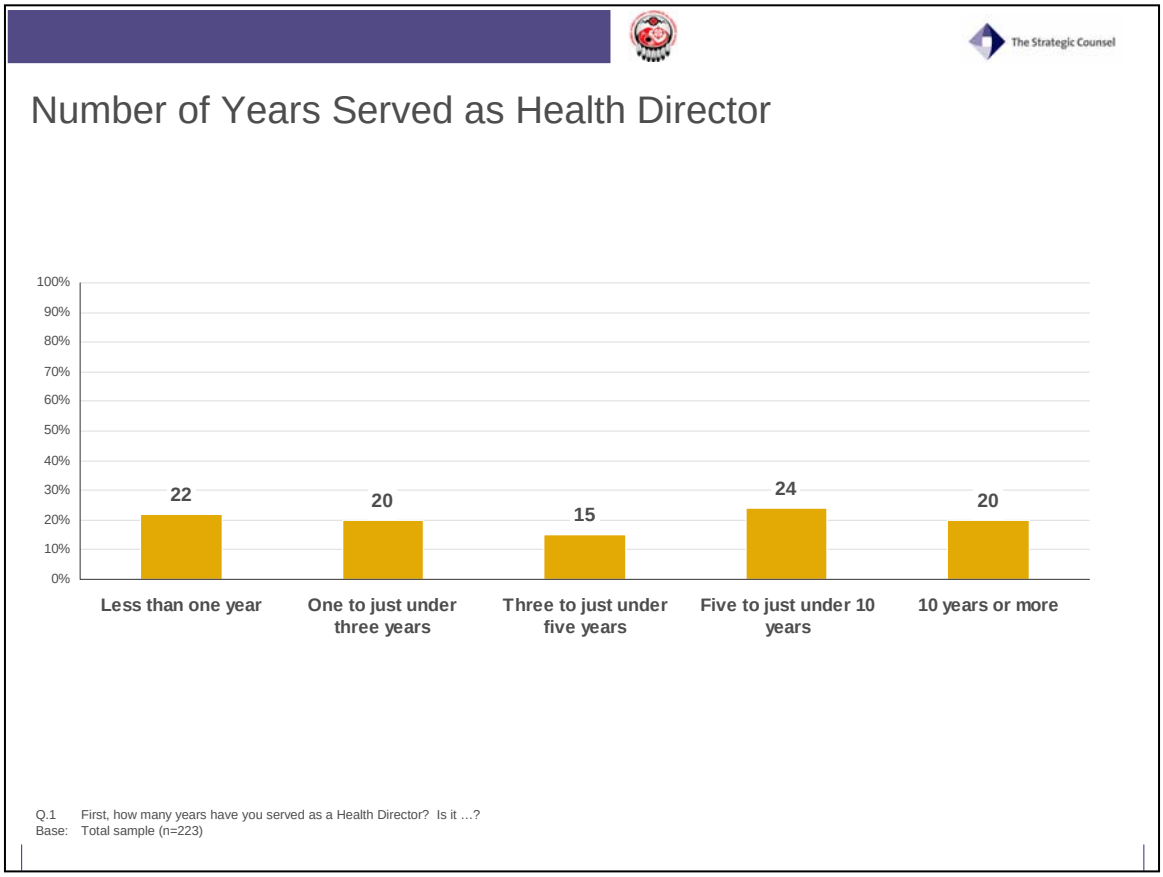
Region	% From Original List	Sample %
Atlantic	8%	9%
Quebec	7 %	6%
Ontario	38 %	31%
Prairies	22%	22%
BC	25%	33%
Total	100%	100%

To view a detailed call disposition report, including response rate calculations, please refer to Appendix C.

IV. Profile of First Nations Health Directors

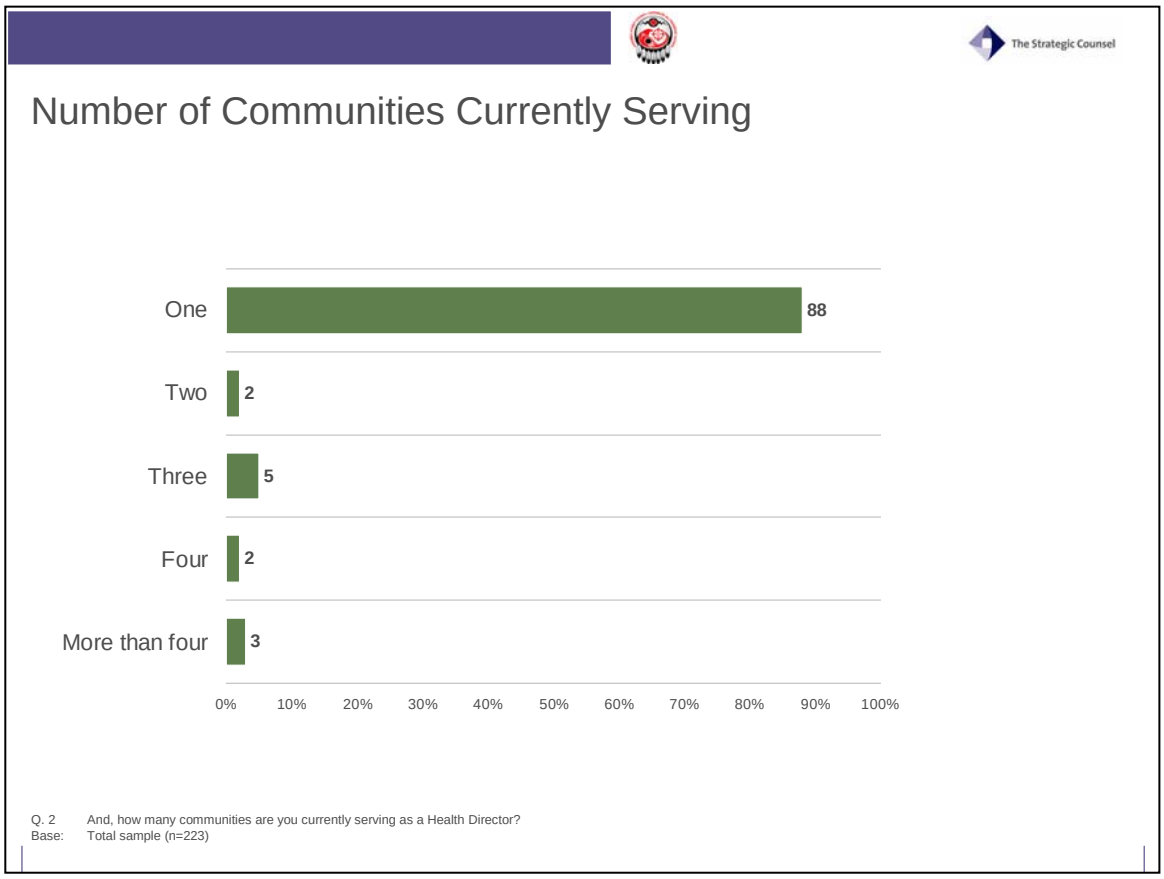
Profile of First Nations Health Directors

The final sample included 223 Health Directors with varying levels of experience on the job and in the community. Twenty-two per cent had served as a Health Director for less than a year, 20 per cent had served one to three years, 15 per cent had served three to five years, 24 per cent had served 5-10 years, and 20 per cent had served ten years or more.



Profile of First Nations Health Directors

The majority of Health Directors (88%) serve in only one community. In addition, most Health Directors were women (82%).

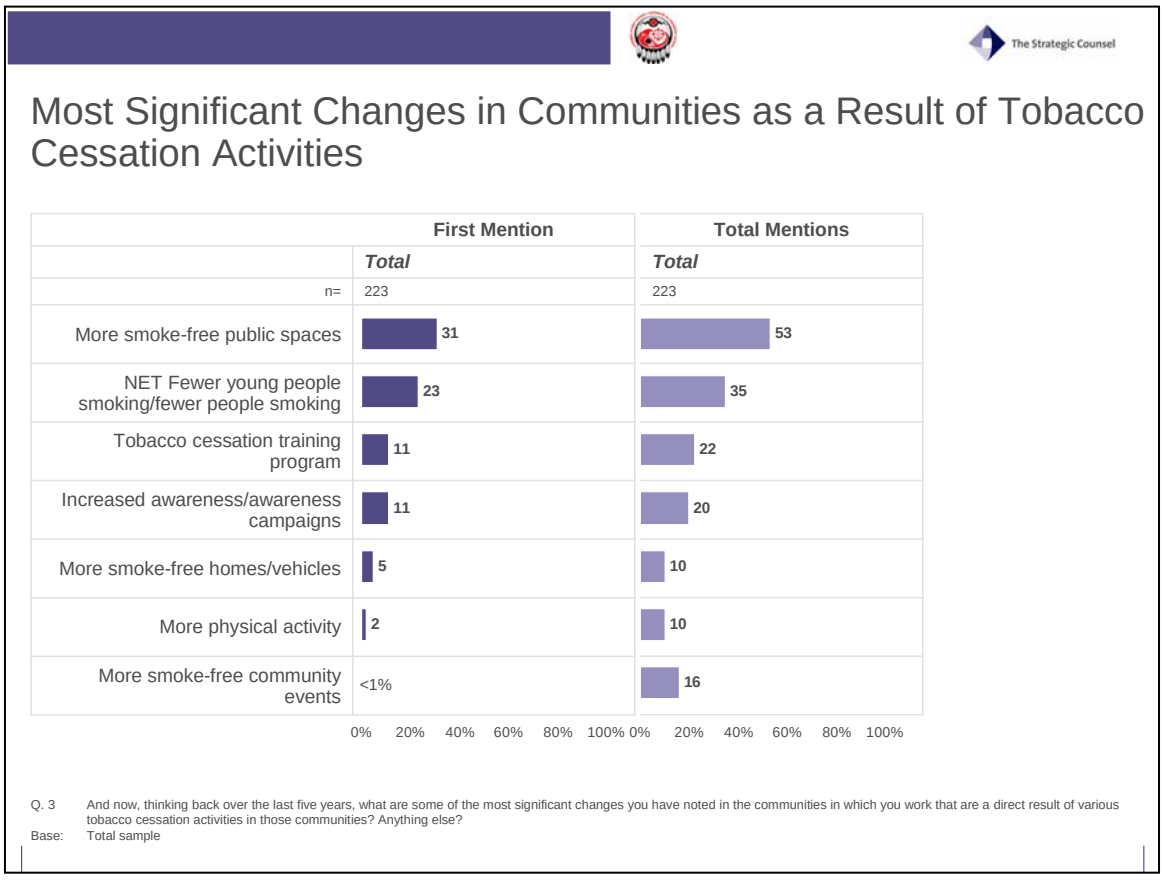


V. Perceived Impact of Tobacco Cessation Activities on Communities

Perceived Impact of Tobacco Cessation Activities on Communities

A. Significant Changes Directly Attributable to Tobacco Cessation Activities

First Nations Health Directors were asked to consider significant changes within their communities over the last five years that they would directly link to various tobacco cessation activities. Far and away, the most prevalent perceived impact has been in the institution of more smoke-free public spaces (53% total mentions). Just over one-third of Health Directors cited fewer people smoking and/or fewer younger people smoking (35%) as a direct outcome of tobacco cessation activities. Other changes of note include the implementation of tobacco cessation programs (22%), increased awareness of the effects of tobacco use and of awareness campaigns (20%) as well as the adoption of more smoke-free community events (16%).



These observations did not vary significantly by the length of tenure as Health Director.

