# iα BPG

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Best Practice Guideline

JUNE 2022

Promoting Smoking Reduction and Cessation with Indigenous Peoples of Reproductive Age and Their Communities
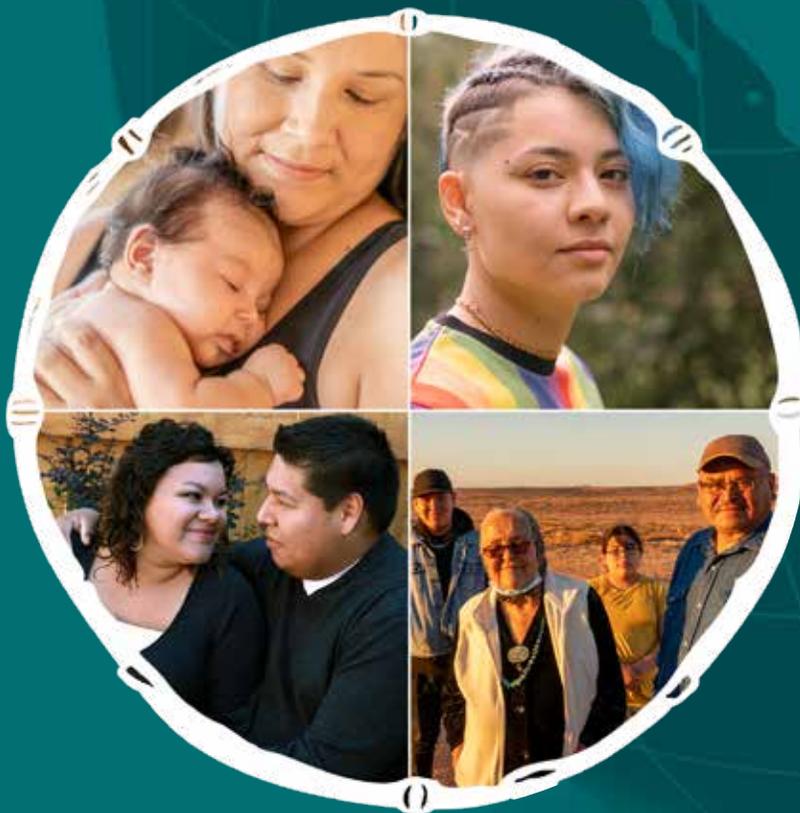
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Declaration of Conflict of Interest

In the context of RNAO best practice guideline development, the term "conflict of interest" (COI) refers to situations in which a RNAO staff member or panel member's financial, professional, intellectual, personal, organizational or other relationship may compromise their ability to conduct panel work independently. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the RNAO panel prior to their participation in guideline development work using a standard form. Panel members also updated their COI at the beginning of each guideline meeting and prior to guideline publication. Any COI declared by a panel member was reviewed by the RNAO best practice guideline development and research team and panel co-chairs. No limiting conflicts were identified. Please see Declarations of Conflicts of Interest Summary.

Acknowledgements

Images

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Contact Information

Registered Nurses' Association of Ontario
500-4211 Yonge Street, Toronto, ON M2P 2A9
Website: RNAO.ca/bpg
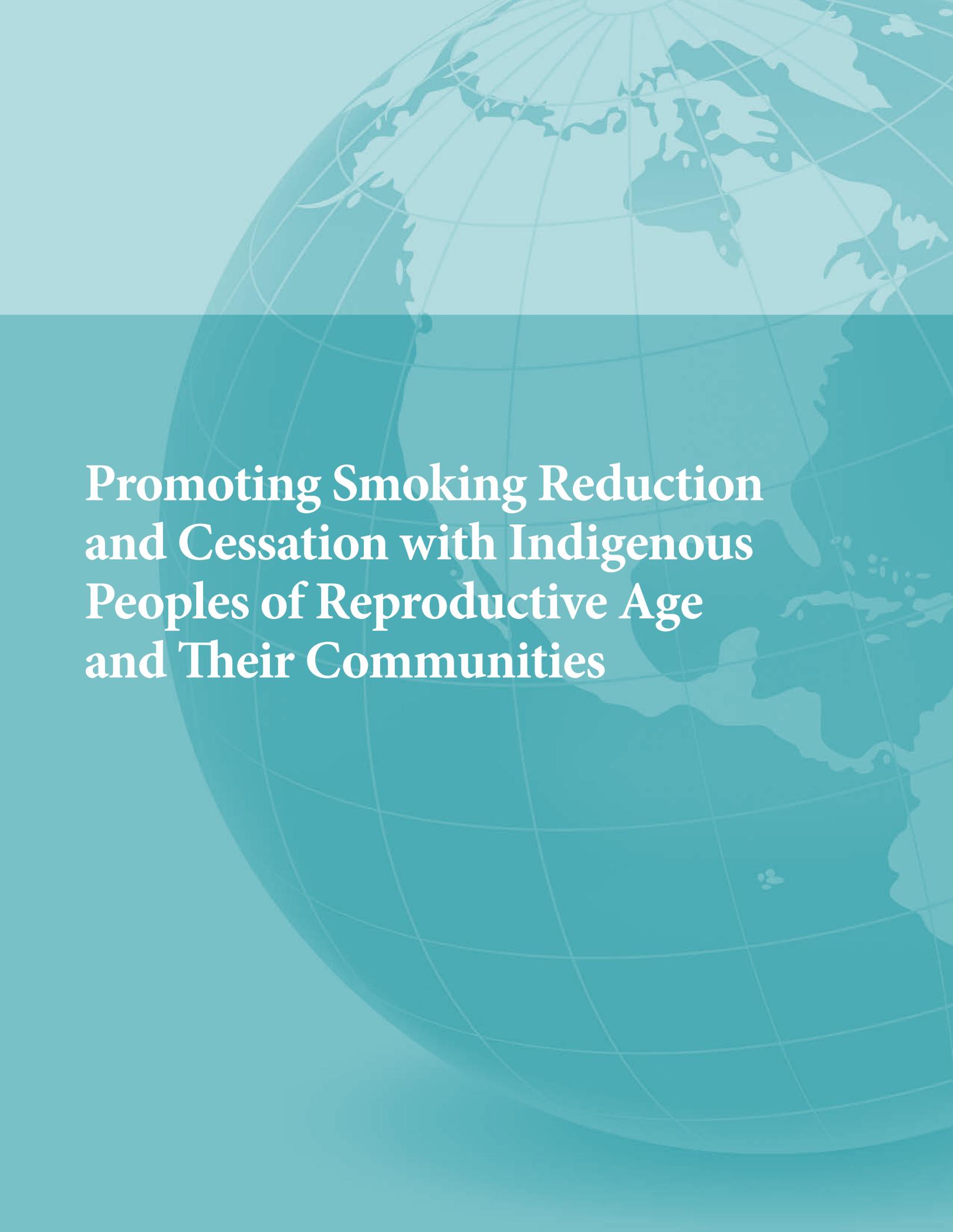
Promoting Smoking Reduction and Cessation with Indigenous Peoples of Reproductive Age and Their Communities

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario

The Indigenous-led guideline panel and the Registered Nurses' Association of Ontario (RNAO) are delighted to present *Promoting Smoking Reduction and Cessation with Indigenous Peoples of Reproductive Age and Their Communities*, a new clinical best practice guideline (BPG). We are humbled to share this first Indigenous-focused BPG with you. We are grateful to the many Indigenous partners central in developing this important guideline – from panel members with lived experience to Indigenous Best Practice Spotlight Organizations® (BPSO) and other stakeholders.

Several foundational frameworks guided us in this work. These frameworks, detailed in our "background" section, include: truth and reconciliation, cultural humility and safety, trauma-informed practice and Indigenous determinants of health and health equity. We aimed to make this BPG culturally safe and beneficial for communities by using these frameworks alongside our existing methodology. RNAO has learned so much as an organization during this process, and will continue to learn, guided by Indigenous partners. We welcome feedback and are thankful to those who take the time to share their input.

We are indebted to many stakeholders who made this BPG a reality. We are especially grateful to the guideline panel co-chairs for their invaluable expertise and stewardship:

- Raglan Maddox, Modewa Clan, fellow, National Centre for Epidemiology and Public Health, The Australian National University
- Amy Wright, Assistant Professor, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

Special thanks to the guideline panel for generously providing their time, diverse knowledge and perspectives to deliver a meaningful and relevant resource that will guide the education and practice of thousands of health providers. We couldn't have done it without you!

Successful uptake of BPGs requires a concerted effort from educators, clinicians, employers, policy-makers, researchers and funders. Nursing and health communities, with their unwavering commitment and passion for excellence in care, provide the expertise and countless hours of volunteer work needed to develop new and next-edition BPGs. Employers have responded enthusiastically by becoming BPSOs, joining more than a thousand service and academic institutions in Canada and abroad. BPSOs have sponsored best practice champions. They have also implemented BPGs and evaluated their impact on client and organizational outcomes.

We invite you to share this BPG with nursing and other colleagues, client navigators and advisors working in Indigenous communities, and the wider health systems and communities within which you work. We all have so much to learn from one another. Together, we must make sure that Indigenous people have access to and receive the best possible health and wellness services.

Doris Grinspun [signature]

Doris Grinspun, RN, MSN, PhD, LLD(hon), Dr(hc), FAAN, FCAN, O.ONT
Chief Executive Officer and Founder Best Practices Guidelines Program
Registered Nurses' Association of Ontario

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BACKGROUND

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How to Use This Document

This **best practice guideline**[G]* (BPG) is a comprehensive document that provides guidance and resources for **evidence-based nursing practice**[G]. It is not intended to be a manual or "how-to" guide; rather, it is a tool to guide best practices and enhance decision making for **nurses**[G], other **health providers**[G] in the **circle of care**[G], educators, health- and social-service organizations, academic institutions, and **persons**[G] and **support networks**[G]. Consistent with the **United Nations Declaration of the Rights of Indigenous Peoples**[G] (UNDRIP) and the World Health Organization's Framework Convention on Tobacco Control (FCTC), this BPG should be reviewed and applied in accordance with the needs of individual health- and social-service organizations, academic institutions or other practice settings, and with the preferences of Indigenous Peoples of reproductive age, their support networks and communities. This document provides evidence-based **recommendation**[G] statements and descriptions of: (a) practice, education and system, organization and policy, (b) benefits and harms, (c) values and preferences, and (d) health equity considerations.

Nurses, members of the circle of care, educators and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols and educational programs to support service delivery. Nurses and members of the circle of care in direct care will benefit from reviewing the recommendations and supporting literature.

If your health-service organization is adopting this BPG, RNAO recommends you follow these steps:

1. Assess your existing policies, procedures, protocols and educational programs in relation to the **good practice statement**[G], recommendations and supporting discussions of evidence in this BPG.

2. Identify existing needs or gaps in your policies, procedures, protocols and educational programs.

3. Note the recommendations that are applicable to your setting and that can be used to address your organization's existing needs or gaps.

4. Develop a plan for implementing recommendations, sustaining best practices and evaluating **outcomes**[G].

Implementation science[G] resources, including the *Leading Change Toolkit*™ (1), are available online here. A description of the *Leading Change Toolkit*™ can be found in **Appendix I**. For more information, see **Implementation science**[G] resources, including the *Leading Change Toolkit*™ (1), are available online.

This BPG falls under the umbrella of the RNAO Indigenous Health Program.

All RNAO BPGs are available for download, free of charge, from the RNAO website. To locate a particular BPG, search by keyword or browse by topic.

We are interested in hearing your feedback on this BPG and how you have implemented it. Please share your story with us.

RNAO's Best Practice Guideline Program's two-decade journey is documented in: Grinspun D, Bajnok I, editors. Transforming nursing through knowledge: best practices for guideline development, implementation science, and evaluation Indianapolis (IN): Sigma Theta Tau International; 2018.

* Throughout this document, terms that are bolded and marked with a superscript G ([G]) can be found in the **Glossary of Terms** in **Appendix A**.

Purpose and Scope

Purpose

RNAO's BPGs are systematically developed, evidence-based documents that include recommendations on specific clinical, healthy work environment and health system topics. They are intended for nurses, members of the circle of care in direct care positions, educators, administrators and executives, policy-makers, researchers, and people with lived experience in health-service and academic organizations. BPGs promote consistency and excellence in clinical care, administrative policies, procedures and education, with the aim of achieving optimal health outcomes for people, communities, and the health system as a whole.

The purpose of this BPG is to provide nurses and the circle of care with evidence-based recommendations on culturally safe and meaningful ways to support **smoking**[G] reduction and cessation with Indigenous Peoples of reproductive age, their support networks and communities to improve health and wellness. The recommendations in this BPG may be directed to one or more of the aforementioned populations based on the evidence. This BPG recognizes that the context in which Indigenous Peoples of reproductive age (including adolescents, **women and persons**[G] who are pregnant or in the prenatal phase and parents) live is in relationship to their support network and greater community.

This BPG emphasizes that Indigenous Peoples of reproductive age, their support network and communities are experts in their health and decision making. Collaboration among the circle of care, people, support networks and communities is therefore essential to achieving improved health outcomes. It is important to note that Indigenous Peoples of reproductive age and their support networks may have health and wellness needs that are more important to them to address, and this should be considered in the implementation of this BPG.

In February 2019, RNAO convened a panel to determine the scope of this BPG and to develop **recommendation questions**[G] to inform the **systematic reviews**[G]. The RNAO panel included a person with lived experience (experience of being Indigenous, pregnant, parent, smoking and quitting smoking). The other members of the panel are interprofessional in composition, comprised of individuals with knowledge and experience in clinical practice, education, research and policy across a range of health-service organizations, academic institutions, practice areas and sectors. The panel included urban and rural representation with First Nations and Inuit community members from across Ontario. These members shared their insights on supporting and caring for Indigenous Peoples of reproductive age, their support networks and communities in primary care, community care, maternal/child settings and everyday life.

To determine the scope and priority recommendation questions for this BPG, a comprehensive review and analysis were completed by the RNAO best practice guideline development and research team and the RNAO panel (see **Appendix C**).

Scope

To determine the scope of this BPG, the RNAO best practice guideline development and research team conducted the following steps:

- conducted an environmental scan of existing guidelines on the topic;

- undertook a literature review to determine available evidence on commercial tobacco interventions in Indigenous perinatal populations and the relevant contextual factors that influence commercial tobacco interventions programs in Indigenous communities;

- led 20 key informant interviews via telephone with health providers, administrators, health policy and public health workers, educators, youth, people with lived experience and researchers who are Indigenous and/or non-Indigenous but work with Indigenous communities;

- attended an on-site visit with an urban Indigenous health team and an on-site visit with an Indigenous midwifery practice setting; and

- consulted with the panel.

This BPG is to be used by nurses, members of the circle of care in primary care, community care and maternal/child settings, and in all domains of practice (e.g., administration, clinical, education, policy and research). It is also to be used by organizations that employ nurses and members of the circle of care, including health- and social-service organizations and academic settings.

The interventions for smoking reduction and cessation in this BPG are specific to **commercial tobacco**[G], which is distinct from **traditional tobacco**[G]. For more information on commercial tobacco, refer to the "Key Concepts Used in this BPG" below. For more information on sacred/traditional tobacco, refer to the section "Traditional Tobacco" in Background Context. Although the terminology "smoking" is used, the scope includes all forms of commercial tobacco products including but not limited to cigarettes, cigars, cigarillos, chewing tobacco, dissolvables, hookah/water pipe/shisha, snuff, roll-your-own cigarettes and pipes. The BPG also aimed to explore the impact of electronic nicotine delivery systems (ENDS), however currently there is very limited research in this area and therefore we did not address ENDS. For more information on the different types of commercial tobacco and ENDS, please refer to **Appendix E**.

The interventions in this BPG focus on smoking reduction and cessation. Smoking cessation is the ultimate goal; however, it is important to recognize that for many people reducing the use of commercial tobacco may be a part of the journey to cessation.

Key Concepts Used in This BPG

Commercial tobacco: Commercial tobacco is manufactured for recreational and habitual use in cigarettes, smokeless tobacco, chewing tobacco, pipe tobacco, cigars and hookah. Commercial tobacco is produced and sold for profit and nicotine is the primary addictive substance that it contains. (2). This tobacco contains thousands of chemicals and produces chemical compounds, many of which are carcinogenic and contribute to cardiovascular disease, chronic obstructive pulmonary disease, emphysema, asthma, diabetes, and cancer (lung, colorectal, cervical, kidney, liver and stomach) — all of which can lead to premature death (2). Commercial tobacco use during pregnancy poses risks to the fetus such as low birth weight and an increased likelihood of sudden infant death syndrome (SIDS) (3). Second hand commercial tobacco smoke exposure also causes acute lower respiratory infections in infants and young children (3).

Cultural safety: Cultural safety is an outcome that is based on respectful engagement that recognizes and aims to address power imbalances inherent across the health system (4). Cultural safety is possible in an environment that is free of racism and discrimination. Indigenous people, families and communities should feel safe when they receive health care and thus be able to share their perspectives, and ask questions; health care providers should respect their beliefs, behaviours and values (4).

Support network: Those individuals whom a person identifies as significant in their life. The network can include individuals who are related (biologically, emotionally, or legally) and/or those with close bonds (friendships, commitments, shared household and child-rearing responsibilities, and romantic attachment) (5).

Circle of care: A team comprised of multiple health and social service providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health care and services to people within, between and across health-care settings (6). Key interprofessional team members supporting Indigenous community members may include: Traditional Healers, Elders and Knowledge Keepers, midwives, doulas, Aunties, nurses, community health workers, social workers, physicians and pharmacists.

Health provider: Refers to both regulated (e.g., nurses, physicians, dieticians and social workers) and unregulated (e.g., community health workers) providers that are part of the circle of care.

> **Regulated health provider**: In Ontario, the *Regulated Health Professional Act, 1991* (RHPA) provides a framework for regulating 23 health professions, outlining the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (7).

> **Unregulated health provider**: Unregulated health providers fulfill a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (e.g., the College of Nurses of Ontario). Unregulated health providers fulfill a variety of roles and perform tasks that are determined by their employer and employment setting. Unregulated health providers only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (8).

Women and persons: Term used to acknowledge that not everyone who is able to become pregnant identifies as a "woman". It is important to note that gender is not a binary assignment; it can refer to the individual and/or social experience of being a man, a woman, both or neither. Social norms, expectations, and roles related to gender vary across time, space, culture and individuals. However, the terminology in certain discussions of evidence may be limited to "women", "mother", etc. based on what is found in the literature.

Smoking: For the purposes of this BPG, smoking refers to various forms of commercial tobacco use including but not limited to cigarettes, cigars, cigarillos, chewing tobacco, dissolvables, hookah/water pipe/shisha, snuff, roll-your-own cigarettes and pipes. In this BPG, recommendations do not apply to ENDs as there is a lack of current research.

Recommendation Questions

Recommendation questions are priority areas of care identified by the panel that require a synthesis of the evidence to answer. These recommendation questions inform the **PICO research questions**[G] (population, intervention, comparison, outcomes) and **PPC research questions**[G] (population, phenomenon, context) that guide the systematic reviews and subsequently inform recommendations. The following were the priority recommendation questions and outcomes, identified by the panel, that informed the development of this BPG. The outcomes are presented in the order of importance, as rated by the panel.

- **Recommendation Question #1**: Should smoking reduction and cessation counselling be recommended for Indigenous women and persons during pregnancy and the post-partum period?

  Outcomes: **Reach**[G], **engagement**[G] and **quit rates**[G].

- **Recommendation Question #2**: What needs (social, cultural, environmental supports) and opinions (with respect to barriers and facilitators) do Indigenous women and persons of reproductive age, their support networks and community, express about smoking cessation interventions?

  Outcomes: Not applicable.

- **Recommendation Question #3**: Should smoking reduction and cessation interventions embedded within broader health and wellness programs be recommended?

  Outcomes: Reach, engagement, acceptability and quit rates.

- **Recommendation Question #4**: Should culturally appropriate and trauma-informed smoking reduction and cessation services be recommended?

  Outcomes: Reach and engagement.

- **Recommendation Question #5**: Should pharmacotherapy (**nicotine replacement therapy**[G] (NRT), or bupropion, or varenicline) be recommended for smoking cessation in pregnant and post-partum women and persons?

  Outcomes: Quit rates, miscarriage & spontaneous birth, mean birth weight.

- **Recommendation Question #6**: Should Indigenous community-led smoking reduction and cessation approaches be recommended?

  Outcomes: Reach and engagement.

- **Recommendation Question #7**: Should undergraduate education for nurses and the interprofessional team and/or continuing professional development for health providers on Indigenous health be recommended?

  Outcomes: Cultural safety, attitude, knowledge and change in practice.

Note: These priority recommendation questions are condensed versions of the more comprehensive PICO and PPC research questions developed by the panel to guide the systematic reviews and development of this BPG. For more on the PICO and PPC research questions and the detailed process of how the panel determined the priority recommendation questions and outcomes, please see **Appendix C**.

Good Practice Statement and Recommendations

The recommendations in this BPG address unique and overlapping areas of care for Indigenous Peoples of reproductive age, their support networks and communities.

Specifically, this BPG covers the following main areas:

- The good practice statement on culturally safe assessment is important guidance that nurses and other people in the circle of care can use in their practice. The good practice statement is believed to be so beneficial that conducting a systematic review to prove its efficacy would be unreasonable. The resulting statement is not based on a systematic review and it does not receive a rating of the certainty or confidence in their evidence or strength (i.e., a rating of conditional or strong) (9).

- **Practice recommendations**[G] that are primarily directed at nurses and other persons in the circle of care who provide direct care to Indigenous Peoples of reproductive age, their support networks and communities. In this BPG, the practice recommendations focus on providing culturally safe and tailored support, involving support networks in care, counselling, and pharmacotherapy (i.e. nicotine replacement therapy) for commercial tobacco reduction and cessation.