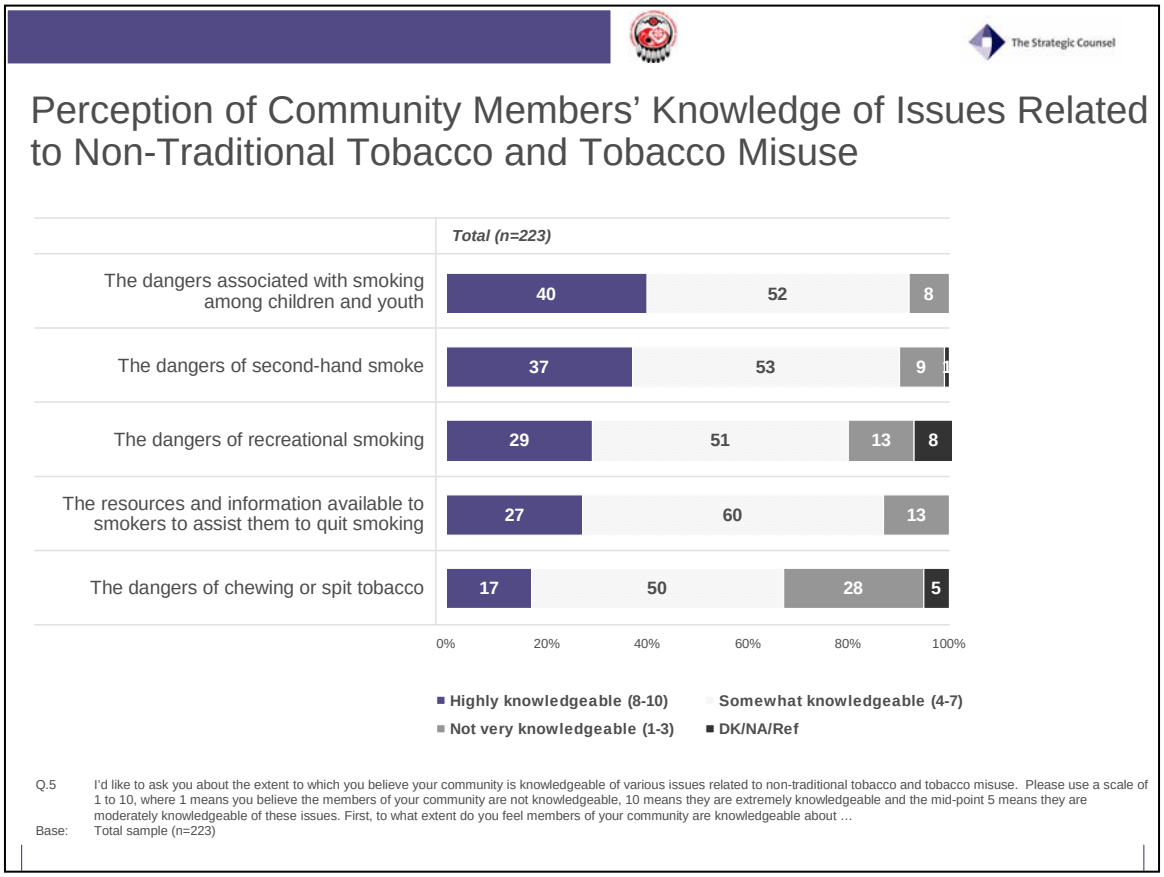
VI. Assessed Awareness of Tobacco Use and Cessation Information in First Nations Communities

Assessed Awareness of Tobacco Use and Cessation Information

A. Perceived Knowledge of the Community

Health Directors perceive the residents of their communities to be at least somewhat knowledgeable about important issues related to the non-traditional consumption of tobacco and tobacco misuse.

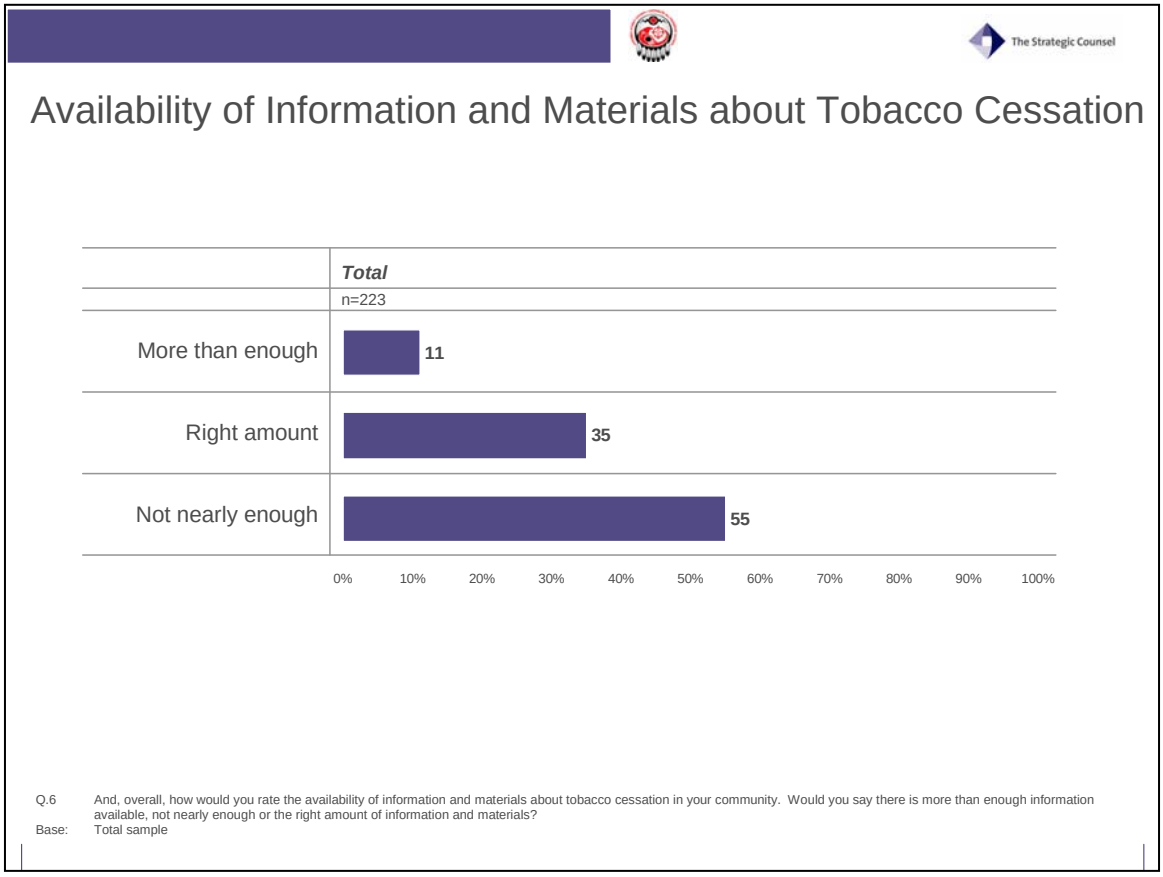
Health Directors indicated that residents in their communities are most knowledgeable about the dangers of smoking, such as dangers associated with smoking among children and youth (40% highly knowledgeable (8, 9, or 10 on a 10 point scale)) and the dangers of second-hand smoke (37%). They assessed residents' knowledge of the dangers of recreational smoking (29%) and of resources and information available to smokers to assist them in quitting smoking (27%) as moderate, while knowledge among community members of the dangers of chewing tobacco (17%) was deemed to be relatively low.



Availability of Tobacco Cessation Materials in the Community

Given that Health Directors perceive residents' knowledge of resources and information available to smokers to assist them in quitting smoking is fair but not particularly high, a majority also claim that there is not enough information and materials on tobacco cessation (55%). About one-third of Health Directors believe the right amount of information is available (35%) and another 11 per cent say there is more than enough information available.

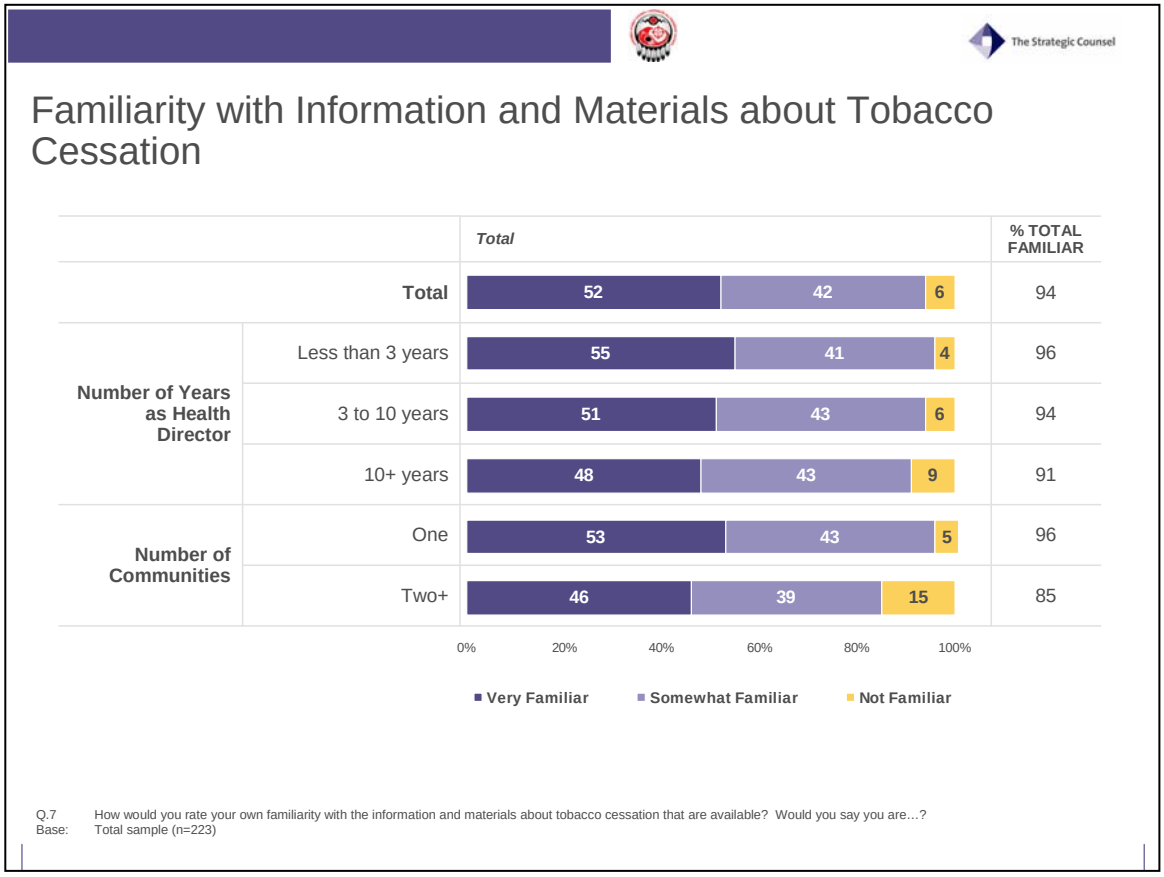
Assessed Awareness of Tobacco Use and Cessation Information



B. Health Directors' Self-Assessed Familiarity with Tobacco Cessation Materials

Health Directors rate themselves as fairly familiar with tobacco cessation information and materials. In fact, virtually all Health Directors (94%) surveyed say they are very (52%) or somewhat (42%) familiar with available information and materials. .

Assessed Awareness of Tobacco Use and Cessation Information



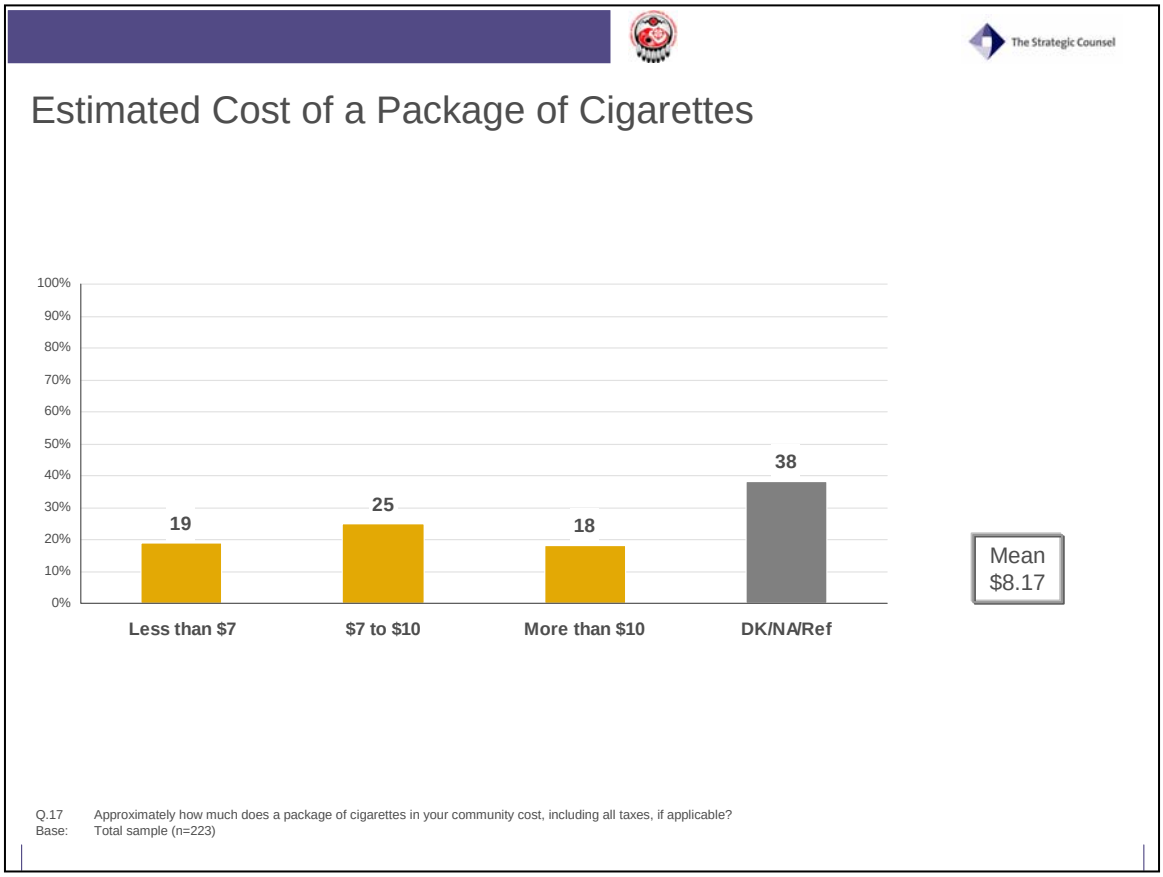
While the percentage of Health Directors who rate themselves as familiar with the materials varies little by the number of years of tenure as a health director or the number of communities in which they work, the number of those scoring themselves as possessing a high level of familiarity drops among longer-serving Health Directors and those that are responsible for two or more communities.

VII. Perceived Cost of Cigarettes and Support for a Price Increase

Perceived Cost of Cigarettes and Support for a Price Increase

A. The Perceived Cost of Cigarettes in First Nations Communities

The estimated cost of a package of cigarettes is $8.17 according to the perception of Health Directors. The reader should note that the estimates provided by Health Directors may or may not reflect the reality with respect to the actual price of a package or carton of cigarettes across Canada.



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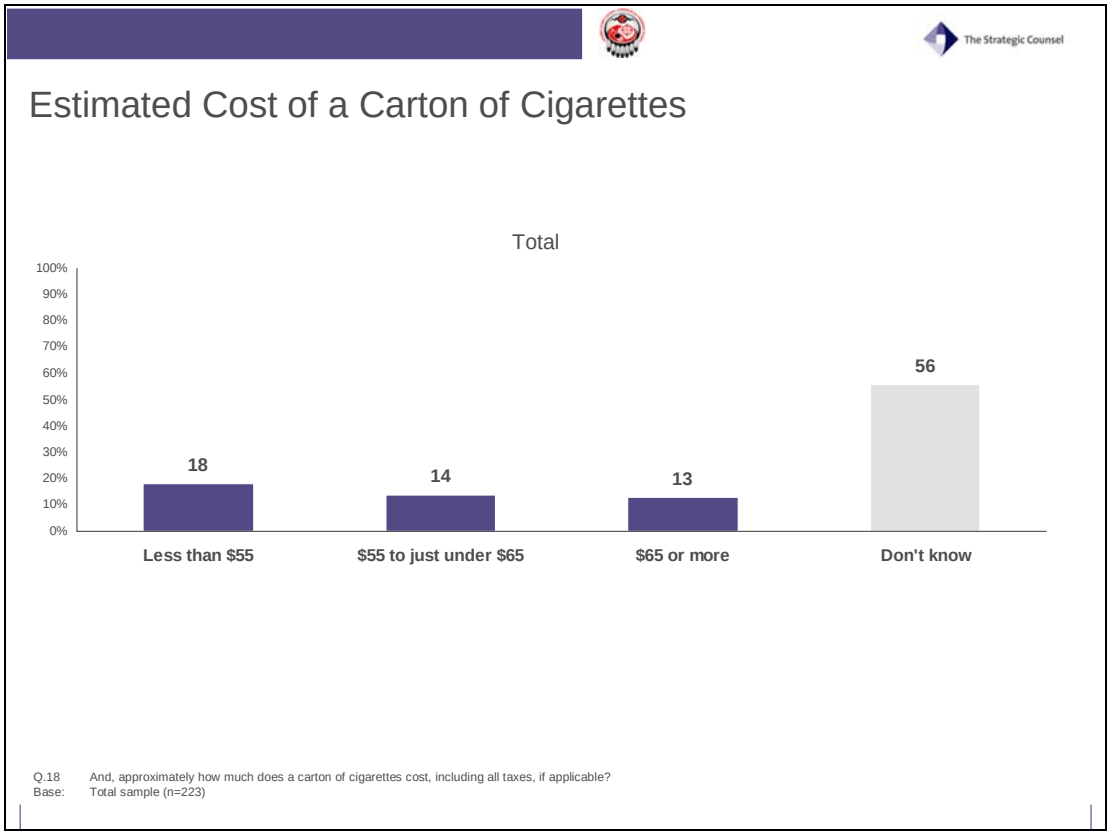
Perceived Cost of Cigarettes and Support for a Price Increase



A significant percentage of First Nations Health Directors indicated they were uncertain of or did not know the price of either a package or carton of cigarettes in the communities they served. This percentage ranged from just almost four-in-ten saying they did not know the price per package and just over half (56%) saying this were uncertain of or did not know the price on a per carton basis.

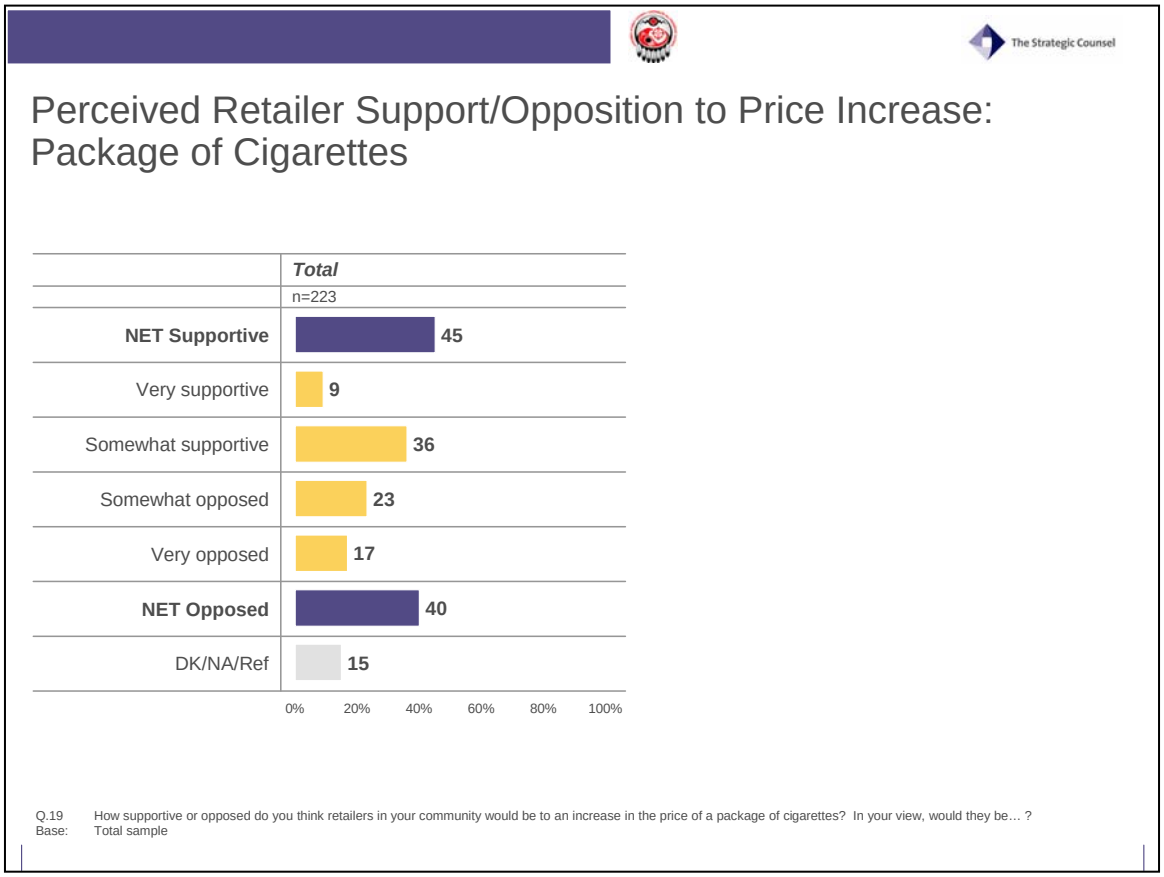
The percentage of those indicating they did not know the price of either a package or a carton of cigarettes varied only minimally or negligibly by the tenure of the respondent with respect to their years as a Health Director or their length of time serving a specific community. While the overall number of those serving two or more communities is relatively small, as a percentage of the total sample, about half among this group indicated they did not know or could not respond to a question about the price of a package of cigarettes. This compares with just over a third (36%) of Health Directors who serve one community only.

Perceived Cost of Cigarettes and Support for a Price Increase

B. Perceived Support among Retailers for a Price Increase

Health Directors were essentially split when asked whether retailers in their communities would support or oppose an increase in the price of commercial tobacco. In general, reaction to this question was fairly muted with 45 per cent indicating retailers would be somewhat supportive (36%) or very supportive (9%) of an initiative to increase the price. The reader should note that these findings represent the perspective of Health Directors only and not the level of support or opposition as expressed by retailers themselves.

By contrast, just under one-quarter (23%) of Health Directors suggested that retailers would be somewhat opposed and an additional 17 per cent indicated they would be very opposed to such a measure. Combined, those suggesting retailers would be opposed amounts to about two of every five (40%) respondents.



On balance, based on the data shown in the chart below, support for an increase in the price of cigarettes among retailers is anticipated to be higher in those areas where the cost of cigarettes is also higher. Note that anticipated support among retailers increases from 40 per cent among those indicating that the price of a

Perceived Cost of Cigarettes and Support for a Price Increase

package of cigarettes is under $7.00 in their community to just over two-thirds (68%) among those indicating a price of $10.00 or more for a package of cigarettes.

	TOTAL (%)	Estimated Cost of Package of Cigarettes (%)			Estimated Cost of Carton of Cigarettes (%)		
		<$7	$7 to <$10	$10 or more	<$55	$55 to <$65	$65 or more
n=	223	43	56	40	39	30	29
Total Supportive	45	40	52	68	39	40	66
Very supportive	9	7	14	20	10	7	24
Somewhat supportive	36	33	38	48	28	33	41
Somewhat opposed	23	19	23	18	23	23	21
Very opposed	17	30	11	3	31	13	10
Don't Know/Refused	15	12	14	13	8	23	3

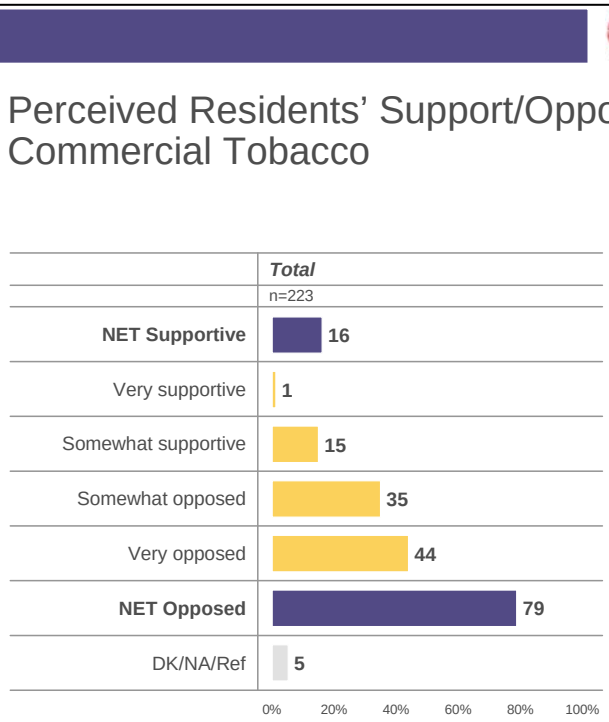
Note: Columns may not sum to 100% due to rounding.

C. Perceived Support among Residents for a Price Increase

In general, Health Directors believe that residents would react both more strenuously and more negatively to a cigarette price increase as compared to how Health Directors believe retailers would respond (as noted earlier). The vast majority (79%) of Health Directors suggest that residents would be very (44%) or somewhat (35%) opposed to increasing the price of a package of cigarettes. Fewer than one-in-five Health Directors (16%) indicate that residents in the communities which they serve would support an initiative to increase the price of cigarettes. Furthermore, only 1% indicate residents would be very supportive.

Perceived Cost of Cigarettes and Support for a Price Increase

Perceived Residents' Support/Opposition to Price Increase: Commercial Tobacco



Q.20 And, overall, how supportive or opposed would residents of your community be to an increase in the price of commercial tobacco? In your view, would they be…?
Base: Total sample

VIII. First Nations Tax on Tobacco Products

First Nations Tax on Tobacco Products

A. Communities Collecting the First Nations Tax on Tobacco Products

Just under one-quarter (24%) of Health Directors surveyed said that the community they serve is currently collecting a First Nations Tax (FNT) on tobacco products. Another 48 per cent indicated this was not the case and 29 per cent said they were uncertain or could not respond definitively one way or another to the question.