- **Education recommendations**[G] that are directed to those responsible for the education of nurses and other persons in the circle of care, such as educators, quality improvement teams, managers, administrators, academic institutions, and health service organizations. In this BPG, the education recommendations focus on providing foundational Indigenous health content within curricula and professional development opportunities.

- **System, organization and policy recommendations**[G] that apply to a variety of audiences depending on the recommendation. Audiences for the implementation of best practices can include nurses and the circle of care, as well as managers, administrators and policy-makers responsible for developing policy or securing the supports required within organizations and/or the broader community, including places of work. In this BPG, system, organization and policy recommendations focus on providing equitable access to services as well as establishing smoke-free spaces.

RNAO BPGs and Other Resources that Align with this BPG

Other RNAO BPGs and evidence-based resources may support implementation of this BPG. See **Appendix B** for RNAO BPGs and other evidence-based resources on the following related topics:

- Breastfeeding
- Client centred learning
- Implementation science, implementation frameworks and resources
- Interprofessional collaboration
- Perinatal depression
- Person- and family-centred care
- Commercial tobacco interventions in daily practice

Interpretation of Evidence and Strength of Recommendations

RNAO BPGs are developed using the **Grading of Recommendations Assessment, Development and Evaluation (GRADE** G) and **Confidence in the Evidence from Reviews of Qualitative Research (CERQual)**G methods. For more information about the guideline development process, including the use of GRADE and GRADE-CERQual methods, please refer to **Appendix C**.

Certainty of Evidence

The certainty of evidence (i.e., the level of confidence we have that an estimate of effect is true) for quantitative research is determined using GRADE methods (10). After synthesizing the evidence for each prioritized outcome, the certainty of evidence is assessed. The overall certainty of evidence is determined by considering the certainty of evidence across all prioritized outcomes per recommendation. GRADE categorizes the overall certainty of evidence as *high*, *moderate*, *low* or *very low* (see **Table 1** for the definition of these categories).

Table 1: Certainty of Evidence

CERTAINTY OF EVIDENCE	DEFINITION
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very Low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Source: Reprinted from: The GRADE Working Group. Quality of evidence. In: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013 [cited 2018 Aug 31]. Table 5.1, Quality of evidence grades. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.wsfivfhuxv4r. Reprinted with permission.

Confidence in Evidence

The confidence in evidence for **qualitative research**[G] (i.e., the extent to which the review finding is a reasonable representation of the phenomenon of interest) is determined using GRADE-CERQual methods (hereafter referred to as CERQual) (11). For qualitative evidence, an overall judgment of the confidence is made per finding in relation to each recommendation, as relevant. CERQual categorizes the confidence in evidence as *high*, *moderate*, *low* or *very low*. See **Table 2** for the definitions of these categories.

Table 2: Confidence in Evidence

CONFIDENCE IN EVIDENCE	DEFINITION
High	It is highly likely that the finding is a reasonable representation of the phenomenon of interest.
Moderate	It is likely that the finding is a reasonable representation of the phenomenon of interest.
Low	It is possible that the review finding is a reasonable representation of the phenomenon of interest.
Very Low	It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Source: Reprinted from: Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. Implement Sci. 2018;13(Suppl 1):1-10. Table 3, Description of level of confidence in a review finding in the CERQual approach; p. 6. Reprinted with permission.

Note: The assigned certainty and/or confidence of evidence can be found directly below each recommendation statement. For more information on the process of determining the certainty and/or confidence of the evidence and the documented decisions made by RNAO guideline development methodologists, please see **Appendix C**.

Strength of Recommendations

Recommendations are formulated as *strong* or *conditional* by considering the *certainty* and/or *confidence* in evidence and the following key criteria (see **Discussion of Evidence** for definitions):

- balance of benefits and harms,
- values and preferences, and
- health equity.

According to Schunemann et al., "a strong recommendation reflects the expert panel's confidence that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation *for* an intervention) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation *against* an intervention)" (10). In contrast, "a conditional recommendation reflects the expert panel's confidence that the desirable effects

probably outweigh the undesirable effects (conditional recommendation for an intervention) or undesirable effects probably outweigh desirable effects (conditional recommendation against an intervention), but some uncertainty exists" (10).

However, when the overall certainty of the evidence is high or moderate, panel members can be confident that the evidence is credible and thus will support a strong recommendation. In addition, panel members would need to ensure that the benefits and harms are not closely balanced, there is reasonable confidence and limited variability in patients' values and preferences (12). However, when the overall certainty of the evidence is low or very low, there is uncertainty regarding the impact of the intervention of interest and panel members should therefore expect conditional recommendations (12).

The exception exists in five paradigmatic situations wherein panel members may be able to justify strong recommendations based on low or very low certainty evidence, as outlined below:

1. There is a life-threatening situation
2. There is uncertain benefit and certain harm
3. There is potential equivalence, one option is clearly less risky or costly
4. There are high similar benefits, one option is potentially more risky or costly
5. There is a potential catastrophic harm (12)

Table 3 outlines the implications of strong and conditional recommendations.

Table 3: Implications of Strong and Conditional Recommendations

POPULATION	STRONG RECOMMENDATION	CONDITIONAL RECOMMENDATION
For health providers	■ The benefits of a recommended action outweigh the harms. Therefore, most persons should receive the recommended course of action. ■ There is little variability in values and preferences among persons in this situation. ■ There is a need to consider the person's circumstances, preferences and values.	■ The benefits of a recommended course of action probably outweigh the harms. Therefore, some persons could receive the recommended course of action. ■ There is greater variability in values and preferences, or there is uncertainty about typical values and preferences among persons in this situation. ■ There is a need to consider the person's circumstances, preferences and values more carefully than usual.
For persons receiving care	■ Most persons would want the recommended course of action and a small portion would not.	■ The majority of persons in this situation would want the suggested course of action, but many would not.
For policy makers	■ The recommendation can be adapted as policy in most situations.	■ Policy-making will require substantial debate and involvement of many stakeholders. Policies are also more likely to vary between regions.

Source: Adapted from: The GRADE Working Group. Quality of evidence. In: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013 [cited 2020 May 11]. Table 6.1, Implications of strong and weak recommendations for different users of guidelines. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.wsfivfhuxv4r.

Note: The strength of each recommendation statement is detailed directly below it and in the **Summary of Recommendations**. For more information on the process used by the panel to determine the strength of each recommendation, please see **Appendix C**.

Discussion of Evidence

The Discussion of Evidence that follows each recommendation includes the following main sections.

1. **Benefits and Harms:** Identifies the potential desirable and undesirable outcomes reported in the literature when the recommended practice is used. Content in this section includes only research from the systematic reviews.

2. **Values and Preferences**: Denotes the relative importance or worth placed on health outcomes derived from following a particular clinical action from a person-centered perspective. Content for this section may include research from the systematic reviews and, when applicable, observations and/or considerations from the panel.

3. **Health Equity**: Identifies the potential impact that the recommended practice could have on health across different populations or settings and/or barriers to implementing the recommended practice in particular settings. This section may include research from the systematic reviews and, when applicable, observations and/or considerations from the panel.

4. **Panel Justification of Recommendation**: Provides a rationale for why the panel made the decision to rate a recommendation as strong or conditional.

5. **Implementation Tips**: Highlights practical information for nurses and members of the circle of care. This section may include supporting evidence from the systematic reviews and/or from other sources (e.g., the panel).

6. **Supporting Resources**: Includes a list of relevant resources (e.g., websites, books and organizations) that support the recommendations. Content listed in this section was assessed based on five criteria: relevancy, credibility, quality, accessibility and timeliness of publication (published within the last 10 years). Further details about this process and the five criteria are outlined in **Appendix C**. The list is not exhaustive and the inclusion of a resource in one of these lists does not imply an endorsement from RNAO. Some recommendations may not have any identified supporting resources.

Summary of Recommendations

GOOD PRACTICE STATEMENT
As part of a wholistic health assessment, a member of the circle of care has a conversation about smoking, in a culturally safe way, with the Indigenous person of reproductive age and their support network. *As a good practice, this statement does not require application of the GRADE system. For more information, please see page 10.*

PRACTICE RECOMMENDATIONS	
RECOMMENDATIONS	**STRENGTH OF THE RECOMMENDATION**
Recommendation 1: It is recommended that smoking reduction and cessation services be Indigenous-led and grounded in a wholistic approach to health and wellness. The circle of care provides culturally safe and tailored services with perinatal Indigenous women and persons and their support network.	Strong
Recommendation 2: It is recommended that the circle of care offer smoking reduction and cessation counselling with Indigenous women and persons during pregnancy and the post-partum period. It is important that counselling is provided in a culturally safe way and that it is part of an overall wholistic approach to health and wellness.	Strong
Recommendation 3: It is recommended that wholistic and culturally specific smoking reduction and cessation services also be offered to the support network of the perinatal Indigenous women and persons who are accessing these services.	Strong
Recommendation 4: It is suggested that, when needed, the circle of care offer nicotine replacement therapy, in addition to counselling, to Indigenous women and persons during pregnancy.	Conditional

EDUCATION RECOMMENDATIONS	
RECOMMENDATIONS	**STRENGTH OF THE RECOMMENDATION**
Recommendation 5: It is recommended that academic settings integrate compulsory Indigenous health and Indigenous cultural safety content into college and university educational curricula for all students entering health professions. *Call to Action #24, Truth and Reconciliation Commission, 2015	Strong
Recommendation 6: It is recommended that health and social service organizations integrate Indigenous health and cultural safety education within continuing professional development for all health providers. *Call to Action #23, Truth and Reconciliation Commission, 2015	Strong

SYSTEM, ORGANIZATION AND POLICY RECOMMENDATIONS	
RECOMMENDATIONS	**STRENGTH OF THE RECOMMENDATION**
Recommendation 7: It is recommended that the circle of care advocate for equitable access to smoking reduction and cessation services for Indigenous Peoples of reproductive age and their support network. This can include access to circles of support and nicotine replacement therapy (NRT).	Strong
Recommendation 8: It is recommended that health service organizations embed smoking reduction and cessation services within existing health and wellness programs.	Strong
Recommendation 9: It is recommended that Indigenous communities advance the health and wellness of all community members through the promotion of indoor and outdoor smoke free spaces.	Strong

Best Practice Guideline Evaluation

Please note that the development of this best practice guideline evaluation section is in progress in collaboration with our Indigenous partners and will be included after initial publication.

RNAO Best Practice Guideline Development and Research Team

Deborah Flores, RN, ONC(C), MN
Guideline Development Co-lead
Guideline Development Methodologist
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Nafsin Nizum, RN, MN
Guideline Development Co-lead
Senior Manager, Research and Guideline Development
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Megan Bamford, RN, MScN
Former Associate Director, Guideline Development
and Evaluation
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Verity Scott, BSc
Guideline Development Project Coordinator
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Glynis Gittens, BA (Hons)
Guideline Development Project Coordinator
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Christina Medeiros, RN, BScN, BPHE, BEd, MN, PhD Candidate
Senior Manager, Evaluation & Monitoring
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Stephanie Voong, RN, MHI
Former Senior Manager, Quality Improvement/
eHealth Specialist
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Shanoja Naik, PhD, MPhil, MSc, BEd, BSc
Principal Data Scientist/Analytics-Health Outcomes
Research, NQuIRE
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, ON

Heather McConnell, RN, BScN, MA(Ed)
Director
International Affairs and Best Practice Guidelines Centre
Registered Nurses' Association of Ontario
Toronto, Ontario

Doris Grinspun, RN, MSN, PhD, LLD (hon), Dr (hc), FAAN, FCAN, O. ONT
Chief Executive Officer
Registered Nurses' Association of Ontario
Toronto, ON

Acknowledgements

Nancy Santesso, RD, MLIS, PhD
Assistant Professor
Department of Health Research Methods, Evidence and Impact, McMaster University
Deputy Director, Cochrane Canada

Systematic literature search completed by:
University Health Network HealthSearch

RNAO Best Practice Guideline Panel

Raglan Maddox, PhD, MPH
Panel Co-chair
Fellow
Commercial Tobacco Free Program Director
Aboriginal and Torres Strait Islander Health Program
National Centre for Epidemiology and Public Health
The Australian National University
Canberra, Australia

Previously:
Post doctoral Fellow and Research Fellow
Post doctoral research in Indigenous Smoking
St. Michael's Hospital, Well Living House
Toronto, ON

Amy Wright, MScN, PhD, Nurse Practitioner-Pediatrics, CNeoN(C)
Panel Co-chair
Assistant Professor, Lawrence S. Bloomberg Faculty of Nursing
University of Toronto
Toronto, ON

Joan L. Bottorff, RN, PhD
Professor, School of Nursing and Director, Institute for Healthy Living and Chronic Disease Prevention
University of British Columbia (Okanagan campus)
Kelowna, BC

Donna Churipuy, RN, MN
Director, Public Health Programs
Peterborough Public Health
Peterborough, ON

Donald Corbiere, RN, BScN
Indigenous lead
Indigenous Affairs Office
City of Toronto
Toronto, ON

Neshma Dhanani, RN, MPH
(September 2018 – January 2020)
Senior Manager, Tobacco Cessation
Canadian Cancer Society
Toronto, ON

Nancy Poole, PhD
Director
Centre of Excellence for Women's Health
Victoria, BC

Juanita Rickard, RN , BScN
Vice-President, Health Program & Policy First Nations
Canadian Indigenous Nurses Association
Ottawa, ON

Jenna Rintoul
Manager
Tungasuvvingat Inuit
Ottawa, ON

Kitty Seager, RPN, CRE, CPT
Staff Nurse
Haldimand Family Health Team
Caledonia, ON

Lisa Seamark, RN
Staff Nurse, Smoking Cessation in Sioux Lookout
Meno Ya Win Health Centre
Sioux Lookout, ON

Patricia M. Smith, PhD
Associate Professor
Northern Ontario School of Medicine
Faculty of Medicine, Lakehead University
Thunder Bay, ON

Corey Wesley, MSc
Ontario Native Women's Association
Health Policy Analyst
Thunder Bay, ON

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Betsy Linklater
Traditional Healer/Elder
Sandy Lake First Nation

Manashe Rae
Traditional Healer /Elder
Sandy Lake First Nation

Nora Jane Meekis
Traditional Healer/Elder
Sandy Lake First Nation

Ashley Brown, RPN
Behavioural Supports Ontario (BSO) Long Term Care
Lead Team
Leamington Mennonite Home
Chatham, ON

Olivia Brundia, RN, BScN, CVAA(C)
Registered Nurse
North Bay, ON

Amanda Cybulski, RN
Registered Nurse
London Health Sciences Centre
London, ON

Neshma Dhanani, RN, MPH
Nursing Instructor
University of Calgary in Qatar
Doha, Qatar

Lucy Doan, MN, NP-PHC
Nurse Practitioner
Inner City Health Associates
Toronto, ON

Tammy Doerle, RN
Whitby, ON

Maria Dzikowska, RN
Clinical Nurse Specialist
Thunder Bay Regional Health Sciences Centre
Thunder Bay, ON

Kim English, RN, BScN, MN, EDD(c)
Professor
Trent/Fleming School of Nursing
Peterborough, ON

Suzanne Fitzpatrick, RN, BScN
Indigenous Midwife Apprentice/RN
Dilico Anishinabek Family Care
Fort William First Nation, ON

Nicholas Fox, RN
Registered Nurse
Trillium Health Partners
Mississauga, ON

Victoria Gilks, RN
Registered Nurse
Northern Outreach Team
Health Sciences North
Attawapiskat, ON

Erin Gisborne, RN, BScN

Clinical Nurse Educator

Royal Victoria Regional Health Centre

Barrie, ON

Janet Greaves, RN (EC)

Nurse Practitioner

Mamaway Wiidokdaadwin Indigenous

Primary Care Team

Orillia, ON

Colleen Heywood, RN

Registered Nurse

University of Ottawa Heart Institute

Ottawa, ON

Sabina Iqbal, BSc (Hons)

Nursing student

Humber College

Toronto, ON

Lyndsey Kakekapetum, CPNP

Prenatal Educator

Sandy Lake First Nation Health Authority

Sandy Lake First Nation, ON

Christine S. Khiyaza, RN, BScN (Hons), MScN, CTE

RN – Smoking Cessation Coordinator

Kingston Health Science Centre

Kingston, ON

Kanika Kohli, RN, BScN, MN

Manager, Clinical Quality & Professional Practice

Sunbeam Community & Development Services

Kitchener, ON

Sierra Land, RN

Registered Nurse

Georgian Bay Family Care Centre and Southlake

Regional Health Centre

Midland and Newmarket, ON

Angela Luciani, RN, MN, MPHTM

Iqaluit, NU

Ashley Malloff, RN, BScN, MHA, PMP, CHE

Quality and Patient Safety Specialist

Queensway Carlton Hospital

Ottawa, ON

Jasdeep Mangat, RN, BScN, M(Ed) Candidate

Registered Nurse

William Osler Health System

Brampton, ON

Mathew McGuigan, RN

Public Health Nurse

Chatham-Kent Public Health

Chatham, ON

Carmel Meekis, MCH

Maternal Child Health, Indigenous Doula

Sandy Lake Health Authority

Sandy Lake First Nation

Greta Meekis, CWP

Child Wellness Coordinator

Sandy Lake Health Authority

Sandy Lake First Nation

Kim Miran, RN, CPMHN

Registered Nurse

Centre for Addiction and Mental Health

Toronto, ON

Allison Moseley, MA

Policy and Standards, Director

University Hospital of the West Indies

Jamaica

Tina Ortolan, BScN

Community Development Manager-Health Programs

Ontario Native Women's Association

Thunder Bay, ON

Priscilla Patterson, BScN, MEd

Professor of Nursing

Mohawk College of Applied Arts & Technology

Hamilton, ON

Jenna Puk, RN, BScN, BSc (Hons.)
Registered Nurse
Royal Victoria Regional Health Centre
Barrie, ON

Juliana Pullano, RN
Registered Nurse
Maple, ON

Lisa Rhodenizer, BPH, PMP
Coordination Advisor, Health Promotion
Central Regional Cancer Program
Newmarket, ON

Jenny Schiffl, RN(EC), MScN, CTE
Primary Health Care Nurse Practitioner
Niagara Health and Government of Nunavut
Ontario and Nunavut

Sondra Seibel, RN
Registered Nurse
Thunder Bay Regional Health Sciences Centre
Thunder Bay, ON

Carnelle Symes, RN, MScN
Nursing Instructor
Red Deer College
Red Deer, AB

Grace Terry, RN, BScN, MSc
Registered Nurse
Muskoka Algonquin Healthcare
Huntsville, ON

Rebecca Welch, RN(EC), NP-PHC, MN, CPMHN(C)
Nurse Practitioner
Juravinski Cancer Centre
Hamilton, ON

Cheryl Yost, RN, BScN, MEd
Nurse In charge
Indigenous Services Canada
Nursing Station
Sandy Lake First Nation

Background Context

Nurturing a "Safer Space" to Come Together

The panel and the RNAO BPG team represent a group of individuals from different places and a variety of backgrounds. The panel was comprised of people with diverse Indigenous and non-Indigenous knowledges, perspectives and lived experiences. The RNAO team acknowledges that its members are non-Indigenous **settlers**[G], whose worldviews, experiences and perspectives may limit their understanding of interpretations of evidence and Indigenous experiences. Therefore, to foster a deeper understanding of Indigenous health, wellness, cultures and lived experiences, the RNAO team members engaged in **critical reflexivity**[G] through ongoing and critical examination of personal and professional misconceptions, values, biases and assumptions about Indigenous Peoples and cultures and how these misconceptions influence perceptions.

The panel co-chairs brought forward the idea of using an **ethical space**[G] framework to undertake the work. They outlined the framework, requested panel input on the rules of engagement and established group norms and expectations at the onset of this work.

An ethical space framework can be used where different knowledge, protocols, and worldviews — such as Indigenous and Western knowledge and worldviews— can meet in a safe and respectful space. Ethical spaces have previously been developed to promote discussions on Indigenous legal issues and the intersection of Indigenous law and the Canadian legal system. An ethical space of engagement can help to foster an environment for dialogue and create a safe space to work together (13). It can offer a framework to examine the diversity and positioning of Indigenous Peoples and Western society (13). This framework was used in the development of this BPG to guide ethical engagement and dialogue on Indigenous health and wellbeing, and the intersection of Indigenous and Western knowledges and research methodologies.

The aim was to create a safe space of mutual and respectful relationships that acknowledges diversity as a strength within the BPG development process itself and actively demonstrates respect for local Indigenous protocols and Indigenous Peoples, including the right to self-determination. Efforts to create a safer space included the act of bringing the circle together, and leading the work, with the love and kindness of an Anishnawbe Nokomis (grandmother). Panel members were given the opportunity to speak, share ideas, and openly provide input as a group and/or in private. The co-chairs consulted one-on-one with each panel member throughout the BPG development process to ensure their voice was heard and to help address any issues or concerns.

The panel and the RNAO team are grateful for the First Nations Elder who opened and closed the in-person meetings with a prayer and smudge, and provided valuable leadership and guidance to the panel and RNAO team for this important work.

Terminology and Language Considerations

It is critical to acknowledge that **First Nations**[G], **Inuit**[G] and **Métis**[G] Peoples are diverse and distinct. Terminology used by health providers is important. Words can empower populations when people are able to self-identify (14). On the other hand, words/designations can infer and represent colonial histories and negative power dynamics (14). A respectful approach by health providers involves using, when possible, the most specific terms to describe a population (14).