Collection of First Nations Tax on Tobacco Products

	TOTAL	No. of Years as Health Director in the Community (%)		
		<3 years	3-9 years	10 years or more
N	223	87	89	47
Yes	24	18	27	28
No	48	45	53	43
DK/NA/Refused	29	37	20	30

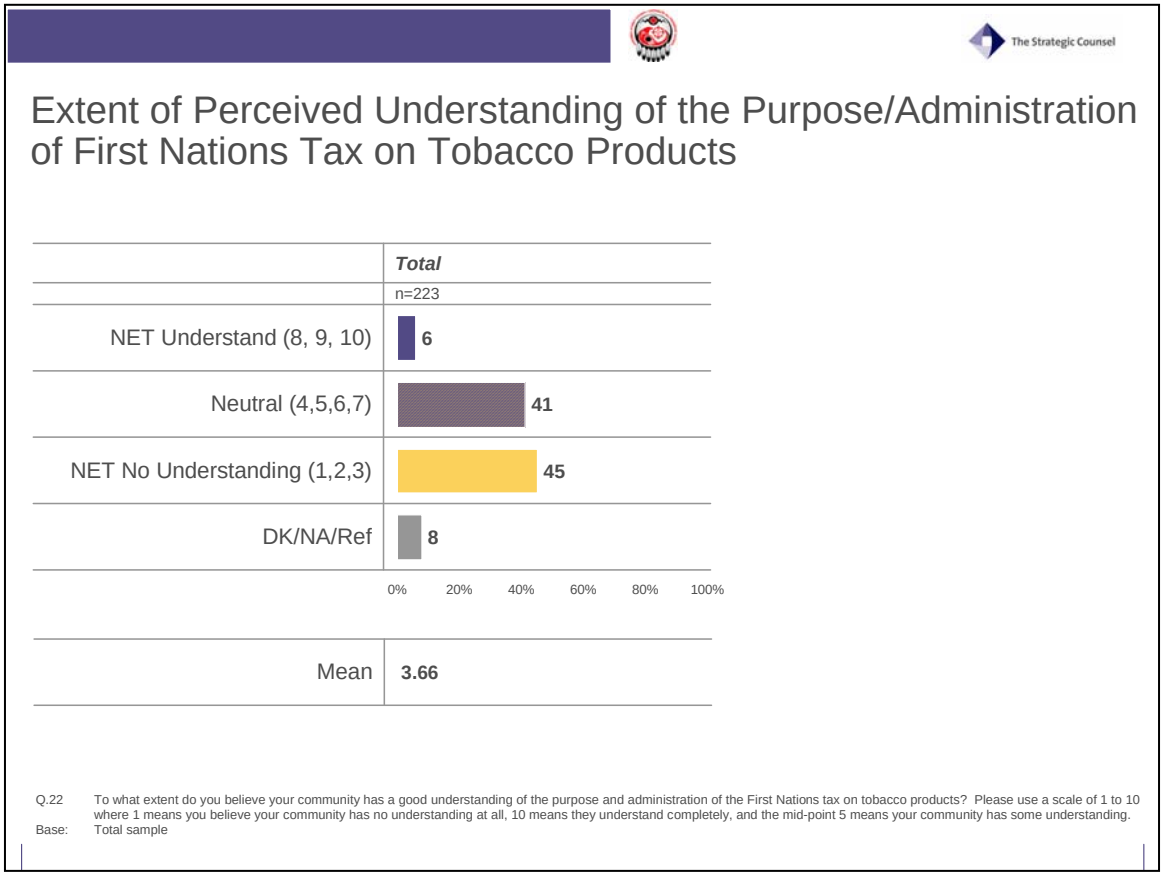
Q21. Is your community currently collecting a First Nations Tax on tobacco products?
[c] Caution: small base size.

As noted in the table above, there is some variability by length of tenure as Health Director in the community. Respondents who have been a Health Director in their community for less than three years (18%) are somewhat less likely to respond in the affirmative regarding the implementation of the First Nations Tax on tobacco products compared with those who have been working as a Health Director in the same community for three years or more.

B. Perceived Level of Understanding of the First Nations Tax on Tobacco Products

The plurality, if not the majority, of Health Directors in all regions indicated that their communities do not have a particularly good understanding of either the purpose or the administration of the First Nations Tax on tobacco products. Half of all Health Directors (50%) claimed their community has a minimal or no understanding at all (i.e. 1 to 4 on a 10-point scale of understanding) of the purpose and administration of the tax. Indeed, fully one-quarter (26%) of all Health Directors surveyed indicated their community has absolutely no understanding at all of the First Nations Tax on tobacco products. The mean score, based on the 10-point scale used

to assess the perceived level of understanding, was 3.7, signifying a relatively modest or low level of understanding.

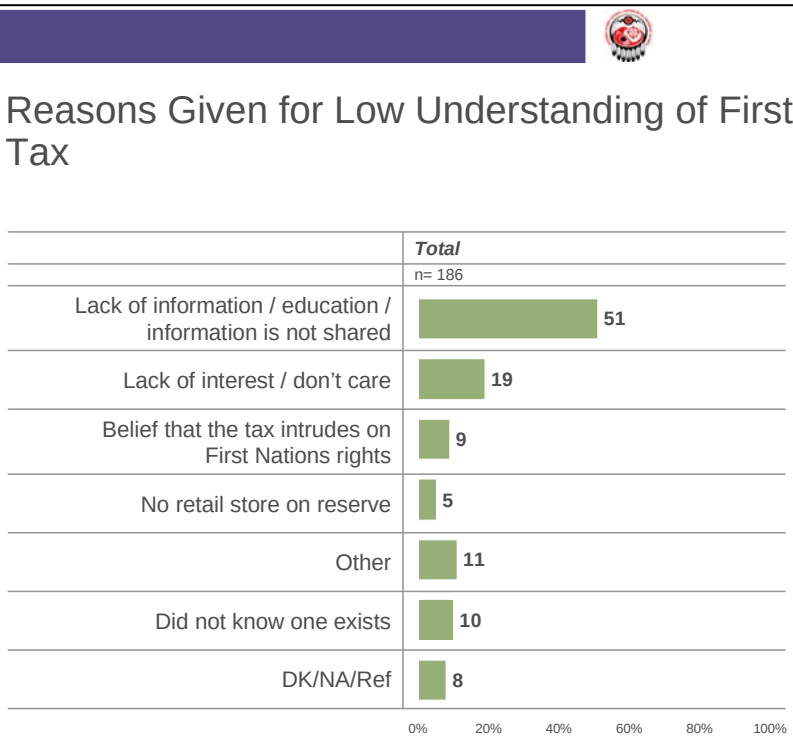


Reasons given among those who indicated there was little to no understanding of the First Nations Tax (i.e. 1-4 on a 10-point scale of understanding) have less to do with fundamental resistance to the tax on the basis that it contravenes the tax exempt status of First Nations as agreed to in various treaties, and more to do with a lack of information about or interest in the First Nations Tax.

Just over half (51%) of respondents commented that the lack of understanding stems from a lack of information and education about the First Nations Tax. Another 20 per cent cited a lack of interest in the FNT, and nine per cent specifically noted that understanding is fundamentally linked to a belief that the First Nations Tax is intrusive on First Nations' rights and tax exempt status. Fewer noted that there was no retail store on the reserve, thus rendering the issue moot, (5%) or a perception that the tax was regressive (<1%) as reasons for low levels of understanding of the First Nations Tax. Finally, some 10 per cent of respondents commented that they simply did not know that such a tax existed.

First Nations Tax on Tobacco Products

Reasons Given for Low Understanding of First Nations Tobacco Tax



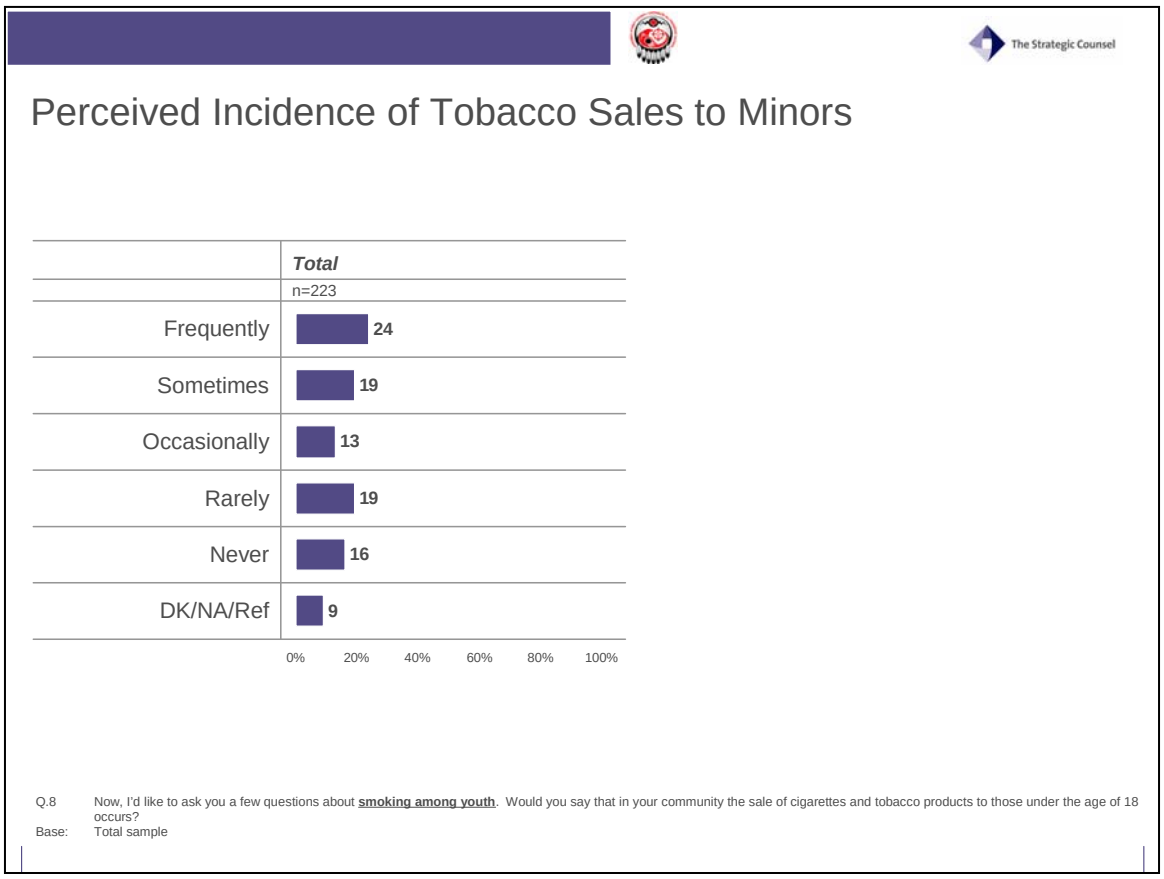
Q.23 In your view, what are the main reasons why there is not a good understanding of the First Nations Tax?
Base: Those who rated understanding in Q.22 as 6 or lower

IX. Smoking Among Youth and Minors

Smoking Among Youth and Minors

A. Prevalence of Smoking among Youth

There is a large degree of variability in the extent of sales of tobacco and cigarettes to those under the age of 18 years in First Nations communities, according to the view of Health Directors. Nearly half of Health Directors (43%) indicate that the sale of cigarette and tobacco products to minors occurs frequently (24%) or sometimes (19%). By contrast, slightly less (35%) say that the sale of these products to minors is rare (19%) or never happens (16%). Another 13 per cent believe that it may happen occasionally.



B. Initiatives to Prohibit or Discourage the Sale of Tobacco Products to Minors

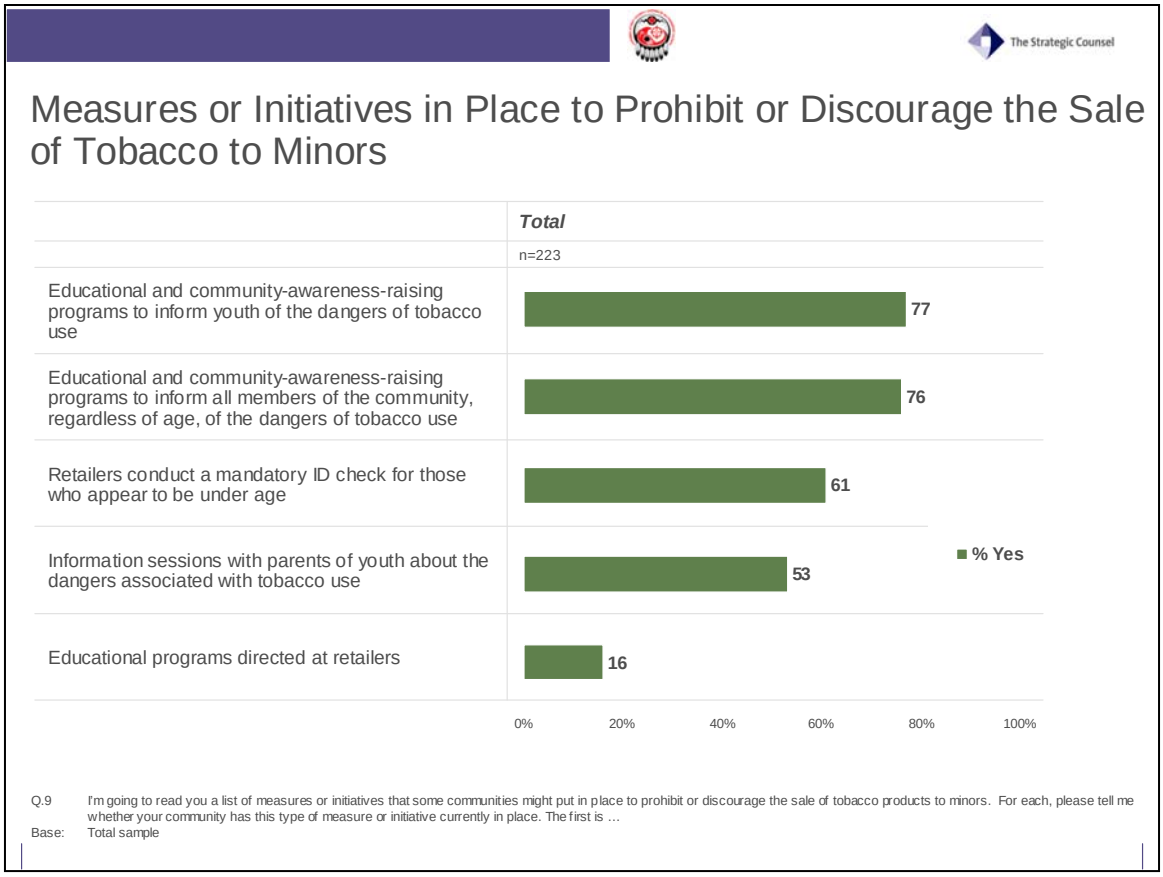
Health Directors were queried regarding the implementation of a series of measures or initiatives to prohibit or discourage the sale of tobacco products to minors in their communities. The majority of directors (77%) say that their communities currently run educational and community awareness raising programs to inform

Smoking Among Youth and Minors

youth of the dangers of tobacco use. Likewise, a clear majority (76%) say that their communities have similar programs in place for residents regardless of age.

Sixty-one per cent of Health Directors say that retailers in their communities conduct mandatory ID checks for those who appear to be under age. Half of the Health Directors surveyed (53%) indicated that their community offers information sessions with parents of youth about the dangers associated with tobacco use.

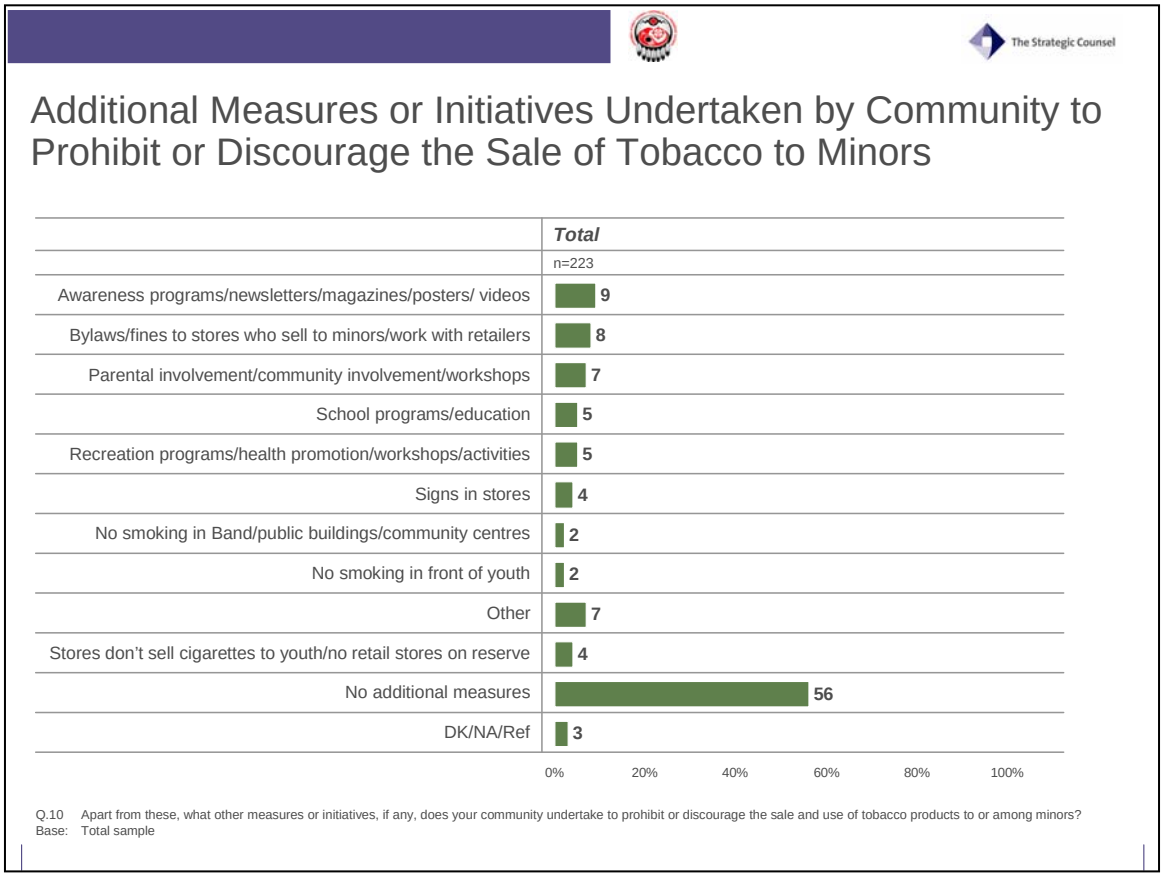
Retailers themselves do not appear to be a formal target of educational or awareness raising activities. Sixteen per cent of Health Directors say their communities offer educational programs directed at retailers.



As a further probe, when asked if their community had taken any additional measures or initiatives to prohibit or discourage the sale of tobacco products to or among minors, more than half of respondents (56%) responded that no additional measures had been taken.

Smoking Among Youth and Minors

Where additional measures had been implemented, approximately one-in-ten (9%) reported using awareness programs or campaigns through various media, while another eight per cent employed by-laws, fines or worked directly with retailers and seven per cent mentioned that their community relied on parental or community involvement.



X. Smoking Bans and Restrictions

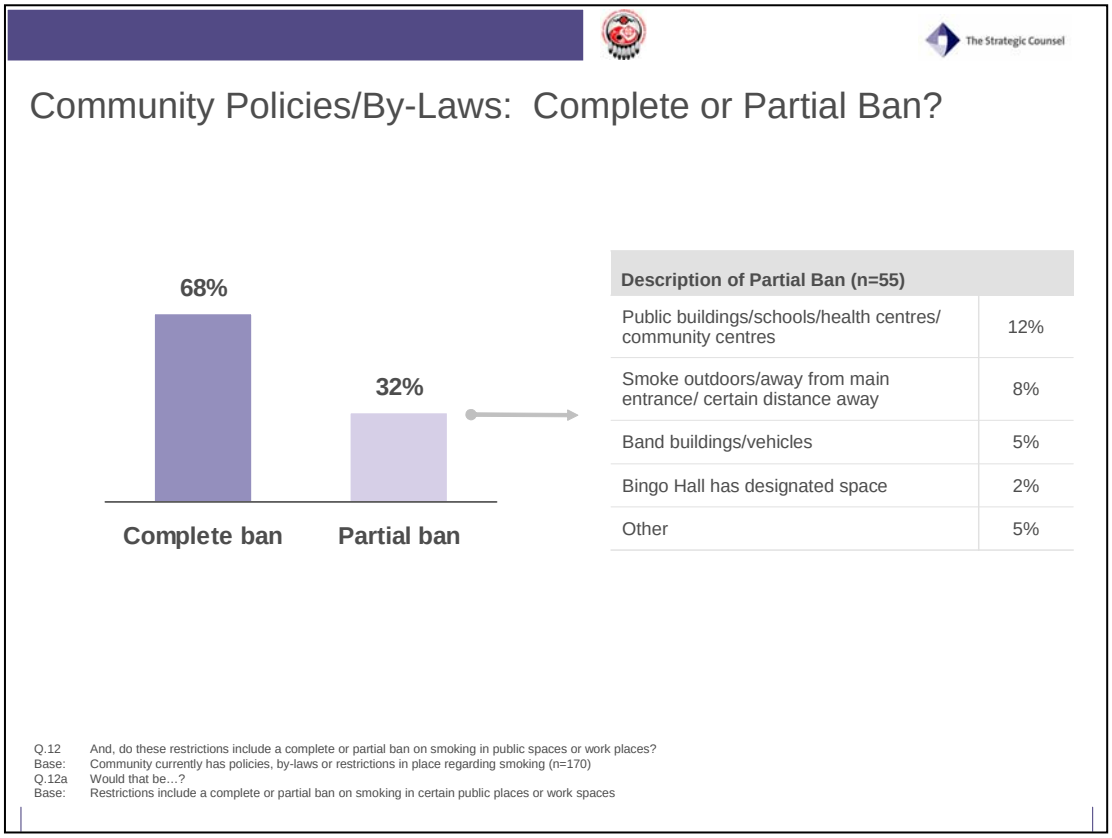
Smoking Bans and Restrictions

A. Extent of Community Ban on Smoking in Public Places

Three-quarters (76%) of Health Directors indicated that their community currently has policies, by-laws or restrictions in place regarding smoking in public spaces or work places, while 23 per cent responded that this was not the case.

For those who responded in the affirmative, in most cases (68%) the restrictions include a complete ban on smoking in public spaces or work places. About one-third (32%) of Health Directors indicated that a partial ban was in effect to allow smoking only in designated areas.

When asked to explain or describe how the partial ban worked, Health Directors commented that the ban was in force for public buildings, health centers or community centers (12%), required that smokers step away from the main entrance of a building or some distance and/or smoke out of doors (8%), was in effect for Band buildings and vehicles only (5%) or included a designated area in bingo halls (2%).



Smoking Bans and Restrictions

For those who had indicated that their community currently did not have any policies, bylaws or restrictions with regard to smoking in public places, the reasons given were as follows:

- Community self-monitors and/or people do not smoke in public places (38%);
- Bylaws are not yet in place or there has been some difficulty instituting such bylaws within the community (21%);
- Lack of initiative or leadership within the community to establish such policies or bylaws (17%);
- Such restrictions are not a priority at the community level (8%); and
- The issue was felt to be a responsibility of the province to legislate and/or establish guidelines (6%).

B. Measures in Place to Enforce the Ban on Smoking in Public Places

Most of the measures in place to enforce a ban on smoking in public places are "soft" or informal measures, rather than strict enforcement via penalties or fines. Just under half of Health Directors (44%) who had indicated that some policies, by-laws or restrictions were in effect regarding smoking in public spaces and work places said that verbal warnings are employed as a means of enforcing the ban. This is far and away the most prevalent measure taken to encourage compliance. Smaller numbers indicated a self-policing approach is taken (14%) in that people simply respect the rights of non-smokers or simply don't smoke in banned areas. Another 12 per cent of Health Directors said that posters or signage is displayed to remind people of the ban on smoking in certain areas. Fewer than one-in-ten (7%) Health Directors said that strict enforcement, surveillance, penalties or fines were levied to ensure compliance with the ban.

When asked, as a follow-up question, whether any other policies, bylaws or restrictions were in place in addition to or instead of the ban on smoking, just seven per cent responded in the affirmative. A description of such measures were varied although about one-third (36% - note this represents only four respondents) did indicate that the community prohibited smoking in Band vehicles.

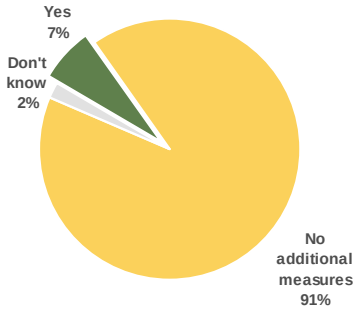
Smoking Bans and Restrictions

Measures in Place to Enforce Smoking Ban

Measures in Place to Enforce Ban

	Total
	n=170
Verbal warnings	44%
People just don't smoke / people respect non-smokers / self monitored	14%
Signage / posters	12%
Security / enforcement / by-laws / surveillance / fines	7%
Other	21%
None	13%
DK/NA/Ref	6%

Any Additional Policies, Bylaws, Restrictions?