The term **Aboriginal**[G] describes the first inhabitants of what is now Canada and includes First Nations, Inuit and Métis Peoples (14). In the Canadian context, this term came into common use after it was used to represent the first inhabitants of Canada in Section 35 [2] of the 1982 Canadian Constitution Act (15). The term Aboriginal remains in use in Canada and is also used to identify the First Peoples in Australia (14). Other international jurisdictions, such as the United States, use terminology such as 'Indian' or 'Native'. In Canada, the use of the term 'Indian', other than in reference to the federal **Indian Act**[G], is considered disrespectful of Indigenous Peoples unless it is used by Indigenous people to describe themselves.

The term **Indigenous**[G] is now more commonly used in Canada to collectively identify people and communities who consider themselves to be of First Nations, Inuit or Métis ancestry. The United Nations (UN) identifies Indigenous people as individuals and groups who have unique and distinctive cultures, languages, legal systems and histories as well as an inherent connection to the environment and their traditional lands and territories (16). The UN identifies Indigenous groups as autonomous and self-sustaining societies that have faced discrimination, marginalization, assimilation of their culture and people due to the arrival of a more populous settler population (16). Aboriginal leaders working with the UN adopted the term Indigenous following the emergence of advocacy movements as a way to identify and unite Aboriginal communities worldwide and create a unified voice at the UN (16).

Terms may be used interchangeably in this BPG to identify the specific group or individuals being described, or to reflect the specific use of language from cited sources. For further details on terminology in this BPG, please refer to the Glossary of Terms (**Appendix A**).

Learning Journey

Indigenous Peoples

Indigenous Peoples have lived on Turtle Island (North America) for millennia before European colonization. In contemporary Canada, First Nations, Inuit and Métis Peoples are commonly identified as Indigenous Peoples. Indigenous Peoples across Canada are diverse; they reside on and off reserve, in urban and rural communities, and in Canada's north (17). The average age of the Indigenous population is considerably younger than that of Canada's non-Indigenous population and the population is growing both on and off reserve (17). There are more than 600 distinct First Nations communities in Canada, of which 207 are in Ontario (18). Most Métis reside in urban areas or Métis communities in Canada's western provinces and Ontario (17), while most Inuit reside in four regions: Nunavik in Northern Quebec, Nunatsiavut in Northern Labrador, Nunavut and the Inuvialuit region of the Northwest Territories. It is important to note that within each First Nation, Métis and Inuit community there are distinct historical, cultural, and spiritual differences. Inuit are distinct from First Nations and Métis populations, particularly with regard to history, language, culture and spiritual beliefs (19).

Indigenous Ways of Knowing

It is imperative that health providers recognize, understand and acknowledge the diversity in First Nations, Métis and Inuit perspectives and worldviews. There are many ways of knowing and doing and methods through which Indigenous Peoples bring knowledge forward, such as meanings, purposes, values, cultural practices and protocols that predate colonization (20). Indigenous Peoples commonly view the world we live in as an integrated whole, where knowledges, wisdom, art and other forms of cultural expression are linked to experiences on the land and with the environment (20).

Traditional or Indigenous Knowledges

Indigenous knowledge systems are **wholistic**[G], dynamic, cumulative and intergenerational. A deep spiritual relationship exists between Indigenous Peoples and their local lands and traditional territories but colonization has resulted in environmental dispossession and cultural disarray. The ways in which peoples have traditionally accessed and lived on these lands has been disrupted (21). Indigenous health is intimately linked to the land, and Indigenous Peoples relationship to the land is inseparable from cultures, social relationships and traditional ways of living (22).

It is essential that health providers be aware of the crucial importance of Elders or Knowledge Keepers in Indigenous cultures, as they hold or keep historical and cultural knowledges (22). Health providers must understand that, when relationships with the land are disrupted, this can negatively influence the health and wellness of Indigenous Peoples (22). In Indigenous cultures, Traditional Knowledges are shared and passed on to younger generations through language, cultural practices, oral traditions, storytelling, songs and ceremonies (20, 23).

Western science often views Indigenous knowledge or ways of generating knowledge as subjective and contextual (20). Canada's educational institutions frequently fail to recognize Indigenous Knowledge and pedagogy (24). Indigenous Knowledge has historically been portrayed as being opposite to western or scientific forms of knowledge (24). The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) proclaims that Indigenous Knowledge is at risk of disappearing and requires protection, and that Indigenous Peoples are entitled to the recognition, full ownership, control and protection of their own cultural and intellectual properties (16).

Indigenous Perspectives of Health

Indigenous Peoples' concepts of health and wellness are influenced by their worldviews, ways of knowing, Traditional Knowledge, and cultures of experience (25). Central to health is the belief in the crucial importance of one's connection to their language, land, beings of creation and ancestry. A caring family and environment are also intimately linked to the health of individuals (25, 26).

For many First Nations, health and wellness are primarily viewed from a wholistic lens that features a balance or interconnectedness between the mental, physical, emotional and spiritual aspects of life. The medicine wheel is often used to conceptualize this understanding of life and these relationships (25).

Métis worldviews include traditional environmental knowledge that was based on community practices and created the foundation for understanding the natural world, for building skills and for behaviours adaptable and applicable to other facets of Métis life (27). Métis health and wellness is wholistic and includes the individual, family, community, neighbourhood and Métis nation across an individual's lifespan (28). The foundation of the Métis worldview is belief in the interconnectedness of all things and the importance of the natural world (27). The Michif language is integral to the evolution of the Métis culture and worldview (27).

Among the Inuit, Inuuqatigiittiarniq represents similar wholistic aspects (linking mind, body and spirit) and provides a worldview of Inuit health (25, 29). Inuit concepts of health represent both individual level attributes and broader social factors within which the individual lives, and integrate the conceptual understanding of the balance, holism and interconnectedness of life and health (25). Inuit Qaujimajatuqangit (IQ) is a worldview shared by Inuit across the circumpolar world (19). IQ helps to define Inuit ways of knowing and details beliefs and values that serve as a guide and expectations (19).

Western or mainstream perspectives of health are generated, recorded, and transmitted using scientific principles and hence differ from Indigenous perspectives of health. Western perspectives dominate the approaches and practices taken by most health providers who think of health as the absence of an illness and whose assumptions frequently **pathologize**[G] Indigenous health inequities. A failure of health providers to approach Indigenous health in the context of colonization, racism and negative stereotypes of Indigenous Peoples can lead to a presumption that poor health status is the result of an individual's own biological failures (30). In contrast, all health provides are advised to adopt an approach that examines the structures and systems in place and their stance in relation to those systems. (31). First Nations, Inuit and Métis knowledge systems have been established through time. Health providers' capacity to understand and value how these knowledge systems define Indigenous health can support the delivery of better informed and culturally safe health care.

Traditional Medicine and Healing

For First Nations, Inuit and Métis, traditional cultural healing practices are integral to health and wellness, however Western health care providers frequently overlook these practices when they seek to prevent and treat chronic health issues. Traditional practices should be acknowledged as central to Indigenous health and wellness and be integrated into and complement Western health-care practices (32). Indigenous collaboration and guidance with non-Indigenous health providers can involve empowering Indigenous experts, learning from Knowledge Keepers, recognizing traditional medicine and healing practices in local communities, and facilitating access to traditional medicine (32). Indigenous approaches to health and wellness commonly consider mental, social, spiritual, physical and ecological dimensions. Central to this approach is the idea of maintaining a healthy balance within the individual and also between the individual, society and the natural world (33). First Nations traditional healing includes knowledge, health and wellness practices, ceremonies, plant, animal or mineral-based medicines and therapies (32). Traditional Healers are considered to be highly knowledgeable and, when necessary, they administer remedies that include herbal treatments and other therapeutic practices, such as Sweat Lodge (sweat bath), fasting, massage, diets, hydrotherapy and mud and clay poultices (33). The Canadian health system has been called on to recognize, acknowledge and value Indigenous healing practices and, when requested by Indigenous Peoples, to integrate these care practices in collaboration with Indigenous healers and Elders (34).

Traditional Tobacco

Many First Nations and Métis communities use traditional tobacco for medicinal, spiritual, sacred and ceremonial purposes. Traditional tobacco is burned, but not inhaled like commercial tobacco products. In some First Nations, when traditional tobacco is burned, the smoke represents an offering (social custom for giving thanks) and used during ceremonial activities (35). Traditional tobacco is the first of four sacred medicines of First Nations peoples (the other three are sage, cedar and sweetgrass). Traditional tobacco is identified as the first plant that the Creator gave to First Nations and Métis Peoples, and the ceremonial burning or smudging of traditional tobacco is used to communicate with the spirit world (35, 36). Tobacco opens the door and permits communication to take place and when one makes an offering of tobacco, they communicate their thoughts and feelings through the tobacco as they pray for themselves, their family and relatives and others (35).

BACKGROUND

The sacredness of tobacco is an important cultural practice of many First Nations in Canada. For many Indigenous Peoples with historical traditional or sacred tobacco practices, these cultural traditions are in jeopardy, due to the loss of cultural practices (37).

Early commercial tobacco smoking was introduced to First Nations and subsequently Métis and Inuit communities through colonization by the first European explorers and settlers through trade (38). Inuit culture was tobacco free, but today the Inuit bear the largest burden of commercial tobacco use among Indigenous Peoples in Canada.

In Canada, the use of traditional tobacco in ceremonial practices during cultural events was deemed illegal under the Indian Act, prompting the use of commercial tobacco in its place (34). See **Appendix G** for further details on cultural protocols for offering traditional tobacco.

The Impact of Colonization on Indigenous Peoples (CONTENT WARNING)

The health and wellness of Indigenous Peoples, families and communities in Canada is inextricably connected with colonization (19, 27, 30). The contemporary impact of colonization on many Indigenous Peoples in Canada is evident in diminished self-determination and a lack of influence on policies that directly pertain to them and their communities (39). Indigenous Peoples also experience catastrophic inequities in health outcomes. The trauma of colonization, on the cultural, social, economic, health and wellbeing experiences of Indigenous Peoples in Canada, has been well documented. However health students and health providers have little understanding about how these colonial processes directly and indirectly contribute to the current health inequalities experienced by many Indigenous Peoples (40). Colonization of Indigenous Peoples in Canada, often enacted through federal legislation, has taken the form of forced assimilation, appropriation of Indigenous lands, stolen resources and harmful resource development, forced relocation of Inuit communities into permanent settlements, the establishment of residential schools, the **Sixties Scoop**^G and disregard for land claims, including those of Métis peoples (19, 30, 39, 40).

The Indian Act is a federal law that has undergone many amendments but remains in effect in Canada today. This law authorizes the Canadian government to regulate and administer the affairs of registered Indians and reserve communities (41). The Indian Act served to strip Indigenous communities and Peoples of land and disrupt Indigenous economies. This created dependence upon colonial authorities by severing sources of food because of restrictions on movement and nomadic hunting and gathering practices (30, 42). These disruptions clashed with Indigenous ways of knowing, doing and relationships with the land. The Indian Act gives the Canadian government the ability to determine who is 'Indian', places restrictions on Indigenous rights to legal representation, and undermines the roles and responsibilities of women in Indigenous societies (30, 42). The Inuit, who historically were nomadic and hunted across the circumpolar north of what is now Canada, were forced under the Indian Act to relocate to remote permanent villages and even experienced the mass slaughter of sled dogs, which were used for traditional nomadic hunting practices (42).

The federal residential school system, established by the Government of Canada after Confederation (1867), systematically removed Indigenous children from their families, homes and communities and institutionalized them into residential schools with the goal of indoctrinating them into the culture of the dominant Euro-Christian Canadian society (34). European civilization and Christian religions were assumed to be superior to Indigenous culture, and Indigenous cultures were deemed savage and brutal—an extreme prejudice that created discriminatory hostilities towards Indigenous cultures and spiritual practices (34). Residential schools were in existence for more than 100 years across Canada (the last one closed in 1996) and it is estimated that over 150,000 First Nations, Métis

and Inuit children passed through residential schools (34). Many children did not survive, and those who did experienced the traumas of separation, loss of family, loss of culture, and loss of language. Many also experienced physical, emotional, mental, spiritual and sexual abuse and some died at the schools or during attempts to escape (30, 34). The traumatic impact on those who survived residential school experiences and their descendants has been profound (34, 40). The Truth and Reconciliation Commission (TRC) travelled across Canada for six years, hearing and witnessing the experiences of Indigenous people who were taken from their families as children, and who endured their childhood in residential schools. The TRC report, released in 2015, summarizes these discussions and the findings of the catastrophic harms inflicted by the residential school system (34). Please refer directly to the [National Centre for Truth and Reconciliation](#) website for further important reading.

Historical trauma impacts health because of the experience of mourning of losses, survivor guilt, and intrusive cognition/emotion. The children of parents who attended residential schools can be affected by their parents "re-living" events from their time in the schools, and because their parents were deprived of learning parenting skills at home (43). The destruction of identities, families and communities and the subsequent intergenerational traumas have caused significant harms and have substantially impeded the transmission of Indigenous cultures, values, beliefs and practices, such as parenting practices, across generations of Indigenous Peoples (30).

Indigenous Determinants of Health and Health Equity

A health inequity is defined as differences that occur in one's health and wellness status that are preventable and identified as unfair and modifiable (44). The catastrophic impact of **Indigenous determinants of health**[G] upon First Nations, Inuit and Métis Peoples and communities manifest differently across these distinct groups (22, 39). However, Indigenous Peoples in Canada share colonialism as the fundamental determinant of their health and wellness and so it is critical to understand the ongoing impacts of colonization. A lens that looks beyond the "social" determinants of health frameworks and considers a variety of additional forces that impact Indigenous health is essential to fully understand and contextualize the health inequities experienced by Indigenous Peoples (22). Indigenous determinants of health are not a result of biological or individual influences; they are unique [to this population] and intersect, and are all essential to understanding how Indigenous Peoples' health is determined (22).

Historical, geographic, economic, narrative and structural determinants influence Indigenous Peoples' health (22). Historical experiences shared by the ancestors of First Nations, Inuit and Métis Peoples are the imposition of colonial institutions and systems, and the disruptions of their distinct lifestyles (39). These experiences continue to impact Indigenous health today through social, political and legal structures that place Indigenous Peoples on the margins of contemporary Canadian society (22, 39). Legislation such as the federal Indian Act has been harmful to the health and lives of First Nations peoples (39). All Indigenous groups have experienced loss of land, language and culture. Racism, discrimination and social exclusion are all shared experiences among Indigenous groups, and Indigenous Peoples in Canada experience multiple inequalities that impact their health (30, 39, 45, 46). A special, deep and spiritual relationship exists between Indigenous Peoples, their local land and traditional territories, and their health (21, 22). The land serves a fundamental health-supporting role that is inseparable from Indigenous cultures, social relationships and traditional ways of living (22). Environmental dispossession has had, and continues to have, devastating impacts on Indigenous health by compromising the transfer and practices of Traditional Indigenous Knowledges across generations, resulting in negative impacts on community health and wellness and cultural identity (22).

Many First Nations, Inuit and Métis Peoples experience poorer health outcomes than their non-Indigenous counterparts and thus disproportionately greater health inequities and inequalities (47). Indigenous Peoples, communities and nations that experience these health inequities carry the additional burden of these health issues and are frequently restricted from accessing the resources they urgently need to address their health needs (39). A lifelong trajectory of health is influenced and impacted by intersecting Indigenous determinants of health (39). Indigenous health outcomes impacted by the Indigenous determinants include infant mortality, unintentional injury mortality, mental health issues, suicide, substance use, cancer, lung disease, arthritis, asthma, hypertension, diabetes, obesity, disability, oral health issues, and infectious diseases (48).

Contemporary Indigenous health inequities are the result of historical and contemporary colonial policies. The additional social determinants that impact Indigenous health include: health care, education, housing security, employment, income, food security, community infrastructure, cultural continuity and environmental stewardship (30, 46). Access to clean drinking water is a fundamental expectation for most Canadians. Access to safe, clean drinking water for many First Nations communities in Canada is not a reality, and many First Nations live under permanent boil water safety advisories (49).

Indigenous Reproductive Care and Health Equity

Many Indigenous women and persons living in rural or remote areas of Canada have no option but to leave their homes in their rural or northern communities at 36 weeks gestational age and move temporarily to hospitals and hotels in an urban setting to give birth. This experience is defined as a mandatory birth evacuation (50). Leaving the community, the land and support network to access labour and birthing services frequently results in cultural, social, emotional and financial hardships, leading to experiences of stress, isolation, loneliness and reduced psychosocial wellbeing (50, 51). Birth evacuation in Indigenous communities is currently guided by Health Canada policy (50). The National Aboriginal Council of Midwives (NACM) strongly advocates for the return of routine reproductive care to Indigenous communities across Canada, but also recognizes that evacuation for access to specialized childbirth services may be medically necessary for some Indigenous women and persons in order to access advanced neonatal care (52).

Systemic Racism and Indigenous Health

The systemic racism and discrimination experienced by Indigenous Peoples in Canada is rooted in Canada's colonial history. These experiences for Indigenous Peoples continue today, are recurrent, and are pervasive across our health system (30). In Canada, health services for Indigenous Peoples are delivered primarily by non-Indigenous health providers; these providers often lack an understanding of the provision of culturally safe health services and of Indigenous health knowledge and perspectives. Implicit or unconscious biases held by health providers, manifested in negative attitudes towards and stereotypes of Indigenous Peoples, make it challenging for Indigenous people to access timely, respectful and culturally safe health services (53). Racism and discrimination cause harm and have a direct impact on the health and wellness of Indigenous Peoples (54). Many First Nations, Inuit and Métis Peoples have reported experiences of being ignored, mocked, belittled and disrespected by health providers in the Canadian health system (55-57). Power imbalances are inherent in our health system. A crucial need exists for all health providers to address these power imbalances and integrate cultural humility and cultural safety into daily practice.

Multiple barriers exist for Indigenous Peoples, families and communities to access health-care in Canada. Health-care for for First Nations Peoples and the Inuit is legislated under the federal Indian Act through the Non-Insured Health Benefits Program. This federal benefits structure can create barriers to care by requiring on-reserve residency for some insured health services and limiting access to health services by onerous approval processes (58).

Self-determination is identified internationally as an Indigenous health determinant (28). The catastrophic impact of residential schools, the Indian Act, and the failure of the Government of Canada to keep Treaty promises have damaged the trust and the relationship between Indigenous Peoples and the government (34). Embracing Indigenous Peoples' right to self-determination within and in partnership with Canada is required (34). Indigenous Peoples' rights to self-determination must be incorporated into Canada's constitutional and legal frameworks and institutions (34). Indigenous Peoples in Canada have the right to access and revitalize their own laws and governance within their own communities, and to protect and revitalize their own cultures, spiritual and religious traditions, customs, ceremonies, languages and other ways of life (16, 34).

Indigenous Motherhood and Parenting

The staggering impact of colonization, residential schools and discriminatory policies on First Nations, Inuit and Métis motherhood continues to affect Indigenous women and persons in their parental roles (59). For many Indigenous women and persons in Canada, mothering is an important avenue for restoring cultural traditions and strengthening family connections that have been negatively impacted by residential schools and other child welfare practices (60). Cultural and Indigenous traditions of motherhood are shared among families and across generations of mothers to daughters through experiences, role modeling, ceremonies and stories. Indigenous women and persons can find strength in motherhood that assists them to assert their identity and self-determination and supports them in resisting racism and social inequities (60). Community-based programming that supports Indigenous mothers can include prenatal programs and access to Indigenous midwifery services.

Commercial Tobacco and Electronic Nicotine Delivery Systems (ENDS) Use Among Indigenous Women and Persons

In Canada and worldwide, there is a higher prevalence of commercial tobacco use among perinatal Indigenous women (61, 62) than among their non-Indigenous counterparts. Researchers conducted a maternity experiences survey of Indigenous women in Canada that identified Inuit women to be at highest risk of smoking commercial tobacco during their pregnancy, whereas First Nations women living off-reserve to be at lowest risk (62). The proportion of women who reported smoking commercial tobacco during their last trimester of pregnancy was 20.6 per cent among First Nations women, 29 per cent among Métis women, and 62.6 per cent among Inuit women (62). The factors that influence the use of commercial tobacco are similar among non-Indigenous and Indigenous populations. Socioeconomic status (SES) is linked directly to smoking; pregnant women who smoke commercial tobacco are disproportionately represented among individuals with lower socioeconomic status who are more likely to experience poverty and less likely to have access to education and job opportunities (63). The burden of reduced SES for many Indigenous people has occurred across generations due to the direct and indirect harms of colonization and the erosion of Indigenous social structures, cultures and community resources (34, 64). Smoking commercial tobacco can be a shared activity among families, support networks and communities. In particular, a partner who uses commercial tobacco can be a significant predictor of whether a woman uses commercial tobacco products before and/or during pregnancy (65).

Commercial tobacco use (including electronic nicotine delivery systems (ENDS)) during pregnancy is well established as the most important modifiable risk factor linked to adverse pregnancy and long-term health outcomes for both mother and child (3). Today's commercial tobacco products contain significant quantities of nicotine, which is one of the most highly addictive substances known (38, 66).

Smoke from commercial tobacco also contains thousands of chemicals and chemical compounds, some of which are directly linked to certain forms of cancer, lung disease and cardiovascular disease (67). Quitting commercial tobacco use, including ENDS use, is extremely difficult. Pregnancy can motivate many women and persons to attempt to quit commercial tobacco and protect the fetal health. Commercial tobacco cessation at any point during pregnancy benefits both the pregnant woman and the baby (68).

Many smoking reduction and cessation services are western centric and currently don't meet the needs of, or engage, Indigenous Peoples and their communities (69). Indigenous women frequently report that they want to stop smoking but feel unable to quit. They may be unaware of cessation support services, find these services difficult to access, and/ or express significant concerns about being stigmatized for smoking (69). Inequitable access to healthcare resources, including commercial tobacco cessation programs, and the disproportionate exposure to Indigenous determinants of health are factors that contribute to the use of commercial tobacco and to the challenges to quitting smoking faced by Indigenous women and persons (70). On the other hand, role modeling, peer and family support, and the offer of culturally responsive (culturally tailored) approaches to smoking cessation have all been identified as vital considerations shaping Indigenous women's perspectives and values concerning smoking cessation during pregnancy (69). Smoking cessation services that do not align with Indigenous values and preferences, and neglect to include family or community supports or address the overall health and wellness of the individual, were identified as barriers to reaching and engaging Indigenous women in smoking cessation during pregnancy (69). The development of a culturally responsive smoking cessation intervention that includes collaboration and partnerships with Indigenous communities is integral to reaching pregnant Indigenous women and engaging them to participate in a smoking cessation program that resonates with their needs (69).

It is likely that most health providers have (or will) encounter Indigenous Peoples in their daily practice and it is essential that they, and students entering health professions, understand the complex factors that influence the use of commercial tobacco by Indigenous Peoples of reproductive age. All pregnant women and persons should be offered smoking reduction and cessation services during pregnancy and the post-partum period. It is a health system priority to identify and employ respectful strategies in order to effectively reduce smoking rates among perinatal Indigenous Peoples. Effective interventions that address commercial tobacco and/or ENDS use by Indigenous Peoples of reproductive age require an understanding of the historical, geographic, economic and structural contexts that surround them. Furthermore, practicing cultural safety involves analyzing power imbalances, institutional discrimination, the ongoing impact of colonization, and relationships as these apply to health settings (53, 71). It is essential to integrate Indigenous culture and cultural safety into commercial tobacco cessation services in order to facilitate wellness (72). Interventions that are culturally safe, and tailored with the community and the individual, are critical to the health and wellness of all Indigenous Peoples (72).

Reconciliation involves an ongoing process of establishing respectful relationships, understanding the impact of the harms that have been inflicted, atoning for the causes (of these harms), affirming the inherent rights of Indigenous Peoples to be free of discrimination, and require that health providers act to change their behaviours (16, 34). Health providers must understand the unique and interconnected historical, structural, social and cultural factors that influence Indigenous health and wellness. Evidence-based guidance will be beneficial to health providers, organizations, and communities as they work to improve access to identified supports and valuable health resources that are designed and delivered in culturally safe, trauma-informed and respectful ways.

Theoretical Frameworks Guiding the Development of this BPG

Truth and Reconciliation

The Truth and Reconciliation Commission of Canada defines reconciliation as an ongoing process of establishing and maintaining respectful relationships between Indigenous and non-Indigenous people (34). Establishing respectful relationships requires an awareness of the past, acknowledgement of the harm that has been inflicted, atonement for the causes, and action to change behaviour (34). Furthermore, supporting reconciliation means working to overcome the inequality between Indigenous and non-Indigenous people with respect to income, health, and living standards, and eliminating/tackling racism, prejudice and sexism. This also aligns with UNDRIP, which affirms that Indigenous Peoples are equal to all other peoples, while recognizing the right of all peoples to be different, to consider themselves different, and to be respected as such (16). Additionally, Indigenous Peoples have a right to health and health services free from discrimination. Article 24.2 of the declaration states (page 18): "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right" (16).

This BPG aims to support reconciliation by working to overcome intersectional forms of inequity faced by all Indigenous Peoples in health settings and by actively supporting the implementation of the Calls to Action of the Truth and Reconciliation Commission of Canada 23 and 24 (34).

Cultural Humility and Cultural Safety

Health policies and the provision of health care must be culturally safe for First Nations, Inuit and Métis Peoples, and not impose ethnocentric perspectives based on colonial viewpoints. Cultural humility is a process of critical self-reflection undertaken to understand personal and systemic biases, and to develop and maintain respectful processes and relationships based on mutual trust (4). A health provider who demonstrates cultural humility humbly acknowledges being a lifelong learner in order to understand the experiences of others (4). Cultural safety is an outcome that is determined by the individual who receives care, and is based on respectful engagement that recognizes and aims to address the power imbalances inherent across the health system (4, 53). Cultural safety exists in an environment that is free of racism and discrimination, in which people feel safe when receiving health care. It can occur when health providers understand power differentials inherent in health delivery and institutional discrimination, and are motivated to fix these inequities through education, system change and lifelong critical reflection about their attitudes, beliefs, assumptions and values (73). Indigenous people, families and communities should be able to share their perspectives, ask questions and be respected by health care providers for their beliefs, behaviours and values (4). The Truth and Reconciliation Commission of Canada Calls to Action highlight the need to bridge the gap between Indigenous clients and non-Indigenous health care providers (34, 53). Integrating cultural humility and cultural safety into the Canadian health care system requires system-wide change.

Trauma-Informed Practice

It's important that health providers understand how an individual's experiences, including their exposure to trauma and violence, can affect their health behaviours and health status and especially their use of substances. It's also important that health providers recognize that reactions such as mistrust of health care systems, or reluctance to engage in care, may be the result of previous negative experiences or injury behaviour (74). Trauma-informed practice means integrating the understanding of past and current experiences of violence and trauma into all aspects of health service delivery (75). Working in a trauma-informed way is essential so that a client is not re-traumatized while receiving care in any health setting (74). Trauma-informed practice involves four principles; developing trauma awareness; providing an opportunity for choice, collaboration and connection; emphasizing safety and trustworthiness; and using a strengths-based and skills building approach (75).

Indigenous Determinants of Health and Health Equity

Indigenous health is influenced by complex, intersecting and interrelated Indigenous determinants and contexts (39). These determinants are more than social determinants alone, and include structural, historical and contemporary determinants that influence the health and wellness of Indigenous Peoples (22). Examining the Indigenous determinants of health provides health providers with a better understanding of how mental, physical, emotional and spiritual health and wellbeing are influenced by the broad range of Indigenous determinants, and the resulting health inequities that impact First Nations, Inuit and Métis Peoples in Canada.

Structural determinants of health can be proximal, intermediate and distal and are all interconnected (39). Proximal determinants that influence Indigenous health include the conventional social determinants of health, such as early childhood development, income and social status, education and literacy, social support networks, employment, working conditions, culture and gender (22). It is well known that experiences of social disadvantage and inequity impact Indigenous health. Intermediate structural determinants of Indigenous health are those that can facilitate or impede health through systems that connect proximal and distal determinants. These determinants include health promotion, health care, education, justice, social support and labour markets, but also Indigenous-specific determinants including relationship with the land, kinship networks, traditional languages and ceremonies and knowledge sharing (22). The most profound structural determinants of Indigenous health are the distal determinants, which represent historical, political, ideological, economic and social foundations (worldviews, spirituality and self-determination) (22).

Recommendations

> **GOOD PRACTICE STATEMENT:**
>
> As part of a wholistic health assessment, a member of the circle of care has a conversation about smoking, in a culturally safe way, with the Indigenous person of reproductive age and their support network.
>
> *As a good practice, this statement does not require application of the GRADE system.*

This is a good practice statement that does not require application of the GRADE system (9). Conducting an initial assessment before developing a plan of care or any intervention is a standard of professional practice (76). A wholistic health assessment that incorporates a conversation about smoking provides an opportunity to know if a person is smoking and/or if they are exposed to smoke. The purpose of the wholistic health assessment is not to focus only on smoking, but to also understand other facets of a person's health including their spiritual and emotional health.

A relationship that is based on trust and respect, and that is supportive and person-centered, must be established in order to initiate a wholistic health assessment. Relational practice is the foundation of a culturally safe approach. Cultural safety requires that health providers exercise cultural humility, which is a process of critical self-reflection on how personal and systemic conditioned biases affect another person's experience and overall well-being (4). Culturally safe practice aims to reduce the power imbalance between the health provider and person receiving care and respects Indigenous Peoples as decision makers in their own care (4).

Practices that ensure confidentiality and consent are critical and include health providers being clear about their role and about why they are asking the question(s), and asking permission before proceeding (77, 78). Ensuring privacy also contributes to cultural safety so it is important that health providers ask about smoking in one-on-one situations. Below are examples of questions to start talking about commercial tobacco use, as adapted from *Doorways to Conversation* (77):

- "I ask all community members about smoking because it's an important part of our overall health."
- "I regularly ask community members about smoking and other substance use. Would it be alright for me to do this now?"

The health provider may also choose to begin the conversation around what is most important to the person and listen for opportunities to make the connection with smoking, such as the person's concern about the health of their children (78). It is also important to have an understanding of the person's relationship with smoking and how it relates to other areas of their life, such as their social life or mental well-being (78). When they document the interaction, health providers should be transparent and let the person know when they are, or are not, recording answers, in order to maintain trust and make the person feel safe (77). Recording information about smoking use may be required for reporting on perinatal records, or necessary for making decisions about care.

Culturally safe practice also requires reducing shame associated with smoking. Regular and ongoing conversations about commercial tobacco use can help to reduce stigma (77). In pregnant women and persons in particular, health providers are encouraged to discuss commercial tobacco use during the first visit as well as at follow-up sessions (78).

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Culturally safe care also involves acknowledging preferences, culture, and traditional practices and being open to including (or facilitating the inclusion) of traditional medicines and ceremonies into care. Thus, as a health provider it is important to recognize that people may be using traditional forms of tobacco.

The following areas can be explored during the assessment:

- current smoking patterns,
- how smoking is a part of the person's life,
- history of smoking,
- smoking status and routines in the person's household/community,
- support mechanisms, and
- the person's strengths and situational advantages.

Cultural safety is ultimately defined by the person receiving care. Thus, the provider can ask the person what matters most in their experience of commercial tobacco use and possible treatment (4). In planning for care after the assessment and discussion, the health provider should support any changes that the person would like to make and not tell them what they have to do (78). The health provider should collaborate to establish a plan of care by understanding what is most important to the person; this helps to enact empowerment and strengthen capacities (78).

Supporting Resources

RESOURCE	DESCRIPTION
Doorways to Conversation: Brief Intervention on Substance Use with Girls and Women. In: Centre of Excellence for Women's Health [Internet], 2018. Available from: http://bccewh.bc.ca/wp-content/uploads/2018/06/Doorways_ENGLISH_July-18-2018_online-version.pdf	■ A resource to help facilitate collaboration in brief intervention for substance use between health providers and girls and women in the preconception and perinatal period. ■ Describes various approaches for working with girls and women in contexts ranging from primary care to sexual health services to anti-violence services.
Trauma Matters: Guidelines for Trauma-Informed Practice in Women's Substance Use Services. In: The Jean Tweed Centre [Internet], 2013. Available from: https://jeantweed.com/wp-content/uploads/2021/11/Trauma-Matters-online-version-August-2013.pdf	■ Guidelines to help health providers plan and deliver services that are based on trauma-informed practices.

RESOURCE	DESCRIPTION
Liberation! Helping women quit smoking: A brief tobacco intervention guide. In: Urquhart, C., Jasiura, F., Poole, N., Nathoo, T. & Greaves, L., 2012 [Internet]. Available from: http://bccewh. bc.ca/wp-content/uploads/2012/05/2012_ Liberation-HelpingWomenQuitSmoking. pdf	▪ A brief tobacco intervention guide to help health providers increase confidence when talking to women about smoking and provide comprehensive support tailored for women.
Talking about Substance Use in Pregnancy. In: Centre of Excellence for Women's Health [Internet], n.d. Available from: https://bccewh.bc.ca/wp-content/uploads/2018/10/Collaborative-Conversation-Ideas_Sept-19-2018.pdf	▪ Tips for health providers on how to cultivate collaborative approaches in speaking about substance use during pregnancy.
Thunderbird Partnership Foundation. A Cultural Safety Toolkit for Mental Health and Addiction Workers In-Service with First Nations People; n.d. [cited 2020 June 15]. Available from: https://thunderbirdpf.org/nnapf-document-library/ [select from "Guidebooks and Tool kits"]	▪ First Nations toolkit with relevant resources and guidance for mental health and addiction workers.

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Practice Recommendations

RECOMMENDATION 1:

It is recommended that smoking reduction and cessation services are **Indigenous-led**[G] and grounded in a wholistic approach to health and wellness. The circle of care provides culturally safe and tailored services with perinatal Indigenous women and persons and their support network.

Strength of the recommendation: Strong

Certainty of the evidence: Low

Confidence in evidence: Moderate

Discussion of Evidence:

Benefits and Harms

There may be benefits to the delivery of culturally safe smoking reduction and cessation services created with Indigenous women, their support network and in collaboration with Indigenous communities. Quantitative and qualitative literature provides some support for the benefits of culturally safe, tailored and Indigenous-led cessation services including that such services can improve the reach and engagement of participants, quit attempts, quit rates and the acceptability of smoking reduction.

To address commercial tobacco use during pregnancy in Indigenous communities, quantitative studies compared culturally tailored and Indigenous-led smoking reduction and cessation programs to usual smoking cessation programs that were accessible by most pregnant people in their local jurisdiction (79-82). The Indigenous-led programs were grounded in a wholistic approach and included interventions that targeted both the individual and their support network in addressing the normalization of commercial tobacco use during pregnancy (81, 83, 84). The smoking reduction or cessation interventions were offered in several Indigenous communities and provided by a circle of care that included Indigenous health providers and other local community members such as Elders and community health workers referred to as "Aunties" and "Native Sisters" (79, 80, 84, 85). The programs that included community-led support provided culturally relevant guidance on specific community level approaches and strategies to tailor the intervention for their community (79, 80, 84, 86). The studies found that community-led, culturally tailored smoking reduction and cessation services facilitate moderate reach and engagement, and that these programs are highly feasible and acceptable to pregnant Indigenous women (80, 84, 86). The literature also outlines that there may be an increase in the number of quit attempts and improvement in some of the overall quit rates following participation in these programs compared to the usual care (i.e., Western centric cessation services in two studies) (79-82, 84, 85). Most participants made multiple quit attempts before successfully achieving cessation (80, 82, 84). For those who were successful at stopping smoking, relapsing to smoking was followed by another quit attempt before consistent abstinence was achieved (84). No harms were reported in the quantitative literature.

Tailored smoking reduction and cessation services may include the strengths and values of the local Indigenous culture and also additional healthy pregnancy goals, such as stress reduction (79, 84). Indigenous health providers integrated traditional cultural practices, cultural strengths and values and historical ancestral teachings into the

delivery of their cessation services (79, 81). In the delivery of culturally tailored smoking cessation and reduction services— and to facilitate cultural and social connectivity—it is important to build on existing community resources and incorporate community strengths, community support networks and the cultural values placed on relationships in the community (81, 84).

Smoking reduction and cessation supports that are created with community members can include cultural activities and bi-weekly support groups that can assist in supporting stress reduction (83, 84). A focus on a strengths-based approach and skill building are features that also promote the engagement of women in smoking cessation services (81, 84). Smoking reduction and cessation services targeting the individual included one-on-one phone counselling delivered by community health workers (79, 86) and frequent home visits (84). Tailored counselling components included:

- discussing the risks and benefits of smoking reduction and cessation with each individual pregnant woman or person;
- encouraging people to quit for the health and wellness benefits of the family and the baby;
- providing the intervention with love, compassion and support; and
- exploring the person's social and environmental barriers to cessation (84).

It's important to ensure that Indigenous voices and cultural practices are included in the design, delivery and evaluation of tailored smoking reduction and cessation services. Indigenous communities' involvement in collaborative and participatory partnerships with health and social service providers assists to guide the design and the inclusion of appropriate cultural practices. The included studies that guided the development of culturally safe and secure smoking cessation interventions, did so by forming a Community Partner Reference Group, Community Advisory Committees or working with an Indigenous service organization that led, tailored and delivered the intervention (79, 80, 82, 84, 86). These groups/committees/organizations consisted of community members, such as Indigenous women, midwives and Indigenous health providers, who shared advice for all aspects of the smoking cessation services and ensured that these services were wholistically designed and delivered in a culturally safe manner within the local context (80, 84, 86). Indigenous health and social service providers are a valuable component of the health and social service workforce as they are closely acquainted with their community's social and cultural background, experiences, challenges and strengths (84, 86).

The qualitative evidence highlighted how Indigenous pregnant women, their support network, community members and health providers identify the need for the integration of the appropriate Indigenous cultural values and practices within individually tailored and community-level smoking cessation services in order to support their uptake. Culturally appropriate cessation supports should be tailored not only to the specific needs of the individual but also for the local community context. All participants expressed a strong interest in having smoking cessation services incorporate a cultural focus, cultural traditions and connections with ancestral knowledge (87-90). Some participants stated it would be helpful to work with health or social service providers who are grounded in participants' worldview and who operate within their cultural protocols (91). Some communities provided culturally targeted smoking cessation supports that included Indigenous community health workers in smoking cessation programs tailored to their specific community population (92, 93). Participants identified Elders and grandparents as culturally relevant community resources who can engage and support their community members, share their wisdom and knowledge, help influence the reduction of smoking in the community and promote community health in other ways (94). Testimonials from Indigenous community members were identified as powerful, and success stories of smoking

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cessation were often linked to Elders and community members (93-95). Participants frequently viewed Elders as important allies in addressing smoking in their communities because of their influence and the respect for them in their communities (96). Some participants reported that group-based approaches are a good cultural fit, when the collective nature of groups aligns with Indigenous cultures. In these circumstances, individuals may be more likely to be motivated to change their smoking behaviour (87). There were no harms reported in the qualitative studies. Indigenous women and persons reported they were seeking reduction and cessation services that provide a trauma-informed environment where they feel safe, where trusted relationships are developed with their health worker, where health workers understand the impact of trauma, and where health and wellness services are provided in a culturally safe manner (89, 90).

The certainty in the quantitative evidence was low due to concerns about how the studies were conducted and small sample sizes. The overall confidence in this evidence was moderate due to moderate concerns about how the studies were conducted.

For more detailed information on the impact of the intervention (Indigenous-led, culturally safe and tailored with the person and community) on the prioritized outcomes, the qualitative experiences reported and the grading of the evidence, refer to the underlined evidence profiles.

See additional content on how health providers can support smoking reduction and cessation in the "Implementation Tips".

See **Appendix H** for further details on cultural safety terminology.

Values and Preferences

Health providers' use of a strengths-based approach to smoking cessation was valued by participants (90). Participants expressed the desire for health workers to approach community members in a non-judgmental, culturally appropriate way and to recognize that participants may prefer health providers to 'meet women where they are' in their smoking journey (90).

Many participants reported that one-on-one conversations with community members or case managers were the preferred interpersonal channels of communication and outreach by community health workers. Participants reported the important value in developing trusting relationships with their health provider, where the participant felt safe to disclose the realities of their lives and feel supported (81).

Participants valued smoking cessation programs that integrated tailored cultural content and that recruited community members to deliver these cessation services in culturally appropriate ways with pregnant women who smoke (86). Some participants expressed the need for positive or strengths-based message use and suggested shifting language use around cessation, and use "stop smoking" rather than "quit smoking" to avoid experiencing negative feelings of failure (97).

A culturally tailored reduction and/or cessation program was valued by participants where the approach was "flexible, strengths-based, family-centred, wholistic, relationship-based, and participant-led" (81).

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Indigenous community health workers know their communities very well and can relate and interact with the participants in a culturally appropriate way (86). These "Aunties" reported that knowing and being involved with their community, and actively going out into the community to offer cessation support, was valued by participants (86).

Participants valued the opportunity to share stories and the activities offered, and the information on strategies for coping (84). When women share their stories in a group-based smoking cessation support founded in the traditions of storytelling, it encourages self-reflection on their life course, the role of people and places in these stories, and their pregnancy (98).

Most participants preferred a fact-based messaging approach on the harms of smoking during pregnancy (79). Consistent with Indigenous cultural values, smoking reduction and cessation programs emphasizing the health and welfare of children were valued by participants (79).

Health Equity

Indigenous community health and social service workers can reach pregnant Indigenous women and persons, and promote access to health care and social services. They are familiar with the local culture and therefore, have a unique ability to reach members of their community. For instance, **Māori**[G] community health workers are an integral part of the health care workforce in New Zealand.

Indigenous women may face barriers in accessing services, such as transportation and cost of nicotine replacement services (NRT). In one study, NRT was provided free of charge to participants and household members (84). Transportation to and from group program settings was also provided free of charge for participants (due to remote geography and no public transit) (84). Please refer to **Recommendation 4** that supports resources for access to NRT.

Panel Justification of Recommendation

The panel identified smoking during pregnancy as a high priority issue for Indigenous women and persons due to the known harms related to smoking. The health inequities experienced by Indigenous people and communities include multiple barriers that make smoking cessation more difficult to achieve and reduce or prevent access to Indigenous-led, culturally tailored smoking reduction and cessation services. The panel acknowledges that access to smoking reduction and cessation supports may not be available from an Indigenous or community-led service and don't assume that community members are seeking this type of program. Conventional (not Indigenous or community-led) smoking reduction and cessation programs are available and accessible for health providers to offer perinatal Indigenous women and persons and their support network. It is imperative that health providers offer smoking cessation and reduction services.

The panel noted that there may be benefits to providing Indigenous-led, culturally safe and tailored smoking reduction and cessation services with Indigenous pregnant women and persons in the quantitative evidence. However, the evidence is uncertain. The panel also noted that it is imperative to address the high prevalence of perinatal smoking in Indigenous communities, as the certain harms of perinatal smoking are well established. The panel further noted that the qualitative evidence highlights the value placed on Indigenous-led and culturally tailored smoking reduction and cessation services that are acceptable by and accessible to Indigenous pregnant women and persons who smoke. There were no harms reported in the literature. According to GRADE methods, there are five paradigmatic situations where panel members can justify a strong recommendation based on low certainty of evidence. Although the certainty of the evidence of the effects was low and the confidence in this evidence was

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moderate, based on the critical importance of addressing the barriers to smoking cessation for perinatal Indigenous women and persons that are rooted in health inequities, and the risk of perpetuating ongoing trauma and the ongoing catastrophic harms related to health inequities and smoking in pregnancy, the panel determined the strength of this recommendation to be strong.