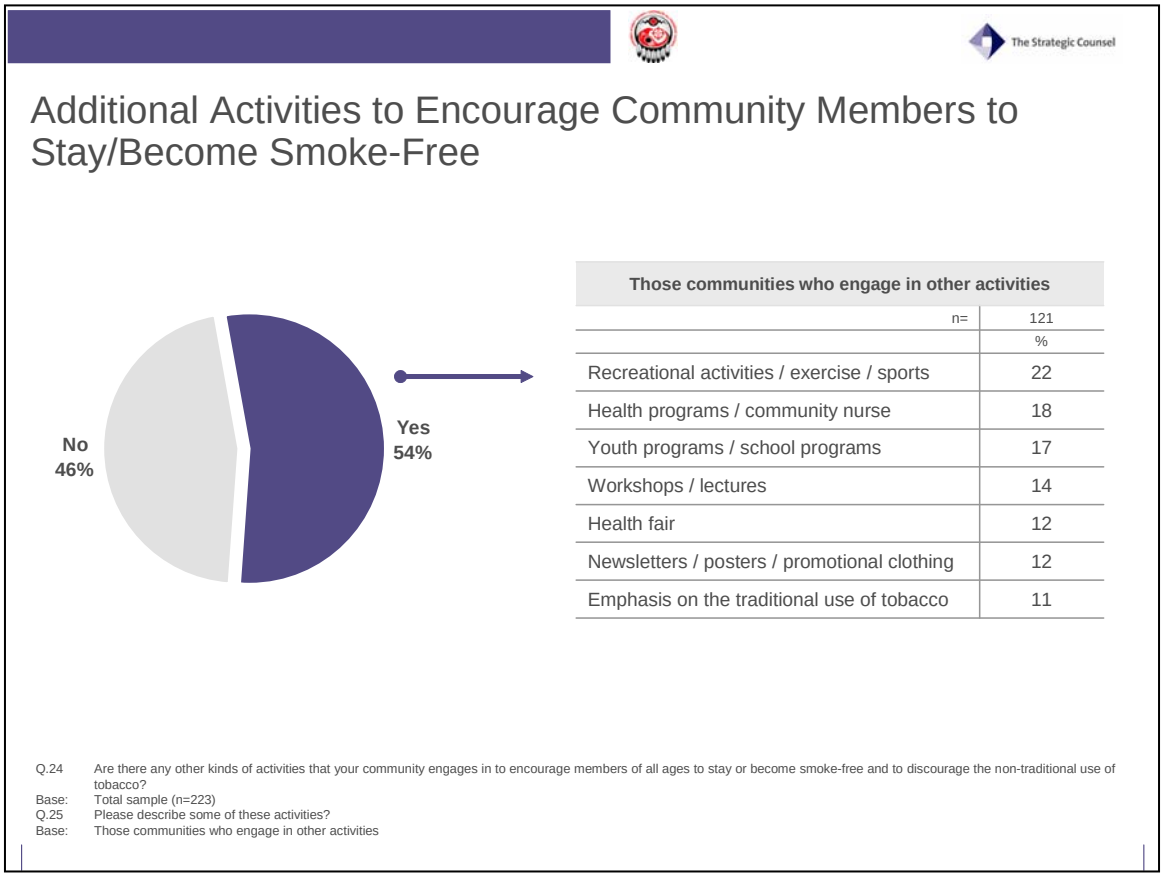
Q.13 What kinds of measures are in place to enforce the ban?
Base: Restrictions include a complete or partial ban on smoking in public places or work spaces
Q.14 And, are there any other policies, bylaws or restrictions in place in your community pertaining to smoking in public spaces or work places in addition to the ban on smoking?
Base: Restrictions include a complete or partial ban on smoking in public places or work spaces (n=170)

XI. Other Community Activities to Discourage Smoking

Other Community Activities to Discourage Smoking

A. Other Activities

Apart from complete or partial bans on smoking, other by-laws and policies, about half of Health Directors (54%) say there are additional activities in their communities to encourage members of all ages to stay or become smoke-free and to discourage the non-traditional use of tobacco.



Common activities include recreational or sporting activities (22%), health programs, including the activities of community nurses (18%), youth or other school programs (17%), and workshops and lectures (14%). Other activities cited include health fairs (12%), newsletters or posters (12%), and a general emphasis on the traditional use of tobacco (11%).

Other Community Activities to Discourage Smoking

B. Perceived Barriers to Further Activity

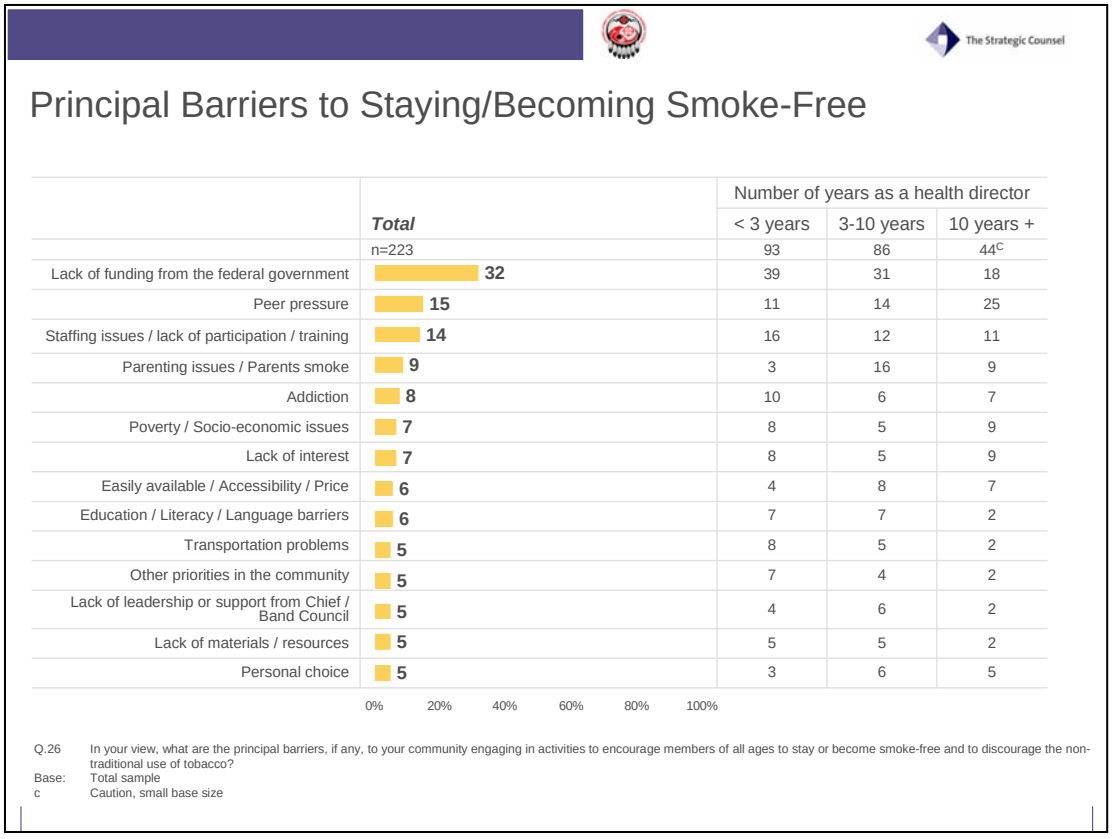
Health Directors identify a number of barriers to engaging in additional anti-smoking or smoking cessation activities. These barriers can be categorized broadly as follows:

1) Systemic/structural issues; and

2) Outside or external influences.

A significant proportion of Health Directors cite a lack of funding from the Government of Canada (32%) as a principal barrier to further activity in this area. Other key structural issues include insufficient resourcing, staffing or training (14%), education, literacy and language barriers (6%), accessibility or transportation (5%), and a lack of support from Chiefs or Band Councils (5%).

Among the key external influencing factors that act as barriers to engaging in other activities are peer pressure (15%) and parents who smoke (9%), in addition to addiction (8%), a general lack of interest in the activities (7%), and availability of tobacco products (including the increase in the number of smoke shops (6%).

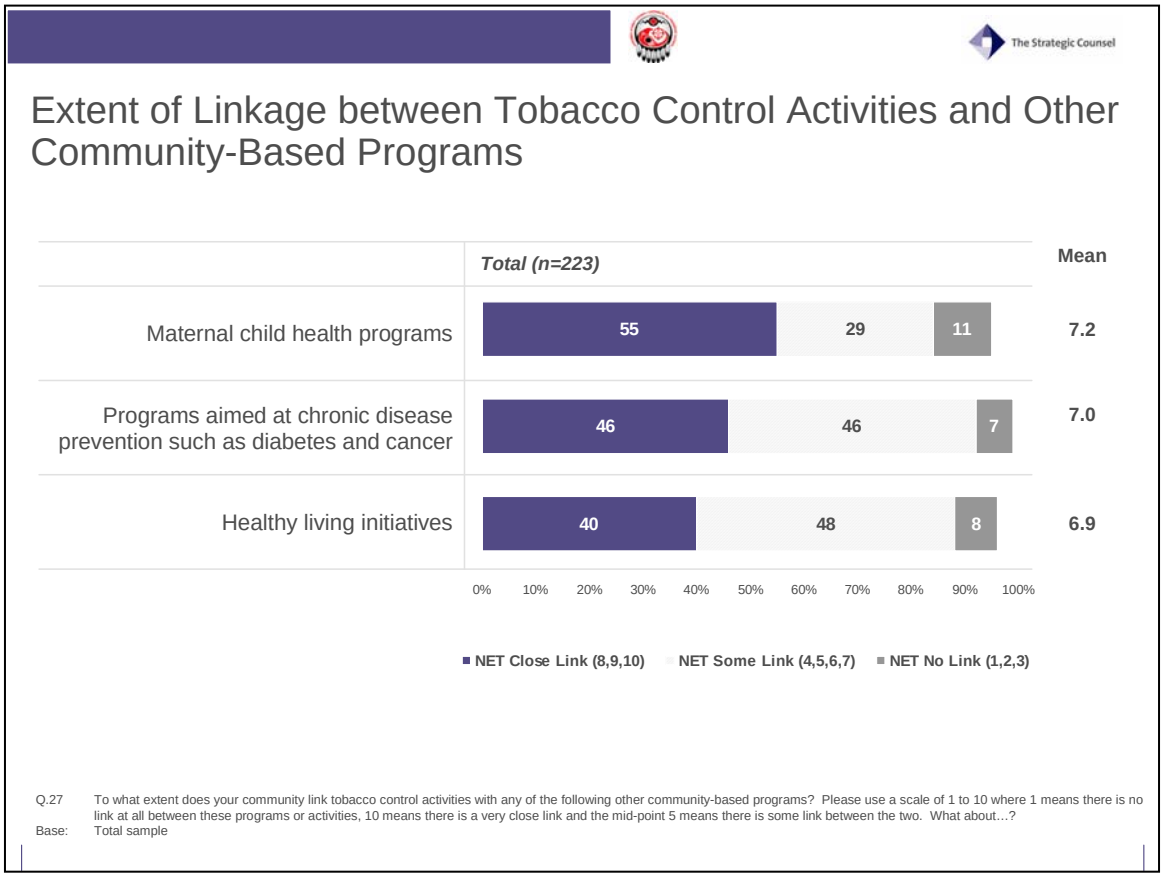


Other Community Activities to Discourage Smoking

Health Directors with varying degrees of tenure cite different issues as barriers. Those with 10 years or more experience are more likely to identify peer pressure as a key barrier, while those with less than 10 years experience are more likely to point to a lack of funding from the federal government.

C. Extent of Linkage between Tobacco Control Activities and Community-Based Programs

Health Directors indicate that tobacco control activities are generally linked to, albeit not necessarily highly integrated with, other community-based programs. This is the case for maternal child health programs (55% saying there are closely linked), programs aimed at chronic disease prevention such as diabetes and cancer (46%) and healthy living initiatives (40%).



D. Partnerships on Tobacco Control Initiatives

Health Directors indicated that their communities partner with a number of organizations, but principally with elders (64%) and the federal government (53%).

Other Community Activities to Discourage Smoking

Partnerships are somewhat less frequent but still reasonably prevalent with other Aboriginal organizations (46%), other First Nations communities (43%), and provincial or territorial governments (40%). It is less the case that communities engage in partnerships with non-governmental organizations (33%).

XII. Appendix A – Advance Communication

Assembly of First Nations
473 Albert Street, 8th Floor
Ottawa, Ontario K1R 5B4
Telephone: (613) 241-6789 Fax: (613) 241-5808
http://www.afn.ca

Assemblée des Premières Nations
473, rue Albert, 8e Étage
Ottawa (Ontario) K1R 5B4
Téléphone: (613) 241-6789 Télécopieur: (613) 241-5808
http://www.afn.ca

June 28, 2007

To: All First Nations, Health Directors

In First Nations and Inuit communities, the prevalence of smoking rates is more than double the rate for the rest of Canada. Given the increased rates of cancer and other tobacco-related illnesses, there is a need to continue to promote the control of non-traditional uses of tobacco in First Nations communities.

As part of the 2006 expenditure review, the First Nations and Tobacco Control Strategy (FNITCS) will no longer be funded. The First Nations and Inuit Health Branch (FNIHB), in collaboration with the Assembly of First Nations (AFN), are working quickly to develop new approaches to tobacco control in First Nations communities. In support of this work, and support access to new federal program resources, FNIHB and AFN are attempting to get better information on what communities are doing with respect to encouraging smoke-free policies and programming.

To obtain this information, a telephone survey is to be conducted by an independent third party, the Strategic Counsel. The survey is directed at Health Directors who have knowledge of what tobacco control activities are occurring in the community, not at individual First Nation community members. The information obtained through the survey will be reviewed jointly by FNIHB and AFN for the strict purpose of developing a new approach to tobacco control in First Nations communities. No personal or community-identifiable information is being collected.

If you have any questions or concerns regarding the purpose and methodology of the survey or any other tobacco-related issue, please contact Wayne Courchene, Special Advisor on Tobacco, at 1-866-869-6789 or wcourchene@afn.ca.

Yours truly,

Valerie Gideon, Ph.D.
Senior Director, Health and Social Secretariat

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Le 28 juin 2007

À : Directeurs et directrices de la santé

Dans les communautés des Premières Nations et des Inuits, le taux de tabagisme est le double de celui de la population canadienne. Compte tenu de l'augmentation du nombre de cas de cancer et d'autres maladies inhérentes au tabagisme, il est nécessaire de poursuivre la promotion de la lutte contre l'usage non traditionnel du tabac dans les communautés des Premières Nations.