Implementation Tips

Implementation tips from the panel

- In the absence of an Indigenous or community-led program, providers should offer conventional smoking reduction and cessation services.

- Including Traditional Healers working with health and social service providers is important and instrumental to the design, delivery and successes of smoking reduction and cessation services.

- A person-centred approach places the community member at the centre of smoking cessation services and acknowledges that they are the experts in their own health and wellness.

- Health and social service providers are to be aware of community specific capacity issues such as the availability of internet, Wi-Fi or other telecommunication routes (e.g., land line and cellular telephone) used in smoking cessation programs to ensure access by all community members who want to participate.

- Although incentives were used in some of the included evidence, the panel cautions that this can be viewed as a colonizing approach. The views towards incentives may differ across Indigenous communities; therefore, it is important for the community or health service organization to determine whether or not incentives should be a part of a smoking reduction and cessation service.

Table 4: Intervention Details from the Evidence

KEY INTERVENTIONS	DETAILS FROM THE EVIDENCE
Cultural tailoring	- Smoking cessation programs can incorporate culture into the messages delivered in cessation services, focusing on families and relevant traditional cultural values and practices such as ways of being healthy (83). - Incorporate a wholistic approach to smoking cessation that represents the mental, emotional, spiritual and physical aspects of Indigenous health and wellness (97). - Include other cultural traditional activities into the cessation services such as drumming, or cooking and eating meals together in way that incorporates Indigenous culture and traditions around food (97). - Emphasize the importance of positive cultural and community activities (e.g., berry picking, art activities) for coping with withdrawal/stress or reducing and preventing smoking and celebrating culture and social connections (81, 83). - Culturally relevant images used in any promotional brochures or virtual resources are more likely to resonate with individuals and communities (97).

KEY INTERVENTIONS	DETAILS FROM THE EVIDENCE
Fostering Indigenous community-led approaches	▪ Community Reference Working Group or Community Advisory Committee: Three studies guided the development of a culturally relevant smoking cessation intervention with a group of Indigenous women, midwives and other health or community workers to ensure that the program was conducted in a culturally safe fashion (80, 83, 84). ▪ Community Health Workers have an intimate understanding of their community's socio-cultural background, experiences, challenges and strengths and are in a unique position to reach and mobilize members to provide peer support for community members (86). ▪ The Community Reference Group was integral to ensuring the smoking cessation program met the needs of Indigenous women in a respectful manner (84). ▪ Partnering with Aboriginal Maternal Infant Health Services ensured that cessation services were provided in a framework of comprehensive pregnancy care that addresses cultural and social needs by a team with ongoing relationships with the women (84).
Addressing social and environmental barriers and managing stress	▪ The provision of smoking cessation services must be understood within the appropriate historical and socio-cultural context around tobacco use (94). ▪ Stress management, increasing self-efficacy, providing quit services in groups and one to one consultation for maternal smokers are all deemed important (92). ▪ Address social norms about tobacco use, emphasizing the importance of positive cultural and community activities for example activities such as berry picking for coping with stress (83). ▪ Use a strengths-based approach to empower client self-efficacy and confidence by celebrating positive actions toward smoking reduction and cessation, however small, that women are successfully accomplishing during their smoking journey (81, 90). ▪ Meet women and persons where they are at in their smoking journey, using a non-judgmental and kind approach to provide a safe space to discuss smoking where the woman or person feels supported (89, 90). ▪ Assist individual women to identify smoking triggers, potential barriers and other social issues they face; support women to identify strategies to manage these and identify other sources of support (84). ▪ Culturally sensitive group-based supports can aid in healing and build resilience for program participants (97).

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KEY INTERVENTIONS	DETAILS FROM THE EVIDENCE
Success stories, testimonials and storytelling	■ Participants shared their experiences on the impact of smoking (95, 97). ■ Participants shared in groups their stories about addressing their smoking and the advice received from health and social service providers (99). ■ Participants reported sharing strategies with each other that helped guide them through nicotine cravings and withdrawal (87). ■ Participants shared stories about how they had successfully asked others not to smoke (95). ■ Participants valued the opportunity to share stories and the information about coping strategies in group-based support meetings (84). ■ Graphic felt boards of the houses and yards of participants were used to explore the management of household smoking (93). ■ One program features digital success stories of women who were successful in stopping smoking (83). ■ Structured commercial tobacco cessation services for First Nations fathers incorporated testimonials, talking circles and storytelling to allow fathers to share their experiences, camaraderie and mutual support of each other on the impact of smoking, and to build resilience (97).

Supporting Resources

RESOURCE	DESCRIPTION
British Columbia Centre of Excellence for Women's Health. Hearing the Perspectives of Aboriginal Girls on Smoking; 2009; [cited 2020 June 15]. Available from: https://bccewh.bc.ca/wp-content/uploads/2012/05/2009_Hearing-Perspectives-Aboriginal-Girls-Smoking-lowres-singles.pdf	■ Summarizes how age, gender, culture and context intersect to shape Indigenous girls' experiences of smoking
Cancer Care Ontario, Indigenous Cancer Control Unit. Indigenous tobacco online resource [cited 2020, June 15]. Available from: www.tobaccowise.com	■ "Tobacco-wise" resources for First Nations, Inuit and Métis ■ Success stories
Cancer Care Ontario. Cancer Care Ontario E-Learning. [cited 2020, June 15]. Available from: https://elearning.cancercare.on.ca/	■ Online learning on Indigenous Cultural Safety ■ Multiple courses available for free
EQUIP (Equipping Health for Equity) Health Care [cited 2021, April 30]. Available from: https://equiphealthcare.ca/ https://equiphealthcare.ca/resources/toolkit/	■ Toolkit and resources to support health providers and organizations to adopt equity-oriented practices ■ Useful ideas, approaches and practices for providers and organizations to tailor to their own local context and needs ■ Trauma-and Violence-Informed Care (TVIC) ■ A tool for Health and Social Service Organizations and Providers

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RESOURCE	DESCRIPTION
Examples of Ontario health services with Traditional Healer resources https://www.chigamik.ca/?s=traditional+Healing&submit=Search https://www.noojmowin-teg.ca https://aboriginalhealthcentre.com/services/traditional-healing/ https://www.misiway.ca/index.php/services/traditional-healing-program https://mushkiki.com/program/traditional-wellness-program/ https://aht.ca/our-approach/traditional-teachings/	▪ Traditional Healers promoting community and community member health and wellness
First Nations Health Authority (FNHA). FNHA's Cultural Safety and Cultural Humility Key Drivers and Ideas for Change; n.d.; [cited 2020 June 15]. Available from: https://www.fnha.ca/Documents/FNHA-Cultural-Safety-and-Humility-Key-Drivers-and-Ideas-for-Change.pdf	▪ Key drivers and Ideas for Change from British Columbia's First Nations Health Authority
First Nations Health Authority (FNHA). FNHA's Policy Statement on Cultural Safety and Cultural Humility; n.d.; [cited 2020 June 15]. Available from: https://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf	▪ Cultural safety and humility recommendations from British Columbia's First Nations Health Authority
Hemsing, N., Greaves, L., Poole, N. Tobacco Cessation Interventions for Underserved Women. Journal of Social Work Practice in the Addictions. 2015 July 3; 15(3): 267-287. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4867857/pdf/wswp-15-267.pdf	▪ Tobacco Cessation Interventions for Underserved Women ▪ Features key components of a woman-centred approach

RESOURCE	DESCRIPTION
Provincial Health Service Authority of British Columbia. National Indigenous Cultural Safety Collaborative Learning Series; 2020; [cited 2020 August 31]. Available from: http://www.phsa.ca/	■ National webinar series that provides an opportunity to share knowledge, experiences and perspectives in support of collective efforts to strengthen Indigenous cultural safety across sectors
Public Health Training for Equitable Systems Change. Health Equity; 2020; [cited 2020, June 15]. Available from: http://phesc.ca/ health-equity#culturalsafety-indigenous	■ A series of Indigenous specific education opportunities on cultural safety, cultural humility and anti-oppression training
Southwest Ontario Aboriginal Health Access Centre. Ontario Indigenous Cultural Safety Program; 2020; [cited 2020, June 15]. Available from: http://www.sanyas.ca/ https://soahac.on.ca/service/traditional-healing/	■ Education in Indigenous Cultural Safety for health and social service providers (some cost is associated with this training program) Information on traditional healing
Thunderbird Partnership Foundation. A Cultural Safety Toolkit for Mental Health and Addiction Workers In-Service with First Nations People; n.d.; [cited 2020 June 15]. Available from: https://thunderbirdpf.org/ nnapf-document-library/	■ Toolkit with relevant resources and guidance for mental health and addiction workers

RECOMMENDATIONS

RECOMMENDATION 2:

It is recommended that the circle of care offers smoking reduction and cessation counselling with Indigenous women and persons during pregnancy and the post-partum time. It is important that counselling is provided in a culturally safe way and that it is part of an overall wholistic approach to health and wellness.

Strength of the recommendation: Strong

Certainty of the evidence of effects: High

Confidence in evidence: Not Applicable

Discussion of Evidence:

Benefits and Harms

Smoking reduction and cessation counselling may offer important benefits. Counselling interventions are those that provide motivation to quit, support or increase problem solving and coping skills (100). Counselling interventions include motivational interviewing, cognitive behaviour therapy, psychotherapy, relaxation, problem solving facilitation and other strategies (100). The literature pertaining to counselling is supported by both direct literature (counselling with Indigenous pregnant and postpartum population) and indirect literature (counselling with non-Indigenous specific pregnant and postpartum population).

For the outcome of quit rates related to counselling within Indigenous pregnant and postpartum populations, the direct literature is limited due to few studies, with only a small number of participants (100). The literature does, however, provide support for counselling in terms of reach and engagement within Indigenous pregnant and post-partum populations (79-81, 86, 101, 102). Counselling approaches had moderate reach and high engagement in Indigenous women and persons during pregnancy and the post-partum time (79-81, 86, 101, 102). It is important to note that the smoking reduction and cessation counselling included components of cultural safety. In particular, counselling was individually tailored, culturally adapted, involved strengths-based approaches, and involved persons' support network. Comparator groups in 4 randomized studies received the usual smoking reduction and cessation care available within the local jurisdiction and this included referrals to quit lines, and the use of a 3 As or 5 As approach. The comparators did not include any components of Indigenous cultural safety. Further details are outlined in the "Implementation Tips".

The indirect literature for increased quit rates in pregnant and postpartum populations is well established in meta-analyses. Overall, indirect meta-analytic literature suggests that, when compared with usual care and less intensive interventions, smoking reduction and cessation counselling increases quit rates in late pregnancy (100). Counselling has also been found to increase abstinence up to 17 months postpartum although the effect from six to 11 months postpartum is not as clear as the effect from birth to five months and 12 to 17 months postpartum (100). The meta-analytic evidence also shows that counselling interventions resulted in a 17% reduction in low birth weight babies, a 22% reduction in neonatal intensive care admissions, and significantly higher average birth weight; the difference in preterm births and stillbirths is unclear (100).

The overall literature was of high certainty. For more detailed information on the impact of the intervention (counselling) on the prioritized outcomes, refer to the evidence profiles.

Values and Preferences

Values and preferences were reported in the direct literature. Indigenous women were satisfied and shared positive views regarding the smoking reduction and cessation programs that incorporated counselling (84, 101, 103). Women also expressed appreciating the frequency of support, information provided, household support and free NRT (84).

Health Equity

All health providers have an ethical responsibility to offer equitable access to counselling to all people who use commercial tobacco. Health providers need to remember that the individual ultimately has the choice of whether to engage in counselling.

Panel Justification of Recommendation

There are benefits of smoking reduction and cessation counselling and no significant harms were identified. The panel agreed that Indigenous women and persons would value the outcomes and that it is unethical not to offer the choice of counselling. Further, the certainty of the evidence was high. Therefore, the panel determined the strength of the recommendation to be strong.

Table 5: Intervention Details from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Culturally adapted counselling	■ Recruitment and/or cessation support given by Indigenous members of the community (79, 86, 103, 104) ■ Utilization of culturally tailored learning material (videos, brochures) (102) ■ Program is based on Indigenous models of health and/or consultation with Indigenous community members (84, 103) ■ Sessions were either in the local language (Yup'ik) and/or English language, depending on the woman's preference (79) ■ Encouraging traditional healthy ways of coping with withdrawal symptoms and/or stress such as positive cultural and community activities (e.g. berry picking or walking on the tundra) (79)

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Strengths-based approaches	■ Positive role-modeling (e.g., videos shown to participants included stories of Alaska Indigenous people who stopped using tobacco during pregnancy) (102, 103) ■ A strengths-based approach was used by engaging with the community reference group, and building on existing service infrastructure, relationships in the community and the community's own strengths (84). ■ Intervention focused on using the strengths and values of the Yup'ik culture (79)
Individually tailored	■ Community health workers (referred to as "Aunties") delivering care determined the frequency and content of intervention delivery based on their engagement with client (86). ■ Individually tailored counselling was provided based on assessment and barriers to quitting. At all visits, progress was assessed and positive feedback given with tailored support and advice (84). ■ Women were asked what additional health topics relevant to pregnancy and the postpartum period they would like to discuss (e.g., prenatal care, breastfeeding, traditional ways of being healthy and managing stress) (79).
Involving the partner and/or family	■ Family-centered counselling including three home visits. In the intervention group, all mothers (and family members who were present) who smoked received usual care plus behavioural "coaching" about the dangers of second-hand smoke exposure to children, commitment to smoking restrictions in the home/car, positive role modeling, and strategies for overcoming obstacles to making smoke-free changes (103). ■ Household members were advised on how to support the woman's quit attempt. Where relevant, they were also encouraged to quit smoking, with support and fortnightly peer support groups vs. no control (84).

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Methods of counselling	■ The duration of counselling may range from brief interventions (less than five minutes) to more intensive interventions, which can last for up to an hour and be repeated over multiple sessions. The evidence supports intensive interventions over less intensive interventions (100).
	■ To use brief interventions such as the 3 or 5 As, counsellors:
	□ Ask about commercial tobacco use
	□ Provide advice to quit smoking emphasizing that no amount of smoking is safe during pregnancy
	□ Assess readiness to set a quit date using motivational interviewing techniques
	□ Assist with quitting using behavioural and problem-solving strategies
	□ Arrange follow-up (79, 101, 102)
	Appendix F outlines how the 5 As can be tailored for individuals.
	■ Counselling may be provided by a range of personnel, including pregnancy care providers, trained counsellors, or others, on-site or by referral to specialist stop smoking services (100)

RECOMMENDATIONS

Supporting Resources

RESOURCE	DESCRIPTION
Ordean A, Wong S, Graves, L. No. 349-substance use in pregnancy. J Obstet Gynaecol Can 2017;39(10): 922–937.e2 Available from: https://pubmed.ncbi.nlm.nih.gov/28935057/	■ Guidelines from the Society of Gynecologists and Obstetricians (SOGC) regarding substance use in pregnancy ■ Similar to the panel, SOGC also recommends that behavioural support should be considered as first-line treatment for commercial tobacco cessation.
Talk Tobacco: Indigenous Quit Smoking and Vaping Support. In: Canadian Cancer Society [Internet], 2020. Available from: https://www.smokershelpline.ca/talktobacco/about	■ Indigenous quit smoking and vaping support operated by the Canadian Cancer Society ■ Free, confidential telephone service that provides telephone-based tobacco cessation counselling service that helps commercial tobacco users quit ■ Developed with input from First Nation, Inuit and Métis and urban Indigenous partners, community members and service providers

RECOMMENDATION 3:

It is recommended that wholistic and culturally specific smoking reduction and cessation services also be offered to the support network of perinatal Indigenous women and persons who are accessing these services.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very low

Confidence in evidence: Moderate

Discussion of Evidence:

Benefits and Harms

A review of the qualitative literature highlights that participants expressed a need for smoking cessation supports to be extended beyond the pregnant person to include their support network (partner, family or whoever the pregnant person identifies). The qualitative evidence emphasizes how the home and community environment influences smoking behaviours. Many pregnant Indigenous women reported living in a smoking environment with multiple family members, including partners, children, extended family members and multiple generations (91, 92). Smoking was also identified as a behaviour that is part of strong social bonds in many extended families and communities (92, 95, 105). Smoking can be associated with community-wide activities and thus serve as an additional barrier to smoking cessation (92). Many participants identified living in a smoking environment as a trigger for smoking and also a barrier to smoking cessation (91-93, 98).

Participants reported that family relationships are important within their household and their community, and that these relationships can act as a facilitator or a barrier to smoking cessation (92, 97, 98, 105). In households where smoking is normalized and when partners smoke, maternal smoking is more common (91, 92, 105) and women found it more difficult not to relapse (91).

Participants commonly reported a lack of social support in attempts to quit smoking, especially when those all around them smoke (91, 92, 105). Mothers, grandmothers and Elders more generally were identified as positive role models for pregnant Indigenous women as they may have never smoked or may have successfully quit smoking (98). Fathers and stepfathers were also identified as role models, however less frequently (97, 98). Partners were identified as either a positive or a negative influence on pregnant Indigenous women smoking during pregnancy (98, 105). Partners who didn't smoke were identified by some participants as supportive and encouraging with cessation attempts, while partners who smoked were less likely to provide support for their pregnant partners to quit smoking (98, 105). Some participants reported that their partner altered their smoking behaviour, such as physically distancing themselves while smoking (91). Having partners tell pregnant women that they should not be smoking was reported as not particularly helpful by participants in the context of the normalization of smoking in the women's social networks, home and communities (91, 98). It is important for families to recognize the how difficult it can be to quit smoking and remain smoke free, and how important their role is in supporting quit attempts and cessation (92). Indigenous women who smoked during a pregnancy identified partners and family members as the people best able to provide support to their cessation efforts to quit smoking (91, 98, 105).

RECOMMENDATIONS

Some participants suggested reaching and engaging not just the pregnant individual but also groups, such as families and households, in sharing the responsibility of smoking cessation (89, 92, 93). Offering smoking cessation services using a family and community-based approach may be required as the high rate of smoking in many communities is a significant barrier (89, 92, 97). The health provider's approach to a culturally safe smoking assessment should include an assessment of the person's environment (89). In addition, supporting the maternal smoker to quit should include strategies that involve the family and household, such as encouraging others not to smoke near them (89, 92). Some pregnant women abstained from smoking for longer if their partners quit at the same time (92).

Stress and trauma are frequently identified as reasons for smoking in pregnancy and a significant barrier to smoking cessation in pregnant Indigenous women, where smoking is frequently used to manage stress to get through each day (89-93, 98, 105). Other stressors reported by some participants included partners who smoked trying to control the woman's smoking behaviour, relationship breakdowns, and intimate partner violence (91, 92, 98, 105). See "Implementation Tips" from the panel for this issue below for further details.

Participants value smoking reduction and cessation services that use a woman/person-centred and trauma-informed approach (89, 90). Participants sought reduction and cessation services that offered safe spaces where health providers are non-judgmental and compassionate and use a strengths-based and culturally safe approach to smoking reduction and cessation (89, 90).

The review of the quantitative evidence on offering tailored smoking reduction and cessation services with the support network (partners and/or family) of perinatal Indigenous women and persons for those who wish to participate, may offer benefits. Smoking cessation interventions that also included offering strategies for smoking cessation to the support network were compared to usual care cessation services that provided brief quit advice at antenatal primary care appointments instead of further cessation services at a local hospital (103, 104). A review of the limited quantitative evidence featured several single-arm studies with no comparator that used a family-centred approach to culturally tailored smoking reduction and cessation with perinatal Indigenous women and persons. This approach may improve reach and engagement of participants into smoking reduction and cessation services, but the evidence is uncertain (84, 103, 104). One study offered, during home visits, 'behavioural' coaching to mothers and family members in the home who smoked. The coaching highlighted positive role modeling, the effects of second-hand smoke exposure and strategies to address barriers to smoking reduction and cessation (103). As well, those who wished to participate were offered more intensive counselling to quit and offered free nicotine replacement therapy and/or referral to a telephone quit line service (103). Additional smoking cessation intervention studies included the partner (if they smoke) in the cessation intervention and attempt to quit, or involved bi-weekly peer support groups that included household members who were advised on how to support the woman's quit attempt and also encouraged to themselves quit smoking (84, 104). One study reported that at least two of the participant's partners quit smoking, and one mother and one father quit during their daughters' pregnancies (84). Another study offering cessation service to significant others (partners) reported a reduction in cigarettes smoked per day by partners, and 60 per cent made quit attempts at three months post baseline and one month postpartum, and one partner had a successful quit attempt at three months (81).

> **CAUTION**
>
> The delivery of smoking reduction and cessation interventions with the support network (such as the partner) should be separate or **delinked**[G]. Health providers can address a person's commercial tobacco use alone, and not in the company of the support network, unless the person wishes them to be involved.

The certainty in this evidence is very low due to limitations in how the studies were conducted and the small number of study participants. The overall confidence in this evidence was moderate. It is likely that the review findings are a reasonable representation of the needs and views of Indigenous women, their partners and their families. For more detailed information of the qualitative experiences reported and the grading of the evidence, please refer to the evidence profiles.

Values and Preferences

There were no additional values and preferences reported in the evidence.

Health Equity

Women's experiences of living in a smoking environment should be understood in relation to the normalization of commercial tobacco use, where smoking is an accepted strategy and is often associated with a place or environment (home, school, social groups) and a means to cope with stress (91, 92, 95, 98). Accordingly, it is important to understand the influence of Indigenous and social determinants of health, such as the historical impact of residential schools, loss of land, nationhood, traditional Indigenous knowledges and cultural identity, as well as contemporary determinants such as housing security, employment, gender roles and disrupted family relationships is critical (94, 95, 97).