À l'issue de l'examen des dépenses de 2006, le gouvernement a décidé de ne plus financer la Stratégie de lutte contre le tabagisme chez les Premières nations (SLTPN). Ainsi, la Direction générale de la santé des Premières Nations et des Inuits (DGSPNI) et l'Assemblée des Premières Nations (APN) ont entamé des travaux communs visant à élaborer rapidement de nouvelles méthodes de lutte contre le tabagisme pour les communautés des Premières Nations. À l'appui de ces travaux et dans le but d'obtenir de nouvelles ressources fédérales pour des programmes, la DGSPNI et l'APN s'efforcent de recueillir des renseignements plus précis sur les mesures prises par les communautés pour favoriser l'application des politiques et des programmes antitabac.

Pour obtenir ces renseignements, la DGSPNI et l'APN ont demandé à un tiers, Strategic Counsel, d'effectuer une enquête par téléphone. Celle-ci s'adresse uniquement aux directeurs de la santé, qui connaissent mieux que les citoyens les activités de lutte contre le tabagisme mises en œuvre dans les communautés des Premières Nations. Les renseignements issus de l'enquête seront examinés conjointement par la DGSPNI et l'APN dans le seul but d'élaborer et de mettre en œuvre une nouvelle méthode de lutte contre le tabagisme dans les communautés des Premières Nations. Aucun renseignement permettant de reconnaître une personne ou une communauté ne sera recueilli.

Si vous avez des questions ou des préoccupations concernant l'objectif et la méthode de l'enquête ou tout autre sujet lié au tabagisme, veuillez communiquer avec Wayne Courchene, conseiller spécial en matière de tabac, au 1 866 869-6789 ou à wcourchene@afn.ca.

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XIII. Appendix B – Questionnaire

Appendix B – Questionnaire

A. English Questionnaire

Survey of First Nations Health Directors
FINAL – July 9, 2007

Introduction:

Hello, my name is _____. I am calling on behalf of the Assembly of First Nations and Health Canada. The *Strategic Counsel* had been contracted to conduct a survey of First Nations Health Directors. The survey is intended to gauge your views on tobacco use and tobacco control programs and activities in your community. The interview will take about 20 minutes.

Please note that this survey is registered with the national survey registration system. The registration system has been created by the Canadian survey research industry to allow the public to verify that a survey is legitimate, get information about the survey industry or register a complaint. The registration system's toll-free telephone number is 1-800-554-9996.

Is now a good time to conduct the interview?
Yes (CONTINUE)
IF No, ASK: We are conducting interviews between July 12th and August 2nd (NOTE: Final field dates to be approved by Project Authority). When would be a convenient date and time at which to call you again?
Do not wish to participate (RECORD, THANK AND TERMINATE)

1. First, how many years have you served as a Health Director? Is it …
   a. Less than one year
   b. One to just under three years
   c. Three to just under five years
   d. Five to just under 10 years
   e. 10 years or more
   f. DK/NA

2. And, how many communities are you currently serving as a Health Director? DO NOT READ – CODE ONLY ONE
   a. One
   b. Two
   c. Three
   d. Four
   e. Five
   f. More than five
   g. DK/NA

3. And now, thinking back over the last five years, what are some of the most significant changes you have noted in the communities in which you work that are a direct result of various tobacco cessation activities in those communities? Anything else? (DO NOT READ PRE-CODED LIST BELOW. ACCEPT UP TO THREE RESPONSES).
   a. Fewer young people smoking
   b. More smoke-free public spaces
   c. More smoke-free community events
   d. More physical activity
   e. Tobacco cessation training programs
   f. More respect for the traditional use of tobacco
   g. Other (specify:_____)
   h. DK/NA

4. Now, for all of the remaining questions, if you are working as a Health Director in more than one community, I would like you to respond based on the situation in the community where I have reached you at this time. How long have you served as a Health Director in this community? Is it …
   a. Less than one year
   b. One to just under three years
   c. Three to just under five years
   d. Five to just under 10 years
   e. 10 years or more
   f. DK/NA

5. I'd like to ask you about the extent to which you believe your community is knowledgeable of various issues related to non-traditional tobacco and tobacco misuse. Please use a scale of 1 to 10, where 1 means you believe the members of your community are not knowledgeable, 10 means they are extremely knowledgeable and the mid-point 5 means they are moderately knowledgeable of these issues. First, to what extent do you feel members of your community are knowledgeable about … (READ AND ROTATE)
   a. The dangers of recreational smoking
   b. The dangers of chewing or spit tobacco
   c. The dangers of second-hand smoke
   d. The resources and information available to smokers to assist them to quit smoking
   e. The dangers associated with smoking among children and youth

6. And, overall, how would you rate the availability of information and materials about tobacco cessation in your community. Would you say there is more than enough information available, not nearly enough or the right amount of information and materials?
   a. More than enough
   b. Not nearly enough
   c. Right amount
   d. DK/NA

7. How would you rate your own familiarity with the information and materials about tobacco cessation that are available? Would you say you are …
   a. Very familiar
   b. Somewhat familiar
   c. Not very familiar

d. Not familiar at all
e. DK/NA

8. Now, I'd like to ask you a few questions about **smoking among youth**. Would you say that in your community the sale of cigarettes and tobacco products to those under the age of 18 occurs …
a. Frequently
b. Sometimes
c. Occasionally
d. Rarely
e. Never
f. DK/NA

9. I'm going to read you a list of measures or initiatives that some communities might put in place to prohibit or discourage the sale of tobacco products to minors. For each, please tell me whether your community has this type of measure or initiative currently in place. The first is … (READ AND ROTATE BUT ALWAYS READ A BEFORE B)

a. Educational and community-awareness-raising programs to inform youth of the dangers of tobacco use	YES	NO	DK/NA
b. Educational and community-awareness-raising programs to inform all members of the community, regardless of age, of the dangers of tobacco use	YES	NO	DK/NA
c. Retailers conduct a mandatory ID check for those who appear to be under age	YES	NO	DK/NA
d. Information sessions with parents of youth about the dangers associated with tobacco use	YES	NO	DK/NA

e. Educational programs directed at retailers	YES	NO	DK/NA

10. Apart from these, what other measures or initiatives, if any, does your community undertake to prohibit or discourage the sale and use of tobacco products to or among minors? (CODE UP TO THREE RESPONSES)

11. Does your community currently have any policies, by-laws or restrictions in place regarding smoking in public spaces or work places?
    a. Yes (CONTINUE TO Q.12)
    b. No (SKIP TO Q.16)
    c. DK/NA

12. And, do these restrictions include a complete or partial ban on smoking in public spaces or work places?
    a. Yes – Would that be a
        i. Complete ban
        ii. Partial ban that would allow smoking only in designated areas. Please describe how this partial ban works? For example, in what areas is it in effect?
    b. No (SKIP TO Q.14)
    c. DK/NA

13. What kinds of measures are in place to enforce the ban? (DO NOT READ LIST. ACCEPT UP TO THREE RESPONSES)
    a. Fines to those caught smoking/smoking in restricted areas
    b. Fines to businesses/organizations permitting smoking in restricted areas
    c. Other: Please specify
    d. DK/NA

14. And, are there any other policies, bylaws or restrictions in place in your community pertaining to smoking in public spaces or work places in addition to the ban on smoking?
    a. Yes (GO TO Q.15)
    b. No (SKIP TO Q.17)
    c. DK/NA

15. Please describe any other kinds of policies, bylaws or restrictions pertaining to smoking in public spaces or work places that are in place in your community? (GO TO Q.17)

16. What are the main reasons why your community does not have any policies, bylaws or restrictions pertaining to smoking in public spaces or work places? (ACCEPT UP TO THREE RESPONSES)

17. Approximately how much does a package of cigarettes in your community cost, including all taxes, if applicable? (RECORD APPROXIMATE PRICE IN $X.XX FORMAT)

18. And, approximately how much does a carton of cigarettes cost, including all taxes, if applicable? (RECORD APPROXIMATE PRICE IN $X.XX FORMAT)

19. How supportive or opposed do you think retailers in your community would be to an increase in the price of a package of cigarettes? In your view, would they be …
    a. Very supportive
    b. Somewhat supportive
    c. Somewhat opposed
    d. Very opposed
    e. DK/NA

20. And, overall, how supportive or opposed would residents of your community be to an increase in the price of commercial tobacco? In your view, would they be …
    a. Very supportive
    b. Somewhat supportive
    c. Somewhat opposed
    d. Very opposed
    e. DK/NA

21. Is your community currently collecting a First Nations Tax on tobacco products?
    a. Yes
    b. No
    c. DK/NA -

22. To what extent do you believe your community has a good understanding of the purpose and administration of the First Nations tax on tobacco products? Please use a scale of 1 to 10 where 1 means you believe your community has no understanding at all, 10 means they understand completely, and the mid-point 5 means your community has some understanding. (IF 7-10 TO Q.22, SKIP TO Q.24)

23. (IF 1-6 TO Q.22, ASK) In your view, what are the main reasons why there is not a good understanding of the First Nations Tax? (DO NOT READ LIST. ACCEPT UP TO THREE RESPONSES – SEE POSSIBLE PRE-CODES BELOW.)

    a. Perception that the tax is regressive (i.e. backward, counter-productive)
    b. Belief that the tax intrudes on First Nations rights
    c. Did not know one exists

24. Are there any other kinds of activities that your community engages in to encourage members of all ages to stay or become smoke-free and to discourage the non-traditional use of tobacco?
    a. Yes (Continue to Q.25)
    b. No (Skip to Q.26)

25. Please describe some of these activities? (ACCEPT UP TO THREE RESPONSES)

26. In your view, what are the principal barriers, if any, to your community engaging in activities to encourage members of all ages to stay or become smoke-free and to discourage the non-traditional use of tobacco? (DO NOT READ LIST. ACCEPT UP TO THREE RESPONSES)

    a. Lack ok leadership/support from the Chief/Band Council
    b. Lack of funding from the federal government
    c. Other more important priorities in the community
    d. Smoking not a problem

e. Other (Specify:_____)
f. No barriers
g. DK/NA

27. To what extent does your community link tobacco control activities with any of the following other community-based programs? Please use a scale of 1 to 10 where 1 means there is no link at all between these programs or activities, 10 means there is a very close link and the mid-point 5 means there is some link between the two. What about …READ AND ROTATE
    a. Programs aimed at chronic disease prevention such as diabetes and cancer
    b. Healthy living initiatives
    c. Maternal child health programs

28. Now, I'm going to list a series of possible partners with which your community may participate on tobacco control initiatives. For each, please tell me whether your community is currently partnering with these organizations or individuals on these types of initiatives. The first is … (READ AND ROTATE)

a. The federal government	YES	NO
b. The provincial/territorial government	YES	NO
c. Non-governmental organizations	YES	NO
d. Other First Nations communities	YES	NO
e. Elders	YES	NO
f. National, national level or regional Aboriginal organizations	YES	NO

29. REGION

THANK YOU VERY MUCH FOR YOUR TIME.

B. French Questionnaire

Sondage auprès des directeurs de la santé des Premières Nations
VERSION FINALE – Le 9 juillet 2007

Introduction :

Bonjour / Bonsoir, je suis _____ et je vous appelle au nom de l'Association des Premières Nations et de Santé Canada. La firme *The Strategic Counsel* a été mandatée pour mener un sondage auprès des directeurs de la santé des Premières Nations. L'enquête vise à recueillir votre point de vue sur le tabagisme et les programmes et activités de lutte contre le tabagisme mis en place dans votre communauté. L'entrevue durera environ 20 minutes.

Prenez note que cette étude est inscrite auprès du système d'enregistrement national. Le système d'enregistrement a été mis sur pied par l'industrie canadienne de la recherche par sondage afin de permettre au public de vérifier qu'une étude est légitime, d'obtenir de l'information au sujet de l'industrie ou d'enregistrer une plainte. Le numéro sans frais du système et le 1 800 554-9996.

Est-ce un bon moment pour effectuer l'entrevue?
Oui (CONTINUER)
SI non, DEMANDER : Nous effectuons des entrevues entre le 12 juillet et le 2 août (REMARQUE : les dates finales devront être approuvées par le chargé de projet.) Quand pourrais-je vous rappeler? Quelle date et quelle heure vous conviendraient le mieux?
Ne désire pas participer (INSCRIRE. REMERCIER ET METTRE FIN À L'INTERVIEW)

30. Depuis combien d'années êtes-vous directeur/directrice de la santé? Est-ce…
    a. Depuis moins d'un an
    b. Entre un an et un peu moins de trois ans
    c. Entre trois ans et un peu moins de cinq ans
    d. Entre cinq ans et un peu moins de 10 ans
    e. Depuis 10 ans ou plus
    f. NSP/S.O.

31. Et combien de communautés desservez-vous présentement à titre de directeur/directrice de la santé? NE PAS LIRE – CODER UNE SEULE RÉPONSE
    a. Un
    b. Deux
    c. Trois
    d. Quatre
    e. Cinq
    f. Plus de cinq
    g. NSP/S.O.

32. En repensant aux cinq dernières années, quels sont certains des changements les plus importants que vous avez remarqués au sein des communautés où vous travaillez et qui sont un résultat direct des activités d'abandon du tabagisme en vigueur dans ces communautés? Y a-t-il autre chose? (NE PAS LIRE LA LISTE PRÉCODÉE. ACCEPTER JUSQU'À TROIS RÉPONSES).
    a. Moins de jeunes fument
    b. Plus de lieux publics sans fumée
    c. Plus d'événements communautaires sans fumée

d. Plus d'activité physique
e. Programmes de formation à l'abandon du tabagisme
f. Plus de respect pour l'utilisation traditionnelle du tabac
g. Autre (précisez :_____)
h. NSP/S.O.

33. Pour le reste des questions, si vous travaillez comme directeur/directrice de la santé dans plus d'une communauté, j'aimerais que vous répondiez en fonction de la situation dans la communauté où je vous ai joint. Depuis combien de temps êtes-vous directeur/directrice de la santé dans cette communauté? Est-ce…
a. Moins d'un an
b. Entre un an et un peu moins de trois ans
c. Entre trois ans et un peu moins de cinq ans
d. Entre cinq ans et un peu moins de 10 ans
e. Depuis 10 ans ou plus
f. NSP/S.O.

34. J'aimerais maintenant vous demander dans quelle mesure vous croyez que votre communauté est bien informée à propos des divers problèmes liés à l'usage non traditionnel ou au mauvais usage du tabac. Veuillez utiliser une échelle de 1 à 10, où 1 signifie que vous croyez que les membres de votre communauté ne sont pas bien informés, 10 qu'ils sont extrêmement bien informés et le point médian, 5, qu'ils sont moyennement informés. Tout d'abord, dans quelle mesure croyez-vous que les membres de votre communauté sont informés… (LIRE ET RENOUVELER)
a. des dangers de l'usage récréatif du tabac
b. des dangers de mâcher ou de chiquer du tabac
c. des dangers de la fumée secondaire
d. des ressources et l'information offertes aux fumeurs pour les aider à cesser de fumer
e. des dangers associés au tabagisme chez les enfants et les jeunes

35. Et, dans l'ensemble, comment évalueriez-vous la disponibilité d'information et de documents au sujet de l'abandon du tabagisme dans votre communauté. Diriez-vous qu'ils a plus que suffisamment d'information et de documents disponibles, vraiment pas assez ou juste assez?
a. Plus que suffisamment
b. Vraiment pas assez
c. Juste assez
d. NSP/S.O.

36. Comment évalueriez-vous votre propre degré de familiarité avec l'information et les documents au sujet de l'abandon du tabagisme qui sont offerts? Diriez-vous que vous êtes…
a. Très familiarisé avec l'information et les documents
b. Assez familiarisé
c. Pas très familiarisé
d. Pas du tout familiarisé
e. NSP/S.O.

37. J'aimerais maintenant vous poser quelques questions au sujet **du tabagisme chez les jeunes**. Diriez-vous que dans votre communauté la vente de cigarettes et de produits du tabac à des mineurs âgés de moins de 18 ans survient…
a. fréquemment

b. parfois
c. à l'occasion
d. rarement
e. jamais
f. NSP/S.O.

38. Je vais vous lire une liste de mesures ou d'initiatives que certaines communautés peuvent mettre en place pour empêcher ou décourager la vente des produits du tabac aux mineurs. Pour chacune, veuillez me dire si votre communauté a ce type de mesure ou d'initiative en place à l'heure actuelle. La première est… (LIRE ET RENOUVELER, MAIS TOUJOURS LIRE A AVANT B)

a. Programmes éducatifs et de sensibilisation de la communauté afin d'informer les jeunes des dangers de l'usage du tabac	OUI	NON	NSP/S.O.
b. Programmes éducatifs et de sensibilisation de la communauté afin d'informer tous les membres de la communauté, peu importe leur âge, des dangers de l'usage du tabac	OUI	NON	NSP/S.O.
c. Détaillants qui vérifient obligatoirement la carte d'identité des jeunes qui semblent mineurs	OUI	NON	NSP/S.O.
d. Séances d'information pour les parents de jeunes au sujet des dangers de l'usage du tabac	OUI	NON	NSP/S.O.
e. Programmes éducatifs	OUI	NON	NSP/S.O.

destinés aux détaillants			

39. Mis à part ces mesures ou initiatives, s'il y a lieu, quelles autres mesures ou initiatives votre communauté met-elle en vigueur pour empêcher ou décourager la vente de produits du tabac aux mineurs ou entre mineurs? (CODER JUSQU'À TROIS RÉPONSES)

40. À l'heure actuelle, est-ce que votre communauté a une politique, des règlements ou des restrictions en vigueur concernant le tabagisme dans les lieux publics ou de travail?
    a. Oui (CONTINUER À Q.12)
    b. Non (PASSER À Q.16)
    c. NSP/S.O.

41. Et est-ce que ces restrictions comprennent une interdiction complète ou partielle de fumer dans les lieux publics ou de travail?
    a. Oui – est-ce
        i. Une interdiction complète
        ii. Une interdiction partielle qui permet de fumer seulement dans des zones désignées. Veuillez décrire comment cette interdiction partielle fonctionne? Par exemple, dans quels endroits est-elle en vigueur?
    b. Non (PASSER À Q.14)
    c. NSP/S.O.

42. Quels genres de mesures avez-vous en place pour appliquer l'interdiction? (NE PAS LIRE LA LISTE. ACCEPTER JUSQU'À TROIS RÉPONSES)
    a. Amendes pour les personnes prises à fumer / à fumer dans des zones interdites
    b. Amendes aux entreprises / organismes qui permettent de fumer dans les zones interdites
    c. Autre : veuillez spécifier
    d. NSP/S.O.

43. Et y a-t-il d'autres politiques, règlements ou restrictions en vigueur dans votre communauté pour ce qui est du tabagisme dans les lieux publics ou de travail, en plus de l'interdiction de fumer?
    a. Oui (ALLER À Q.15)
    b. Non (PASSER À Q.17)
    c. NSP/S.O.

44. Veuillez décrire tout autre genre de politiques, règlements ou restrictions ayant trait au tabagisme dans les lieux publics ou de travail en vigueur dans votre communauté? (ALLER À Q.17)

45. Quelles sont les principales raisons pour lesquelles votre communauté n'a pas de politiques, règlements ou restrictions ayant trait au tabagisme dans les lieux publics ou de travail? (ACCEPTER JUSQU'À TROIS RÉPONSES)

46. Environ combien coûte un paquet de cigarettes dans votre communauté, y compris les taxes, s'il y a lieu? (INSCRIRE LE PRIX APPROXIMATIF SOUS FORME X,XX $)

47. Et environ combien coûte une cartouche de cigarettes, y compris les taxes, s'il y a lieu? (INSCRIRE LE PRIX APPROXIMATIF SOUS FORME X,XX $)

48. À quel point croyez-vous que les détaillants de votre communauté seraient en faveur ou opposés à une hausse du prix des paquets de cigarettes? Selon vous, seraient-ils…
    a. Très en faveur
    b. Assez en faveur
    c. Assez opposés
    d. Très opposés
    e. NSP/S.O.

49. Et, dans l'ensemble, à quel point les résidents de votre communauté seraient-ils en faveur ou opposés à une hausse du prix du tabac commercial? Selon vous, seraient-ils…
    a. Très en faveur
    b. Assez en faveur
    c. Assez opposés
    d. Très opposés
    e. NSP/S.O.

50. À l'heure actuelle, est-ce que votre communauté collecte une taxe des premières nations sur les produits du tabac?
    a. Oui
    b. Non
    c. NSP/S.O. -

51. Dans quelle mesure croyez-vous que votre communauté a une bonne compréhension du but et de la gestion de la taxe des premières nations sur les produits du tabac? Veuillez utiliser une échelle de 1 à 10, où 1 signifie que vous croyez que votre communauté n'en a aucune compréhension, 10 qu'elle en a une parfaite compréhension et le point médian, 5, que votre communauté en a une certaine compréhension. (SI 7-10 À Q.22, PASSER À Q.24)

52. (SI 1-6 À Q.22, DEMANDER) Selon vous, quelles sont les principales raisons pour lesquelles votre communauté ne comprend pas bien la taxe des premières nations? (NE PAS LIRE LISTE. ACCEPTER JUSQU'À TROIS RÉPONSES – VOIR CODES PRÉLIMINAIRES CI-DESSOUS)

    a. Perception que la taxe est régressive (c'est-à-dire inversée, contre-productive)
    b. Croyance que la taxe s'ingère dans les droits des Premières Nations
    c. Ne sait pas qu'une telle taxe existe

53. Y a-t-il d'autres genres d'activités auxquelles participe votre communauté afin d'encourager ses membres de tous âges à ne pas fumer ou à cesser de fumer et à décourager l'usage non traditionnel du tabac?
    a. Oui (Continuer à Q.25)
    b. Non (Passer à Q.26)

54. Veuillez décrire certaines de ces activités? (ACCEPTER JUSQU'À TROIS RÉPONSES)

55. Selon vous, s'il y a lieu, quels sont les principaux obstacles qui empêchent votre communauté de participer à des activités visant à encourager ses membres de tous âges à ne pas fumer ou à cesser de fumer et à décourager l'usage non traditionnel du tabac? (NE PAS LIRE LA LISTE. ACCEPTER JUSQU'À TROIS RÉPONSES)

a. Manque de leadership / soutien du Chef / du Conseil de bande
b. Manque de financement de la part du gouvernement fédéral
c. Autres priorités plus importantes dans la communauté
d. Le tabagisme n'est pas un problème
e. Autre (Précisez :_____)
f. Aucun obstacle
g. NSP/S.O.

56. Dans quelle mesure votre communauté lie-t-elle les activités de contrôle du tabac à ces autres programmes communautaires? Veuillez utiliser une échelle de 1 à 10, où 1 signifie qu'il n'y a aucun lien entre ces programmes ou activités, 10 qu'il y a un lien très étroit et le point médian, 5, qu'il y a un certain lien entre les deux. Qu'en est-il de… LIRE ET RENOUVELER
   a. Programmes visant la prévention des maladies chroniques comme le diabète et le cancer
   b. Initiatives de vie saine
   c. Programmes de santé maternelle et infantile

57. Je vais maintenant vous lire une série de partenaires possibles avec lesquels votre communauté pourrait participer à des activités de contrôle du tabagisme. Pour chacun, veuillez me dire si votre communauté a, à l'heure actuelle, un partenariat avec ces organismes ou personnes pour ces types d'initiatives. Le premier est… (LIRE ET RENOUVELER)

a. le gouvernement fédéral	OUI	NON
b. le gouvernement provincial / territorial	OUI	NON
c. des organismes non gouvernementaux	OUI	NON
d. d'autres communautés des Premières Nations	OUI	NON
e. les aînés	OUI	NON
f. des organismes autochtones nationaux, à l'échelle nationale ou régionaux	OUI	NON

58. RÉGION

MERCI BEAUCOUP DE VOTRE PARTICIPATION.

XIV. Appendix C – Call Dispositions

Appendix C – Call Dispositions

Record Of Contact

Project Name: Health Directors **Project Number: 20069** **Field Start Date: 07-12-07** **Field End Date: 08-10-07**	**Call Centre(s)** Toronto ☑ **Ottawa** ☐

	Total #	%
Total Completes	**223**	**59.79%**
A. Total Numbers Attempted		
Total Call Records	373	
Total Unallocated		
Quota Full - No Dial		
Total Numbers Attempted (Net Potential Sample)	**373**	
Ineligible Numbers		
Number Changes / NIS	11	**2.95%**
Business / Fax / Cell Phone / Computer	10	2.68%
Phone Number Problem		
Call Blocked		
Quota Full	1	0.27%
Duplicate Numbers	6	1.61%
Total Invalid Numbers	*28*	*7.51%*
B. Total Eligible Numbers *(Net Potential Sample - Total Invalid #s)*	**345**	**92.49%**
C. Total Asked		
Call Back: Hard Appointments	4	1.07%
Call Back: Soft Appointments	61	16.35%
Partial Complete		
Not Available Until After Survey	1	0.27%
No Answer	9	2.41%
Answering Machine	23	6.17%
Busy	1	0.27%
French Callback	10	2.68%
Language Problem: Other	1	0.27%
Respondent Not Available	1	0.27%
Other Problem	7	1.88%
Didn't Dial		
Total Unreachable	*118*	*31.64%*
Total Asked (Total Eligible Numbers - Total Unreachable)	**227**	**60.86%**

Refusals

Upfront	3	0.80%
2nd Refusals		
Do not call list		
Eligible Respondent Refusal		
Middle Refusal		
Total Refusals	*3*	*0.80%*

D. Cooperative Contacts (Total Asked - Refusals) 224

No such person	1	0.27%
No Call Status		
Completed Interviews	223	59.79%
Total Cooperative Contacts	**224**	**60.05%**

Response Rate = Cooperative Contacts / Total Eligible #s	64.93%
Incidence = Completes / Cooperative Contacts	99.55%
Refusal Rate = Total Refusals / Total Asked	1.32%