Panel Justification of Recommendation

The panel identified smoking during pregnancy as a high priority issue for Indigenous women and persons due to the known harms related to smoking and the significant impact of Indigenous determinants of health upon health equity. The panel members noted that current smoking cessation resources do not meet the needs of Indigenous Peoples and communities. The panel emphasized that, although the evidence is uncertain, most people would benefit from Indigenous-led, culturally safe care, and from health and social service providers using culturally responsive and tailored approaches that include the support network in smoking reduction and cessation. The panel further noted that the qualitative evidence also highlights the value placed on the inclusion of the support network in smoking reduction and cessation services to address the needs of pregnant Indigenous women. According to GRADE methods, there are five paradigmatic situations where panel members can justify a strong recommendation based on very low certainty of evidence, such as the potential catastrophic harm. Although the certainty of the evidence of the effects of this intervention is very low and the confidence in the evidence is moderate, based on the critical importance of addressing the certain harms from smoking, and the risk of perpetuating ongoing trauma and health inequities, the panel therefore determined the strength of this recommendation to be strong.

Implementation Tips

Implementation tips from the panel

- Health providers follow the pregnant or postpartum person's preferences for offering reduction and cessation supports to their circle of support (partner and family).

- There is a critical need for health providers to offer commercial tobacco cessation to partners and/or family with a trauma informed, person-led and culturally safe approach.

- Health providers have a conversation alone with the client that includes assessing the woman's environment and identifying who smokes in that environment. It is important that health providers are aware of power imbalances and potential risks for abuse. Please refer to the good practice statement for further information on assessing the smoking environment.

Supporting Resources

RESOURCE	DESCRIPTION
Hemsing, N., Greaves, L., Poole, N. Tobacco Cessation Interventions for Underserved Women. Journal of Social Work Practice in the Addictions. 2015 July 3; 15(3): 267-287. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4867857/pdf/wswp-15-267.pdf	■ Outlines the components of a woman-centred approach to smoking cessation ■ Information on delinked approaches here
Homes, C., & Hunt, S. (2017). Indigenous Communities and Family Violence: Changing the conversation [cited 2020 June 15]. Available from: https://www.nccih.ca/docs/emerging/RPT-FamilyViolence-Holmes-Hunt-EN.pdf	■ National Collaborating Centre for Aboriginal Health on understanding family violence
Ontario Native Women's Association. [cited 2020 June 15]. Available from: http://www.vawlearningnetwork.ca/our-work/issuebased_newsletters/Issue-25/Issue_25.pdf	■ Indigenous women, intimate partner violence and housing resource information
University of British Columbia. Dads In Gear Indigenous. 2017; [cited 2020 June 15]. Available from: https://www.dadsingearindigenous.ca/	■ British Columbia nicotine cessation resources tailored to fathers and other men

RECOMMENDATION 4:

It is suggested that the circle of care offers nicotine replacement therapy, in addition to counselling, when needed with Indigenous women and persons during pregnancy.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Low

Confidence in evidence: Not Applicable

Discussion of Evidence:

Benefits and Harms

There is some literature about the use of pharmacotherapy, specifically nicotine replacement therapy (NRT), for pregnant women and persons who smoke (106). However, at this time there is not enough literature to support the use of bupropion and varenicline for pregnant women and persons who smoke (106). NRT is an alternate, medicinal form of nicotine intake, available in slow acting transdermal patches that provide a slow release of nicotine over a 24-hour period (available in 7mg to 21 mg; one mg is approximately equivalent to one cigarette) and fast-acting oral options (gum, lozenge, inhaler, and mist/spray) which take 5-10 minutes for the nicotine to be felt (mist acts within 90 seconds) (107). Overall, NRT is likely to be safer than smoke (106) because the products contain only nicotine in a non-combustible delivery system and do not include the toxins of smoke inhalation, carbon monoxide, or the harmful chemicals in commercial tobacco, many of which are carcinogenic.

Literature suggests that NRT, when provided with counselling, may improve quit rates in late pregnancy, compared to counselling and other behavioural support alone (106). However, the evidence is of low certainty due to concerns about how studies were conducted and the small number of events (106). In terms of safety, there is insufficient literature to conclude whether NRT has either a positive or negative impact on rates of miscarriage, stillbirth, mean birth weight, low birth weight (less than 2500 g), preterm birth (less than 37 weeks), NICU admissions, neonatal death, congenital abnormalities or caesarean section (106).

For more detailed information on the impact of the intervention (NRT) on the prioritized outcomes, refer to the evidence profiles.

Values and Preferences

There was no literature that reported on the values and preferences of pregnant women and persons taking NRT.

Health Equity

Although NRT, in addition to counselling, may be effective in improving quit rates, access to NRT across Indigenous communities remain inconsistent. For more information on low cost or no-cost NRT across Canada, refer to the Supporting Resources. Further, refer to **Recommendation 7** regarding evidence supporting equitable access to NRT.

RECOMMENDATIONS

Panel Justification of Recommendation

There may be benefits of NRT. However, the panel expressed that there is uncertainty about potential harms (miscarriage, stillbirth, mean birth weight, low birth weight, preterm birth, NICU admissions, neonatal death, congenital abnormalities or caesarean section) and that the literature is still limited. The panel agreed that NRT is still safer than smoking, especially because the only ingredient in NRT is nicotine in a non-combustible delivery system compared to the more than 7,000 chemicals in a smoked cigarette, among which at least 69 of the chemicals are carcinogenic. However, the panel acknowledged that not everyone may want to take NRT. Therefore, the panel determined the strength of the recommendation to be conditional.

Implementation Tips

Implementation tips from the panel

- It is important to start with counselling as a first-line intervention. When that is not effective, then health providers can offer NRT.

- Where organization directives or standing orders do not include NRT, follow your organizational cessation program.

- There are various forms of NRT, such the nicotine patch, nicotine gum, nicotine lozenge, nicotine inhaler, nicotine pouches and nicotine spray.

- For recommendations of pharmacotherapy (NRT, bupropion and varenicline) for non-pregnant persons, refer to Recommendation 3.1 in the RNAO BPG *Integrating Tobacco Interventions into Daily Practice, Third Edition*.

- It is important that health providers are aware of the different forms of NRT and instruct persons on how to use it properly.

- It is important to note that vaping nicotine is the not the same as receiving nicotine from NRT. Although nicotine can be vaped/smoked using e-cigarettes and cartridges (ENDS), there is insufficient evidence of the potential long-term effects (benefits or harms) of electronic cigarettes as a harm reduction approach in pregnant women and persons. For more information, refer to the U.S. Centers for Disease Control and Prevention statement in the "Supporting Resources".

Supporting Resources

RESOURCE	DESCRIPTION
CADTH. Drugs for smoking cessation: Information for health professionals [internet]. Available from: https://www.cadth.ca/sites/default/files/pdf/drugs_for_smoking_cessation.pdf	■ Overview of different forms of NRT and recommended dosing ■ This resource also includes information on other forms of pharmacotherapy (e.g., bupropion, varenicline) for the general, non-pregnant population.
Cost of Nicotine Replacement Therapy. In: HelpThemQuit.ca. Available from: https://www.helpthemquit.ca/treatment/costs-coverage	■ An overview of the reimbursement coverage of NRT across Canada, by province ■ **Note**: this resource is industry developed
Electronic Cigarettes. In: Smoking & Tobacco Use [Internet]. Available from: https://www.cdc.gov/tobacco/basic_information/e-cigarettes/index.htm	■ Remarks on the use of electronic cigarettes from the Centers for Disease Control and Prevention (CDC) ■ The CDC states that currently, there is no evidence of the potential long term effects (benefits or harms) of electronic cigarettes as a harm reduction approach in pregnant women.
Ordean A, Wong S, Graves, L. No. 349-substance use in pregnancy. J Obstet Gynaecol Can 2017;39(10): 922–937.e2 Available from: https://www.jogc.com/article/S1701-2163(17)30470-X/fulltext	■ Guidelines from the Society of Gynecologists and Obstetricians (SOGC) regarding substance use in pregnancy ■ Similar to the panel, SOGC also recommends that behavioural support should be considered as first-line and NRT and/or pharmacotherapy can be considered if counselling is not successful.

Education Recommendations

RECOMMENDATION 5:

It is recommended that academic settings integrate compulsory Indigenous health and Indigenous cultural safety content into college and university educational curricula for all students entering health professions.

*Call to Action # 24, Truth and Reconciliation Commission, 2015

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very low

Confidence in evidence: Low

Discussion of Evidence:

Benefits and Harms

The literature examines a range of Indigenous health and Indigenous cultural safety interventions that deliver content as part of educational curricula for students entering health professions and include a variety of learning opportunities, ranging from brief modules on Indigenous health learning, elective or compulsory courses on Indigenous health, and/or a range of Indigenous health and cultural safety content embedded into existing programming. Improving educational curriculum content on Indigenous health and Indigenous cultural safety for students entering health professions is essential, as noted in the Truth and Reconciliation Commission. The panel prioritized this recommendation area and systematic review to provide educational institutions with guidance on important content and strategies to support evidence-based practice changes.

Across the studies, Indigenous health and cultural safety education includes curricular content on the historical context of Indigenous health and the contemporary health inequities experienced by many Indigenous people in Canada, and content on educating students entering health professions about their essential role in providing respectful and culturally safe health and wellness services. Most of the studies used a pre-test, post-test design, with no control or comparison group, and measured outcomes that included health service student knowledge and perceived cultural competencies. Quantitative evidence indicates that compulsory Indigenous health and cultural safety education for students entering health professions may improve student knowledge of Indigenous health and scores on a variety of cultural measures. The majority of students entering health professions demonstrated a perceived increase in Indigenous health knowledge (108, 109). Following the completion of various Indigenous health and cultural safety education curricula, students entering health professions had improved scores on a variety of cultural measures, such as cultural awareness, cultural competence or cultural capability (110-113). One study offered an **immersion experience**[G] for podiatry students that included reflective journaling and demonstrated improvements in student scores on a cultural safety measure (from baseline) eight months following the immersion experience (113). Providing learning opportunities for students entering health professions that facilitate **reflective practice**[G], **critical reflexivity**[G] and critical thinking can foster the development of cultural capabilities (110-113). A few students found a brief immersion experience in a remote Indigenous community too confronting (114). No additional harms related to the integration of Indigenous health and cultural safety content into college or university educational curricula were reported in the quantitative studies.

The qualitative evidence explored the experiences of students entering health professions participating in Indigenous health and cultural safety education curricula. Students entering health professions reported an improvement in their knowledge about Indigenous history and culture, health disparities/challenges, the impact of past events and governmental policies, and traditional practices and the health beliefs of Indigenous communities (115). Studies outlined how learning processes that require critical reflexivity allowed students to better understand how their own personal beliefs and values and societal values can impact their behaviour and their practice (116). Shifting from theoretical knowledge to practical understanding included the discovery of new knowledge and confronting 'new truths' that were associated with transformative learning (116). Students most frequently reported that educational immersion experiences, and participating in reflection and critical reflexivity, improved their capacity to provide culturally safe care and brought about a greater awareness of the social determinants of health and their impact on Indigenous health (110, 115-118). There were no harms reported in the qualitative evidence.

The certainty in the evidence was very low due to limitations in how the studies were conducted and the variation in the tools used to measure student knowledge and cultural safety. The overall confidence in the evidence for qualitative findings was low due to limitations in how the studies were conducted.

For more detailed information of the quantitative evidence, the qualitative experiences reported and the grading of the evidence, please refer to the evidence profiles.

Values and Preferences

Students entering health professions placed value on Indigenous curricula when it provided them with specific knowledge or skills that can be transferred to clinical practice (108, 109). Students entering health professions also valued small group teaching and reflective processes (112).

Students entering health professions valued clinical immersion experiences that provide experiential learning opportunities (114). Face-to-face cultural experiences were identified as immensely valuable and likely to remain with students in their future practice with Indigenous clients (114). Students reported that learning from clients themselves and reflecting on these experiences was a valuable strategy (114). Some students entering health professions valued immersion learning as a life-changing experience (111). In particular, students valued storytelling sessions delivered by Indigenous Peoples that enabled them to understand the first-hand impact of Indigenous histories upon health outcomes (111, 118). Participants placed a strong value on clinical placements because they allow students entering health professions the opportunity for rich experiential learning that will enhance their clinical and professional practice skills and provide opportunities to apply new learning in real world situations (111, 117). Midwifery students valued Indigenous learning opportunities including an immersion experience that supported their ability to build respectful relationships with Indigenous clients (119).

Health Equity

Education on the health inequities that can impact the health of Indigenous Peoples and their communities was included in educational interventions in many of the reviewed studies (110, 112, 114, 117, 118). Learning about the impact of the social determinants of health on Indigenous Peoples' health was also addressed in the interventions in many of the included studies (109, 111, 112, 114, 117, 118).

RECOMMENDATIONS

Panel Justification of Recommendation

This recommendation could have been a good practice statement however, the panel agreed that it was essential to address the Truth and Reconciliation Commission Call to Action for medical and nursing schools in Canada to implement compulsory Indigenous health and cultural safety education into curricula for all students entering health professions (34). The panel prioritized the urgent need for the education of students entering health professions that must include Indigenous health and Indigenous cultural safety education to address a significant curriculum gap. Therefore, the panel posed a recommendation question to examine the evidence on the impact of integrating Indigenous health and cultural safety education into the curricula for students entering health professions. In addition, this evidence can support educators and academic institutions by providing detailed information on the delivery of this education as outlined in the evidence. There are benefits in the available studies associated with the delivery of Indigenous health and cultural safety education to students entering health professions, although the evidence is uncertain. Minor harms related to student discomfort with the content were reported in a few studies. The certainty of the evidence is very low and the confidence in the evidence is low. According to GRADE methods, there are five paradigmatic situations where panel members can justify a strong recommendation based on very low certainty of evidence, such as the ongoing potential for further catastrophic harm if students entering health professions do not receive essential curricular content on Indigenous health and cultural safety education. The benefits of receiving Indigenous health and cultural safety education far outweigh any potential minor harm for students entering health professions. Students can be supported during this difficult, but essential learning. Despite the very low certainty in the evidence, it is ethically sound to ensure the provision of Indigenous health and cultural safety education into entry-to-practice curricula for all future health-care providers. The panel identified the critical importance of emergent action in response to the TRC Calls to Action (34). Therefore, the panel determined the strength of this recommendation to be strong.

Implementation Tips

Implementation tips from the panel

- Canadian resources for Indigenous health and cultural safety education are well established and links to accessing these resources are provided in the supporting resources.

- Learning about Indigenous health and cultural safety is an ongoing lifelong process.

- One-time Indigenous health and cultural safety modular learning is not sufficient.

- Indigenous health can be integrated into maternal child health, family/life course and community health learning within curricula for students entering health professions, threaded throughout health service student curricula, and not parceled off as a separate module or entity.

- Opening doors for Indigenous students to enter into health service programs should be a high priority for all academic settings offering these programs. Additional resources and staff should underpin this health system capacity building.

- Collaboration with Indigenous Chairs, faculty, and allies in the design, delivery and evaluation of Indigenous health and cultural safety curricula is essential.

- A focus on skills-based learning is required that includes cultural safety, conflict resolution, human rights and anti-racism as identified in Call to Action #24, Truth and Reconciliation Commission (34).

Table 6: Intervention Details from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Critical reflexivity	■ Reflective practice is an essential component of immersion learning experiences and supports students' exploration of their own identity and any preconceived belief, biases and assumptions they hold about Indigenous Peoples and communities, and how these impact their behaviour and practice (117). Examining these assumptions is an integral part of experiencing cultural humility, engaging in lifelong transformational learning, and developing cultural awareness (112, 117, 118). Students discussed their clinical experiences and possible misconceptions during an evening group reflection activity (110). Researchers observed a link between the themes of recognition of privilege, suspension of judgment, reframing the situation and demonstrating cultural consciousness (110). ■ Students deconstructed their beliefs and assumptions during critical reflective writing assignments with regular feedback from their instructors. Students felt safe and were comfortable sharing negative stereotypes, recognized their own discomfort, indicated their readiness to change and developed an action plan to address them (109, 110, 112, 114, 117). ■ Midwives described how they were changed by learning about the impact of colonization on Indigenous Peoples and the long-term consequences. They identified this process as essential to be able to establish rapport with Indigenous women, along with a willingness to deeply question their own personal assumptions and consideration of the views, perspectives and lived experiences of others (119). ■ Ongoing critical reflection allowed nursing and midwifery students to deeply examine the impact of their own cultural identity and discover how their own personal attitudes, biases and values influence how they deliver health services (116).
Collaboration and relationship building with Indigenous Peoples, organizations and communities	■ A Métis community collaborated and informed the design, implementation and delivery of an Indigenous health immersion course for physiotherapy students in rural Saskatchewan, Canada (117). This collaboration respected and integrated Métis perspectives and worldview throughout the immersion education (117). ■ Working collaboratively with Indigenous communities involved having Elders identify the learning goals and activities for the students participating in an immersion experience (109, 110, 114). ■ An urban Indigenous health centre collaborated with the Indigenous Physicians' Association of Canada and Queen's University to develop the core competencies for a compulsory Indigenous health learning module that was integrated into occupational health students' learning (109).

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Indigenous health and cultural safety learning methods	A variety of educational/pedagogical approaches were utilized to develop and deliver a range of Indigenous health education courses and cultural immersions.

A variety of educational/pedagogical approaches were utilized to develop and deliver a range of Indigenous health education courses and cultural immersions.

- Individual studies delivered Indigenous health content to nursing students (110, 118), medical students (111, 114, 115), occupational therapy students (109), physiotherapy students (117), podiatry students (113) and an inter-professional course for all health and social service students (112).

- Duration: The length of the Indigenous health courses varied. Immersion courses varied from 1.5 days (115), 4 days over 2 semesters (113), 1 week (112), to 4-6 weeks (117) and classroom-based courses ranged from 3 hours to 12 weeks (109, 112).

Methods of instructional delivery varied and frequently used multi-method approaches that included one or more of the following:

- Clinical/cultural immersion (108, 110, 111, 113-115, 117, 118)

- Indigenous voices (109-111, 115, 117)

- Indigenous cultural activities (110, 111, 114, 115, 117)

- Didactic (classroom): classroom education (108, 109, 112) or classroom education associated with immersion (110, 111, 117)

- Workshops (112, 114, 117, 120, 121)

- Self-directed online learning (109, 112, 118)

- Case-based learning: a case-based assignment was used to measure cultural safety pre and post clinical immersion (115); five studies utilized case-based learning approaches (108, 121)

- Reflective group discussions (109-113, 117, 118, 121, 122)

- Reflective written assignments were included in the evaluation of students entering health profession curricula in 14 studies (108, 113)

- Reflective journaling was utilized by participants (113)

- Video media (108, 117)

- Art therapy (111)

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Indigenous Health and Cultural Safety education curriculum content (Includes curricular content from studies included in **Recommendations 5 and 6**)	Indigenous health and cultural safety education content included: ■ Critical reflexivity/reflective learning (108-110, 112, 113, 116-120, 122-125) ■ Addressing power differentials (116, 119) ■ Indigenous worldviews (109, 113, 117) ■ Traditional cultural practices (108-110, 114, 117, 118, 121) ■ Indigenous ways of knowing and concepts of health and healing (109-112, 115, 117, 120, 123, 125, 126) ■ Racism and discrimination (117, 118, 123, 125) ■ Colonization (112, 117, 121, 123, 125) ■ Intergenerational trauma (109, 110, 115, 117, 118, 123) ■ Historical policies or legislation (109, 112, 115, 118) ■ Indigenous histories and cultures (111, 113, 114, 117, 123) ■ Social determinants of health (109, 111, 114, 115, 117, 121) ■ Health inequities/disparities (108-110, 114, 115, 117, 118, 121-124, 126)

Supporting Resources

RESOURCE	DESCRIPTION
Canadian Association of Schools of Nursing Documents: Canadian Association of Schools of Nursing (CASN). Educating Nurses to Address Socio-Cultural, Historical, and Contextual Determinants of Health Among Aboriginal Peoples 2013; [cited 2020 June 15]. Available from: https://casn.ca/wp-content/uploads/2014/12/ENAHHRIKnowledgeProductFINAL.pdf Framework of Strategies for Nursing Education to Respond to the Calls to Action of Canada's Truth and Reconciliation Commission; 2020; [cited 2021 Mar 2]. Available from: https://www.casn.ca/wp-content/uploads/2020/11/EN-TRC-RESPONSE-STRATEGIES-FOR-NURSING-EDUCATIONTRC-Discussion-Paper-Revised-date-Final.pdf	■ A national consensus framework on Indigenous health education for pre-licensure nurses in Canada ■ Identifies what nurses need to learn to address sociocultural, historical, and contextual determinants of health among Indigenous Peoples and how pre-licensure education can prepare them ■ Working with the Canadian Indigenous Nurses' Association, CASN framework reflects on the TRC report findings and provides direction to schools of nursing and a framework of strategies to address the TRC Calls to Action in nursing education.
Lakehead University. Online modules addressing Truth and Reconciliation [cited 2021 June 1]. Available from: https://www.lakeheadu.ca/about/news-and-events/news/archive/2020/node/62047	■ Learning modules addressing Truth and Reconciliation Actions ■ 8 module series
Truth and Reconciliation Commission of Canada [Internet] Truth and reconciliation commission of Canada: Calls to action [Internet]. Winnipeg (MB): Truth and Reconciliation Commission of Canada; 2015; [cited 2021 November 30]. Available from: https://nctr.ca/records/reports/	■ Reports on the Truth and Reconciliation Commission of Canada calls to action to redress the legacy of residential schools and advance the process of Canadian reconciliation. ■ Includes a specific call to action for medical and nursing schools to require a course on Indigenous health issues.
University of British Columbia. Centre for Excellence in Indigenous Health; 2020; [cited 2020 June 15]. Available from: https://health.aboriginal.ubc.ca/programming/ubc23-24/	■ Interdisciplinary course on Indigenous cultural safety that aims to prepare future health care professionals to provide quality and culturally safe care ■ Includes schools of nursing and medicine

Note: Additional resources can be found in the "Supporting Resources" for **Recommendation 6**.

RECOMMENDATIONS

RECOMMENDATION 6:

It is recommended that health and social service organizations integrate Indigenous health and Indigenous cultural safety education within continuing professional development for all health providers.

*Call to Action # 23, Truth and Reconciliation Commission, 2015

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very low

Confidence in evidence: Low

Discussion of Evidence:

Benefits and Harms

Integrating Indigenous health and Indigenous cultural safety education within continuing professional development for all health providers is essential learning in Canada, as noted in the Truth and Reconciliation Commission Calls to Action. The panel identified continuing professional development on Indigenous health and cultural safety as a prioritized recommendation area (and the accompanying systematic review) to provide health and social service organizations with guidance on important content and strategies to support evidence-based practice changes.

Continuing professional development (CPD) or continuing learning is the way health professionals engage in learning processes throughout their careers to enhance their practice (76). The relevant studies included one randomized controlled trial (with a comparison group receiving usual care) while the remaining studies used a pre-test, post-test design, with no control or comparison group, and measured outcomes that included provider knowledge, attitude and perceived cultural safety. Five studies examined the impact of continuing professional development education around Indigenous cultural safety on practicing health professionals' perceptions of Indigenous Peoples and awareness on culturally safety outcomes. The health providers receiving CPD education across the studies included nurses, family physicians, midwifery academics and dieticians. The format and length of this course delivery ranged from a half-day workshop supported by cultural mentors, to classroom-based workshops over a six-week period, to a semester-long series of workshops and yarning circles, and a one-year long online community of practice. Yarning circles are an Indigenous research method that is culturally safe and involves the verbal sharing (discussion) and critical reflection of knowledges and perspectives in a group that is inclusive and respectful of each person's views (123, 125). A community of practice is a virtual peer mentoring method where health providers can participate in organized sessions that are a safe place to discuss, explore, reflect and debrief on various learning topics (120, 122).

The evidence suggests that continuing professional development (CPD) on Indigenous health education may improve health provider attitudes towards Indigenous people and their self-assessed awareness of cultural safety (121-124, 127). Participants reported gaining a deeper contextual understanding of Indigenous Peoples' culture by listening to Indigenous Peoples' stories and participating in discussions around these shared lived experiences (123). No harms were reported in the quantitative evidence related to integrating continuing professional development on Indigenous health and cultural safety for health.

Three qualitative studies examined the experiences of practicing health service providers participating in Indigenous health and cultural safety courses for continuing professional development. Health providers and academics expressed a greater understanding of cultural safety and how that translates to their clinical or academic practice. Participants described the importance of having a safe space to discuss sensitive topics such as racism and being different (120, 125). These discussions created feelings of discomfort as previously held assumptions were challenged and resulted in the development of a deep sense of cultural respect for Indigenous Peoples and the providers' desire to connect authentically (120, 125). Participants reported a change in how they viewed the client-provider relationship, a shift from an illness or pathology-focused approach to a client-focused approach (115). Participants highlighted the importance of relationship building that includes listening and minimizing the client-practitioner power differential through the use of informal speech and open body language (115).

There were no harms reported in the qualitative evidence (120).

The certainty of the evidence was very low due to concerns about how the studies were conducted and the small number of studies. The overall confidence in this evidence was low due to moderate concerns about how the studies were conducted and minor concerns about data adequacy. For more detailed information of the qualitative experiences reported and the grading of the evidence, please refer to the evidence profiles.

Values and Preferences

Participants (midwifery academics) in one study valued a safe and supportive space (yarning circles) and wanted to see this activity continue to support their growth in awareness of cultural safety and provide ongoing opportunities for critical reflexivity (125).

Participants said that the most effective Indigenous health learning occurred during workshops, interactive discussions with peers, case-based scenarios and role playing where a debriefing component was included in the learning (121).

Health Equity

Two studies included education content on Indigenous and social determinants of health and the health inequities or disparities that exist for many Indigenous people (115, 123).

Panel Justification of Recommendation

This recommendation could have been a good practice statement however, the panel agreed that it was essential to address the Truth and Reconciliation Commission (2015) call to action for Indigenous cultural competency training for all health care professionals. The panel prioritized the urgent need for access to ongoing health provider education on Indigenous health and cultural safety to address a significant gap in continuing health provider professional education requirements. Therefore, the panel posed a recommendation question to examine the evidence on the impact of health organizations providing Indigenous health and cultural safety education for all health providers. In addition, this evidence can support health organizations by providing detailed information on the delivery of this education as outlined in the evidence. There may be benefits reported in the available evidence associated with the delivery of Indigenous health and cultural safety education to a variety of health care professionals, and no significant harms were reported in the evidence. The certainty of the evidence is very low and the confidence in the evidence is low. According to GRADE methods, there are five paradigmatic situations where panel members can justify a

strong recommendation based on very low certainty of evidence, such as where there is potential for catastrophic harm associated with health and social service providers not receiving essential Indigenous health and cultural safety education. In the absence of harms in the included literature, the panel identified significant benefits for all Indigenous Peoples through Indigenous health and cultural safety education for all health-care professionals. The panel noted the potential further harms of not implementing this intervention, such as health providers providing unsafe care. The panel identified this recommendation to be foundational to ethical practice and the critical importance of emergent action in response to the TRC Calls to Action (34). Therefore, the panel determined the strength of this recommendation to be strong.

Implementation Tips

Implementation tips from the panel

- Integrate Indigenous health and cultural safety education throughout health service organizational processes, policies and culture including employee orientation, annual education, employee performance appraisals and supervisory support and consultation.

- Ongoing evaluation of specific learning objectives for Indigenous health and cultural safety professional development education is required. Administrators and institutions are responsible for keeping up to date with current evidence.

- Recognize, within Indigenous health and cultural safety education, that all Indigenous nations and communities are unique and diverse.

- Continuing professional development certification in Indigenous health and cultural safety must be accessible for all non-Indigenous health providers working in Indigenous communities and with Indigenous community members.

RECOMMENDATIONS

Table 7: Implementation Tips from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Collaboration and consultation with Indigenous faculty and community members	■ Use of a respectful partnership approach to conduct the yarning sessions where an Indigenous professor mentors a non-Indigenous midwifery professor (123, 125). This collaboration highlighted the importance of respect and commitment to this educational partnership (123, 125). ■ Cultural respect program implementation involved local Indigenous Community organizations (126).
Relationship building with Indigenous clients and communities	■ Moving away from an illness-focused approach to a client-focused approach and an emphasis on working in partnership with clients to improve their health (115) ■ Practitioner-client relationship building involves good listening skills, trust, respect and ensuring clients are comfortable (115) ■ Some participants emphasized the benefits of being an ally, and being non-judgmental and developing relationships on an equal footing (115) ■ A partnership between a midwife and a woman is based on respect and trust and acknowledges equality within this relationship (125) ■ Developing a deep cultural respect for Indigenous people in the Community of Practice learning facilitates improved provider practices that are relational, reciprocal, humble and community-driven (120, 122)
Critical reflexivity/ reflection by health service providers	■ Participants were encouraged to engage in critical reflexivity and open communication to facilitate a deeper understanding of Australian Indigenous health and culture (123) ■ Participants described reflective conversations as thought provoking, leading to personal and professional examination of their cultural misconceptions, biases, assumptions and values (125) ■ Providers participated in facilitated reflection exercises (120) ■ Personal reflections completed by providers were presented during group discussions (124)

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Indigenous health and cultural safety learning methods	Methods of instructional delivery varied and frequently used multi-method approaches that included one or more of the following: **Clinical placements** ■ ranging from four weeks to 12 months involved three primary health care physicians and one psychiatrist working in an urban Indigenous primary health clinic for CPD on Indigenous health and cultural safety (115) **Workshops** ■ WoTWoD (Ways of Thinking, Ways of Doing) Cultural Respect Program was delivered using a workshop (121) ■ Participants listened to personal stories from Indigenous people about the impact of colonization, residential schools, intergenerational trauma, historical governmental policies, and what it is like to be Indigenous (123) ■ Cultural awareness training workshops, each delivered for two hours, included self-reflection exercises, group discussions, case studies and written learner guides (124) ■ Workshops (and yarning circles) (123) ■ One four-hour face-to-face workshop was conducted to introduce dietitian participants and support the establishment of trust for their upcoming Community of Practice learning (120, 122) ■ Canadian rheumatologists participated in an Indigenous health program delivered via experiential workshops that incorporated skills-based teaching to improve client health care experiences (121) **Yarning circles** ■ A yarning circle approach was used by midwifery academics to honor Indigenous culture and voice (123, 125). Australian Indigenous people recognize yarning as a narrative method of sharing stories, information and knowledge (123, 125) **Community of Practice (CoP)** ■ A facilitator-led two-hour virtual CoP, delivered every six weeks for 12 months where dietitians shared stories of practice and challenges in their work (122). The CoP offered dietitians opportunities for safe discussions and increased dietitians' confidence (120)

RECOMMENDATIONS

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
	Reflective discussions ■ A variety of providers participated in reflective discussions on practice, developing deeper understanding and respect for Indigenous people and collective learning (120, 122-125) ■ Medical specialists in Canada (rheumatology) identified interactive discussion with peers, workshops, role playing and de-briefing discussions as effective learning experiences (121) **Cultural mentors** ■ Yarning sessions included an Indigenous professor (mentor) and a non-Indigenous midwifery academic (mentee) (123) ■ Cultural mentors guided activities to embed cultural respect into provider practices (123) **Case studies** ■ A case study that required providers to respond to questions on clinical decision-making before their CPD and reflect upon their responses following their education (115) case studies supported cultural awareness education (124)
Indigenous health and cultural safety educational content	See **Recommendation 5** for overall educational content across included studies.

Supporting Resources

RESOURCE	DESCRIPTION
Allan, B., Smylie, J. First Peoples, Second Class Treatment, the role of racism in the health and well-being of Indigenous Peoples in Canada [Internet]. Toronto. Wellesley Institute; 2015 [cited 2020, June 15]. Available from: https://www.sac-oac.ca/sites/default/files/resources/Report-First-Peoples-Second-Class-Treatment.pdf	■ This paper explores the role of racism in the health and well-being of Indigenous Peoples in Canada. It provides an overview of the historical and contemporary contexts of racism that have and continue to negatively shape the life choices and chances of Indigenous Peoples in this country, and then examines the ways in which racism fundamentally contributes to the alarming disparities in health between Indigenous and non-Indigenous Peoples.
Canadian Public Health Association. Transforming Our Response: Practical Tips on Providing Trauma-Informed Care for First Nations, Inuit and Métis Women, Girls and Gender Diverse People; 2020 [cited 2020, August 31]. Available from: Part 1: https://www.youtube.com/watch?v=IttfFKqT3yQ Part 2: https://youtu.be/lVcg5-DH9mk Part 3: https://www.youtube.com/watch?v=em3Gc4ggO2c	■ Free three-part archived webinar series: Transforming Our Response: Practical Tips on Providing Trauma-Informed Care for First Nations, Inuit and Métis Women, Girls and Gender Diverse People
Cancer Care Ontario. Cancer Care Ontario elearning. (2020, cited June 15). Available from: https://elearning.cancercare.on.ca/	■ Online learning on Indigenous Relationship and Cultural Awareness Courses ■ Multiple courses available for free
Evidence Brief: Wise Practices for Indigenous-specific Cultural Safety Training Programs; 2017 [cited 2021 Feb 23]. Available from: http://www.welllivinghouse.com/wp-content/uploads/2019/05/2017-Wise-Practices-in-Indigenous-Specific-Cultural-Safety-Training-Programs.pdf	■ Well Living House evidence brief that features wise practices from peer-reviewed evidence and grey literature on designing and implementing cultural safety education programs for health providers in Ontario.
Indigenous Certification Board of Canada; 2020 [cited 2021, Feb 23] Available from: https://icboc.ca/	■ Directory of ICB OC accredited education offered by various organizations (2020)

RECOMMENDATIONS

RESOURCE	DESCRIPTION
National Collaborating Centre for Indigenous Health (NCCIH). NCCIH Publications & Multimedia; [cited 2020, June 15]. Available from: https://www.nccih.ca/en/default.aspx	▪ National Indigenous organization that supports First Nations, Inuit, and Métis public health renewal and health equity through knowledge translation and exchange ▪ A range of knowledge, resources and publications freely accessible for any health providers such as fact sheets, newsletters, reports, videos, webinars and podcasts
Provincial Health Service Authority of British Columbia. National Indigenous Cultural Safety Collaborative Learning Series; 2020; [cited 2020 August 31]. Available from: http://www.icscollaborative.com/	▪ National webinar series provides an opportunity to share knowledge, experiences and perspectives in support of collective efforts to strengthen Indigenous cultural safety across sectors
Public Health Training for Equitable Systems Change. Health Equity; 2020; [cited 2020, June 15]. Available from: http://phesc.ca/health-equity#culturalsafety-indigenous	▪ A series of Indigenous specific education opportunities on cultural safety, cultural humility and anti-oppression training
Southwest Ontario Aboriginal Health Access Centre. Ontario Indigenous Cultural Safety Program; 2020; [cited 2020, June 15]. Available from: http://www.sanyas.ca	▪ Education in Indigenous Cultural Safety for health and social service providers ▪ There is a cost is associated with this training
Thunderbird Partnership Foundation. A Cultural Safety Toolkit for Mental Health and Addiction Workers In-Service with First Nations People; n.d.; [cited 2020, June 15]. Available from: https://thunderbirdpf.org/nnapf-document-library/	▪ Develops and supports using culture as intervention, and wholistic healing and wellness approaches of First Nations of Canada as defined with the First Nations Mental Wellness Continuum Framework and the Honoring Our Strengths Renewal Framework ▪ Cultural safety toolkit ▪ Document library also provides additional relevant resources and offers free downloads of all these resources
Truth and Reconciliation Commission of Canada: Calls to action [Internet]. Winnipeg (MB): Truth and Reconciliation Commission of Canada; 2015 [cited 2021, Nov 30]. Available from: http://nctr.ca/reports.php	▪ Reports on the Truth and Reconciliation Commission of Canada calls to action to redress the legacy of residential schools and advance the process of Canadian reconciliation. ▪ Includes a specific call to action for medical and nursing schools to require a course on Indigenous health issues.

System, Organization and Policy Recommendations

> **RECOMMENDATION 7:**
>
> It is recommended that the circle of care advocate for equitable access to smoking reduction and cessation services for Indigenous Peoples of reproductive age and their support network. This can include access to circles of support and nicotine replacement therapy (NRT).
>
> **Strength of the recommendation:** Strong
>
> **Certainty of the evidence of effects:** Very low
>
> **Confidence in evidence:** Moderate

Discussion of Evidence:

Benefits and Harms

A review of the quantitative literature identified one single-arm study with no comparator group that examined a smoking reduction and cessation intervention in pregnant women and their partners. The study included a strengths-based, culturally relevant approach to promote smoking reduction and cessation by promoting participants' personal agency and empowering them to address the stress in their lives (81). The key features of this intervention included art activities, case managers in an advocacy role, and no cost NRT (81). When the circle of care advocates for pregnant women in a smoking reduction and cessation program, the evidence reported good reach and engagement, with participants participating in multiple components of the intervention and reporting high levels of satisfaction with the program (81). Some participants and their partners made multiple quit attempts and two participants successfully quit at one month postpartum (81). There were no harms reported in the quantitative literature. The certainty of the evidence was very low due to concerns about how the study was conducted and the small sample size.

A review of the qualitative literature highlights the need expressed by many participants for equitable access to commercial tobacco cessation supports. However, the overall confidence in this evidence was moderate due to serious concerns about adequacy of data. Participants across these studies included Indigenous women of childbearing age, youth, mothers, fathers, partners, extended family members, Elders, Indigenous and non-Indigenous health providers and key community members. Equitable access to commercial tobacco cessation supports should be available at the individual level (accessible support groups, no cost NRT, supportive health and social service providers), include support networks (partners, household members, friends/peers and extended family networks) and be collectively facilitated at the community level (smoke-free space policies, Elders and culture) (87, 89-99, 128). For additional details at the community level, see **Recommendation 1** on culturally safe services and **Recommendation 9** on smoke-free spaces.

Many participants described the need for culturally safe cessation resources to address the context and stresses of women's lives and include support groups (also referred to as "circles of support"), such as sharing circles, coordinated by health and social service providers to help support pregnant women and young mothers who smoke (87, 89-92, 99). Support groups offer a space for women to get together to feel safe, discuss commercial tobacco cessation, share stories, provide each other with encouragement and share strategies and solutions that can successfully guide them through dealing with cravings, the symptoms of nicotine withdrawal and management of their stress (87, 89-92, 99). Support groups in particular were identified as beneficial, where pregnant women and young mothers

can share challenges and the solutions around trying to quit smoking (87, 90-92, 96, 99, 128). Pregnant women who smoke describe how important it is for health and social service providers to be supportive, encouraging and non-judgmental in their efforts to promote women's attempts to quit smoking and remain smoke free (87, 89-92, 99). Pregnant women reported seeking health providers who can coordinate support groups to build their support networks during the cessation process (87, 91). Participants also reported a need for easily accessible information, cessation programs, ongoing supports to stay quit and helpful and understanding health and social service workers (87, 91). A recent study included a culturally-tailored, trauma informed smoking cessation intervention where Indigenous case managers also worked to foster wrap-around services for women when required. These services included co-creating solutions to smoking triggers, such as navigating bureaucratic processes, and accessing income, food and housing security (89). Case managers frequently provided support to pregnant women by accompanying them to appointments to provide advocacy and continuity and to ensure the delivery of culturally safe services (89).

Some participants said providers and others neglect to or are inconsistent about offering NRT resources and information during health care visits (99). Offers of NRT were described by some participants as fragmented, having occurred only once and frequently not being supported with cessation services or a referral to cessation services (99). It was identified as important and helpful when health and service providers offer consistent and positive cessation advice that includes NRT (91, 97, 99). Pregnant women are seeking some consistency in the offering, communicating awareness of, and education around the use of NRT to support their cessation efforts and efforts to stay quit (87, 91, 97). Pregnant women and male partners who smoke identified access to no cost NRT as necessary and seek these supportive cessation resources (91-93, 96, 97, 99). For additional details on effectiveness NRT for pregnant women who use commercial tobacco, refer to **Recommendation 4**.

Extended family social networks that include strong family connections within and across community families foster important social connections (91, 92, 95). Many participants reported a lack of social support within their networks to help them quit smoking because most people in their circle of support were smokers (91). Many young pregnant women and mothers do not have control over their household environment (95). For example, they may not be contributing financially to the household expenses, which may limit their voice in choosing to live in a smoke free environment (91, 95). Many participants considered it vital to have, as part of their social network, a non-smoking friend, mother, or family member who supports their quit attempt (91, 93, 128, 129).

Participants noted the importance of families who acknowledge the difficulty in quitting smoking and provide their support (92, 93). Social support from partners, other family members and friends/peers was perceived by participants as being important in supporting pregnant women and mothers to stay tobacco free (87, 128). Participants most frequently identified mothers as highly valued sources of social support (98, 128). Mothers were also identified as influential role models for pregnant women during their pregnancy (98, 128). Participants reported being less likely to smoke around their mothers, and mothers were also identified as key supporters who offer encouragement to their daughters' cessation efforts (98). Other maternal figures, such as grandmothers, were also identified as instrumental in providing support for those trying to quit smoking (98). Fathers described the importance of framing positive messaging in cessation services, as positive messages are less likely to lead to feelings of failure (97). Participants identified the support of intergenerational conversations to be important to support cessation (97).

Helpful support from partners, family members and friends frequently took the form of listening, talking, sharing stories, providing a buddy system, not sharing tobacco, and suggesting other strategies to help to manage stress (87, 91, 128). See further details from the evidence in the "Implementation Tips" below.

Participants expressed the wish to break the cycle of smoking in their communities (98). Many participants credited the influence of the community at large, community members and leaders such as Elders, midwives or Aunties as highly credible and effective in supporting smoking cessation efforts (87, 94, 96, 99 128). Community leaders, such as Elders, are respected, held in high regard and are identified by participants as having an insider's understanding of the psychosocial influences experienced by many young pregnant women and mothers of young children in their community (87, 92, 94, 96, 99, 128). Some participants described the important role of Elders in supporting cessation efforts through community leadership and the establishment of new smoke-free rules in the community (96, 98).

Participants also identified the integration of a wholistic approach in cessation supports by health and social service providers, one that includes the mental, emotional, physical and spiritual aspects and relevant cultural content, as nurturing and fostering for the delivery of culturally safe cessation services (87, 97). Participants identified as beneficial smoking cessation supports that offer a good cultural fit, where these supports integrate community spiritual and cultural traditions and connect with ancestral knowledge (87). There were no harms related to health providers advocating for equitable access to commercial tobacco cessation resources reported in the literature.

For more detailed information of quantitative and the qualitative findings and the grading of the evidence, please refer to the evidence profiles.

Further details are located in **Table 8: Intervention Details from the Evidence** below.

Values and Preferences

The qualitative literature highlights the value of access to resources such as NRT, preferred social supports such as mothers, Indigenous case managers, and the integral role of the community and community leaders in supporting Indigenous women to stop smoking (89, 90, 92, 96, 99, 128. The fostering of trusted relationships between participants and their case managers was highly valued and considered a fundamental social support for participants' continued engagement in the smoking cessation intervention (89). Participants valued the dependability of Indigenous case managers who were identified by participants as extremely supportive and trusted (89). In smoking cessation programs, participants valued the opportunity to engage in culturally meaningful activities (arts, painting, dancing, crafts, music) to help deal with cravings, speak to peers and heal by strengthening their connections with their culture (90).

Health Equity

The use of NRT mitigates the side effects of nicotine withdrawal for pregnant women and supports successful cessation, but many participants identified the cost of NRT to be a significant barrier. Taxpayer subsidized NRT is necessary to enable access to these important cessation resources (87, 91-93, 97, 98). Depending on the jurisdiction, NRT may be subsidized by the taxpayer with certain limitations or it may not be accessible without payment (93). For more information refer to the "Implementation Tips" for further details. Refer to **Recommendation 4** for additional details on NRT.

Women's experiences are understood in the context of the normalization of commercial tobacco use and the accepted strategy of using smoking to reduce stress and promote socializing (95). The ability of pregnant women and mothers of young children to establish and maintain a smoke-free home is influenced by housing shortages, unemployment, family dynamics and gender roles (95).

Multiple social inequalities that include race, social class, location and other dimensions of difference all collide to create the forces that impact commercial tobacco use by the individual, the family and the community (94, 96). Social disruptions occur through the impact of residential schools, and the loss of land or nationhood, traditional cultural practices and cultural identities. These disruptions have marginalized many Indigenous women and have resulted in the socioeconomic conditions and poor health that many women experience today (92, 94, 96, 105). Efforts to reduce widespread commercial tobacco use will also require broad policy changes that will address barriers related to the social determinants of health experienced by Indigenous Peoples in many communities (92, 96, 97, 99).

Panel Justification of Recommendation

The panel identified smoking during pregnancy as a high priority issue for Indigenous women and persons due to the known harms related to smoking and the significant impact of Indigenous determinants of health, on health equity. The panel members noted that current smoking cessation resources do not meet the needs of Indigenous Peoples and communities. The panel emphasized that most people would benefit from the circle of care advocating for equitable access to smoking reduction and cessation services for Indigenous Peoples of reproductive age and their support network; however, the evidence is uncertain. The panel further noted that the qualitative evidence also highlights the need for Indigenous-led and culturally tailored cessation supports that consider the context and stress in the lives of Indigenous women and persons. According to GRADE methods, there are five paradigmatic situations where panel members can justify a strong recommendation based on very low certainty of evidence, such as where there is potential for further catastrophic harm. Although the certainty of the evidence about the effects of this intervention is very low and the confidence in the evidence is moderate, the panel determined the strength of this recommendation to be strong based on the critical importance of addressing the certain harms from smoking, and the need for advocacy to urgently address inequities related to accessing smoking reduction and cessations services and break the cycle of smoking.

Implementation Tips

Implementation tips from the panel

- Support groups such as sharing circles or social circles should be culturally appropriate and reflect the importance of including cultural safety and traditional health healing within the specific setting.
- Access to no cost or low cost NRT will vary by jurisdiction and health and social service providers should be aware of how NRT can be accessed in their practice settings where appropriate.
- Supports such as sharing circles can be delivered in person, via social media, virtually, or can be digital in design.
- Some individuals may prefer not to participate in smoking reduction and cessation support groups and instead wish to participate on an individual basis.

Table 8: Intervention Details from the Evidence

KEY FACILITATORS	DETAILS FROM THE EVIDENCE
All providers use a non-judgmental, positive and supportive approach	■ Women indicted that health providers need to be more supportive, less judgmental, and provide encouragement (91). Providers require an understanding of the complexity of smoking during pregnancy that includes the health outcomes for both women and children and emotional responses and coping mechanisms in order to offer help and foster informed and emotionally supportive smoking cessation services (91, 99).
	■ Participants identified a preference for supportive, non-judgmental approaches to smoking cessation supports delivered by community members or, where gaps exist, non-community members (87).
	■ Participants emphasize that quitting is hard and they seek encouragement to make positive choices around cessation (92).
	■ Participants recommended that health providers be aware of barriers to smoking cessation for pregnant women and, to mitigate those barriers advocate for women for resources to address their socio-economic stressors, and inform women about evidence-based cessation services tailored to meet the client's individual needs and preferences (91).
	■ Trusted relationships and relationship building can be fostered between participants and health providers using a non-judgmental and empathic approach for assessments without pressure, and using informal discussion (yarning) and deep listening to allow a safe space for participants to share their unique, personal stories with adequate time (89).
	■ Health providers must understand the impact of trauma, create an environment of safety and trust, and support a community member's choice and autonomy in a culturally safe and trauma-informed way (90).

RECOMMENDATIONS

KEY FACILITATORS	DETAILS FROM THE EVIDENCE
Facilitate quit services such as sharing circles or social circles for stopping smoking that includes pregnant women and women with young children	▪ Participants highlighted the need for group-based supports. The value of participants being able to go through cessation experiences with others and share the benefits of these supports was clear (87). ▪ Develop support networks for maternal smokers to encourage smoking cessation attempts (92). ▪ Participants identified that the focus of cessation service should be not only on pregnant women who smoke, but also on their partners, family, friends and community members (128). ▪ Participants emphasized the importance of a culturally tailored approach to facilitate how services are provided (87, 97). ▪ Women suggested health service workers could coordinate group supports—to build a support network during the quitting process—that can include sharing stories and discussing strategies that could guide women through cravings and withdrawal in real time (99). ▪ Programs such as "mom and tots" or group-based sharing or walking outside in fresh air helped participants to remain smoke free (91).
Facilitate expanding circles of support	▪ Participants reported a lack of supports within their social networks. Participants reported that non-smoking members of their social network (partners, family members and friends) could best help women try to quit smoking during their pregnancy (91). ▪ Most participants identified social support from partners or the baby's fathers and family and friends as essential to be smoke free and manage stress (97, 128). This support can be provided by asking others not to smoke around them, or keeping busy with creative work (one example: beading and sewing) (128). ▪ Most participants reported that they valued peer support from Indigenous health and workers and/or service providers (midwives, "Native Sisters") (128). ▪ Some participants suggested a buddy system would be helpful with ongoing support to stay quit (91). ▪ Offering cessation supports that also include partners and fathers was identified as important (97). See **Recommendation 5** for further details. ▪ A focus on health and wellness and positive cultural activities during pregnancy, directed at the community at large, was identified as helpful (128). ▪ Participants suggested a variety of approaches for cessation that include those for the individual, group activities and help from others, and comprehensive accessible programs at the community level that include a wholistic approach (91).

KEY FACILITATORS	DETAILS FROM THE EVIDENCE
	■ Culturally based commercial tobacco cessation strategies that target the entire community to reduce smoking during pregnancy (128) ■ Participants identified community support as necessary and particularly helpful to support successful quit attempts (99)
Advocate for and promote the offering of no-cost NRT, where appropriate	■ Women identified the need for easy access to affordable NRT; learning about the variety of NRT options motivated them to try it (91) ■ Provide consistent advice around NRT. Participate in conversations about the benefits of NRT, and support this with other cessation resources (counselling, support groups such as talking circles) or referrals to other cessation resources (99) ■ One program combined case management support, with individualized and tailored smoking cessation support including NRT (89).
Educate health and social service workers on cessation services	■ Health and social service organizations ensure that those who work with pregnant women who smoke are provided with educational training to ensure tobacco cessation knowledge and competency in their clinical environment (91). ■ Health providers use a strengths-based approach to smoking cessation that focuses on celebrating the inherent strengths of Indigenous Peoples, fosters participant self-agency and supportive relationships at the family and community level, and facilitates non-judgmental access to both health and social service resources that can help address the impact of the social determinants of health (89).

Supporting Resources

RESOURCE	DESCRIPTION
Chigamik Community Health Centre [Internet]; 2020 [cited 2020 June 15]. Available from: https://www.chigamik.ca/blog/event/getting-started-smoking-awareness-reduction/	■ Established support group (Quit Café) integrated into smoking cessation strategies in Midland, ON Community Health Centre
Ontario Federation of Indigenous Friendship Centres [Internet]; 2020 [cited 2020 June 15]. Available from: https://ofifc.org/	■ Multiple centres across Ontario offering Indigenous supports
Ontario Native Women's Association (ONWA) [Internet]; 2020 [cited 2020 June 15]. Available from: https://www.onwa.ca/	■ Various resources for Indigenous women and women's issues in Ontario
Seventh Generation Midwives, Baby Bundles Program [Internet]; 2020 [cited 2020 June 15]/ Available from: https://www.sgmt.ca/baby-bundle-program	■ Midwifery services providing perinatal care for Indigenous families in Toronto, ON

RECOMMENDATIONS

RECOMMENDATION 8:

It is recommended that health service organizations embed smoking reduction and cessation services within existing health and wellness programs.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Low

Confidence in evidence: Not Applicable

Discussion of Evidence:

Benefits and Harms

There is a lack of direct evidence related to smoking reduction and cessation interventions within broader health and wellness programs in Indigenous communities. As a result, the support for this recommendation is from systematically gathered observations by panel members and indirect literature in the broader, non-Indigenous populations.

Four panel members had experiences in embedding smoking reduction and cessation interventions within broader health and wellness programs in Indigenous communities through substance use and harm reduction programs, baby and youth programs, regional cancer care programs, Indigenous health and wellness programs and a family health team that specializes in obstetrics. In terms of estimated reach of the programs, responses ranged from "unsure", "10-15 people" to "large". In terms of engagement, those who provided answers estimated that engagement (meaning completion of program) ranged from 75-80 per cent. In terms of acceptability, responses in general were that people appreciate the support and that there was very good client feedback. Other observed benefits reported by persons receiving care included increased quit attempts, confidence, connections and social support, knowledge of impact of tobacco and ability to receive a "package" of services together (ranging from diet and exercise, housing and employment support and other harm reduction). There were no harms expressed by the panel as a result of embedding smoking cessation and reduction interventions within broader health and wellness programs.

Indirect literature suggests that embedding commercial tobacco cessation interventions within broader health and wellness programs (when compared to usual care, no embedding of commercial tobacco cessation interventions, or less treatment intensive controls) may improve quit rates (130-133). In the systematic reviews, smoking cessation services were embedded within primary care, cancer care settings and dental settings. There were no harms expressed in the literature related to embedding smoking cessation interventions within broader health and wellness programs.

The overall evidence (panel observations and indirect evidence) was of low certainty due to limitations in how studies were conducted and the small number of study participants. For more detailed information about the impact on the prioritized outcomes of embedding smoking reduction and cessation interventions within broader health and wellness programs, refer to the evidence profiles.

Values and Preferences

Panel members commented that the community would value smoking reduction and cessation services embedded within other health and wellness programs as they prefer and ask for "one-stop" services and programs. Panel members also discussed that persons like smoking reduction and cessation services and the opportunity to self-determine their ability to engage with the cessation service.

Health Equity

The panel emphasized that embedding smoking reduction and cessation interventions within existing health and wellness programs will improve access to support for Indigenous Peoples of reproductive age and the broader community. The integration recognizes that there is not a single best time to stop smoking and that it is important to have an upstream approach to health.

Panel Justification of Recommendation

Conventionally based on GRADE methods, this recommendation could have been voted conditional since the certainty of the evidence of the effects was low. The panel agreed that there may be benefits and that no harms were identified from embedding smoking reduction cessation interventions within health and wellness programs. According to GRADE methods, there are five paradigmatic situations where panel members can justify a strong recommendation based on very low certainty of evidence, such as where there is potential for catastrophic harm. The panel emphasized that the recommendation could improve access for Indigenous Peoples and avoid the known harms of people not being able to get timely, equitable access to smoking reduction and cessation interventions. Further, the panel emphasized the wholistic approach to health care that is central to Indigenous beliefs. Therefore, the panel determined the strength of the recommendation to be strong.

Implementation Tips

Implementation tips from the panel

- It is important to note that embedding smoking reduction and cessation services does not only involve screening, but also involves discussing risks in a non-judgmental and trauma-informed way and supporting empowerment of persons to make harm reducing and cessation decisions.

Table 9: Implementation Tips from the Evidence

KEY INTERVENTION	DETAILS FROM THE EVIDENCE
Examples of commercial tobacco reduction and cessation interventions that were embedded in existing health and wellness programs	■ Behavioural interventions for tobacco cessation conducted by oral health professionals incorporating an oral examination component in the dental office or community setting (130) ■ Behavioural interventions (individual or group smoking cessation sessions, telephone conversations, brochures, choosing a quit date, quit-smoking kits) in primary care or cancer care settings (131, 132) ■ Pharmacotherapy in primary care or cancer care settings (131, 132) ■ Multi-component smoking cessation interventions in primary care setting (132, 133) ■ Additional components such as financial incentives, no-cost NRT, homework assignments and multifactorial community care (132)

RECOMMENDATIONS

RECOMMENDATION 9:

It is recommended that Indigenous communities advance the health and wellness of all community members through the promotion of indoor and outdoor smoke free spaces.

Strength of the recommendation: Strong

Certainty of the evidence of effects: Very Low

Confidence in evidence: Moderate

Discussion of Evidence:

Benefits and Harms

A review of qualitative literature highlights the need for smoke free spaces. Smoke free spaces can include both indoor and outdoor spaces where people do not smoke (such as in community spaces, homes and cars). Many persons within studies described how smoking is a way of life and smoking is normalized within the home and community (87, 91, 93, 95, 96, 98, 105). For instance, some mothers explained how within their household there may be several smokers, who were difficult to avoid (93). They also said that smoking was very prevalent in popular community social gatherings, such as bingo halls (96).

Further, mothers and family members described setting smoke free rules in the home and outside the home to protect the health and wellness of their children/grandchildren (93, 95, 129, 134). Strategies included requesting others to smoke away from the house, not smoking in other settings where there may be children, not allowing children into a house or car where people were smoking, as well as finding ways to protect against third hand smoke such as changing clothes after smoking (129). Community members, especially mothers, expressed how important Elders were as allies in establishing smoke free spaces (94). Many participants said Elders had firsthand experiences of the harmful effects of smoking and had made important changes that served as role models (94).

There were no voiced harms in regards to promotion of smoke free spaces. However, some participants acknowledged the barriers in the implementation of smoke free rules within their own home, such as having little control over their home environment and/or the difficulty involved in asking others to smoke further away from the house, especially in bad weather (95, 129, 134).

It is likely that these review findings are a reasonable representation of the values expressed by participants. The qualitative evidence was of moderate confidence due to methodological limitations in the individual studies. The certainty in the evidence is very low because of the same concerns, as well as the range in the interventions described and the inability to identify an estimate of effect. For more detailed information on the findings across qualitative studies, refer to the evidence profiles.

Values and Preferences

The literature highlights how many Indigenous mothers value smoke-free spaces and actively put in efforts to maintain smoke free spaces in order to protect their children (93, 95, 129).

Health Equity

There was no direct literature regarding the impact of smoke free spaces on health equity. However, there is indirect literature on barriers in health equity that may limit mothers from establishing and maintaining smoke free homes; barriers include housing shortages, unemployment, dynamics within families and gender roles (95). Women often did not have support of family members and control over domestic space (95). Furthermore, community gatherings in which commercial tobacco use is prevalent, and where smoking restrictions are not in place, such as bingo halls, provide mothers with an opportunity for paid work, an accessible haven from stress, isolation and demands of childcare, and the prospects of extra money from prizes (96).

Panel Justification of Recommendation

Conventionally based on GRADE methods, this recommendation could have been considered for a good practice statement. However, the panel wanted to review the evidence to provide guidance for implementation within communities. The certainty of the evidence of the effects was very low and the confidence in evidence was moderate. No quantitative evidence examined the implementation of smoke-free spaces with Indigenous communities. Other forms of evidence outlining the implementation of smoke-free spaces in Indigenous communities exists, but is difficult to summarize and the potential for any future comparator studies is unlikely, as it may not be considered ethical. According to GRADE methods, there are five paradigmatic situations where panel members can justify a strong recommendation based on very low certainty of evidence, such as where there is the possibility of a catastrophic harm. The panel emphasized that the recommendation would avoid the catastrophic harm of negative health effects from second hand smoking for the pregnant women and persons, their children and the wider community. Overall, the panel agreed that the benefits outweigh the harm and, where possible, smoke-free spaces adopted in a culturally safe way with community members can lead to better outcomes for all. Therefore, the panel determined the strength of the recommendation to be strong.

Implementation Tips

Implementation tips from the panel

- Indigenous communities are self-governed, and it is important to respect their decisions. When a community and/or community leader is ready to establish smoke-free spaces, the health provider can support the promotion of smoke-free spaces. It is critical that health providers establish trust prior to any attempt to help facilitate smoke free spaces within the community.

Supporting Resources

RESOURCE	DESCRIPTION
Blue Light Community Campaign. In: Healthy Together Now [Internet]. Available from: https://healthytogethernow.net/wp-content/uploads/2011/09/Blue-Light-Project-Summary.pdf	■ Information on the process and reflections on the Blue Light Community Campaign, a smoke-free home initiative in Thompson, Manitoba
Go Blue NU. In: NuQuits [Internet]. Available from: https://nuquits.gov.nu.ca/tobacco-facts/second-hand-smoke	■ Campaign around protecting homes and communities from second-hand smoke in support of the "Tobacco has no place here" initiative in Nunavut, Canada ■ Links to chat or phone options for quit supports
Smoke-free spaces. In: Public Health Sudbury & Districts [Internet]. Sudbury (ON): Public Health Sudbury & Districts; 2020. Available from: https://www.phsd.ca/health-topics-programs/tobacco/smoke-free-spaces	■ Website that provides guidance and resources on creating smoke free policy

Research Gaps and Future Implications

The RNAO best practice guideline development and research team and the panel identified priority areas for future research (outlined in **Table 10**). Studies conducted in these areas would provide further evidence to support high-quality and equitable support for Indigenous Peoples of reproductive age, families and communities. The list is not exhaustive; other areas of research may be required.

Table 10: Priority Research Areas per Recommendation Question

| RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
RECOMMENDATION QUESTION #1: **Should smoking reduction and cessation counselling be recommended for Indigenous women and persons during pregnancy and the post-partum period?** **Outcomes:** Reach, engagement and quit rates.	■ Impact of tailored commercial smoking cessation counselling with Indigenous pregnant women and their perceptions of receiving culturally safe care ■ Impact of smoking cessation counselling from Indigenous community health workers on levels of engagement and quit rates ■ Development and evaluation of tailored, culturally appropriate resources to support health providers in offering smoking cessation in collaboration with Indigenous women, their partners, family and communities
RECOMMENDATION QUESTION #2: **What needs (social, cultural, environmental supports) and opinions (with respect to barriers and facilitators) do Indigenous women and persons of reproductive age, their support networks and community, express about smoking cessation interventions?**	■ The needs of partners and other family members so they can support Indigenous women who are trying to quit commercial tobacco use
RECOMMENDATION QUESTION #3: **Should smoking reduction and cessation interventions embedded within broader health and wellness programs be recommended?** **Outcomes:** Reach, engagement, acceptability and quit rates	■ Impact of embedding smoking cessation interventions within broader health and wellness programs specifically in Indigenous communities ■ Indigenous communities' perceptions and needs regarding embedding smoking cessation interventions within broader health and wellness programs

RECOMMENDATIONS

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
RECOMMENDATION QUESTION #4: **Should culturally appropriate and trauma-informed smoking reduction and cessation services be recommended?** **Outcomes:** Reach and engagement	■ Impact of culturally safe smoking reduction and cessation services with Indigenous communities ■ Examining the delivery of culturally safe care from the perspectives of those receiving the care, not the perspective of the health and social service provider, as cultural safety is determined by the recipient ■ Quantitative and qualitative studies on Indigenous health and cultural safety that include Indigenous traditional medicines and healing
RECOMMENDATION QUESTION #5: **Should pharmacotherapy (nicotine replacement therapy, bupropion or varenicline) be recommended for smoking cessation in pregnant and post-partum women and persons?** **Outcomes:** quit rates, miscarriage & spontaneous birth, mean birth weight	■ Effect of nicotine replacement therapy on smoking cessation and fetal outcomes ■ Effects of bupropion in pregnant women on smoking cessation and fetal outcomes ■ Effects of varenicline in pregnant women on smoking cessation and fetal outcomes
RECOMMENDATION QUESTION #6: **Should Indigenous community-led smoking cessation approaches be recommended?** **Outcomes:** Reach, engagement, quit rates, quit attempts	■ Quantitative studies examining Indigenous community led, culturally safe smoking cessation programs ■ Qualitative studies examining Indigenous experiences in Indigenous community-led, culturally safe smoking cessation programs
RECOMMENDATION QUESTION #7: **Should undergraduate education for nurses and the interprofessional team and/or continuing professional development for health providers on Indigenous health be recommended?** **Outcomes:** cultural safety, attitude, knowledge, change in practice	■ Impact of the delivery of Canadian Indigenous health and cultural safety education for students entering health. professions and practicing health providers ■ Qualitative research examining the delivery of culturally safe care where Indigenous Peoples and communities evaluate the delivery of cultural safety ■ Curriculum gaps in Indigenous cultural safety and health courses ■ Develop validated tools to measure the degree of cultural safety fostered by students entering health professions and health providers ■ Impact on Indigenous teaching staff ■ Quantitative and qualitative studies on Indigenous health and cultural safety that include Indigenous traditional medicines and healing

Implementation Strategies

Implementing guidelines at the point of care is multi-faceted and challenging. It takes more than awareness and distribution of BPGs for practice to change: BPGs must be adapted for each practice setting in a systematic and participatory way to ensure that recommendations fit the local context (135). The RNAO *Leading Change Toolkit*™ (2021) provides evidence-informed processes for this (see **Appendix I**).

The *Leading Change Toolkit*™ uses two complementary frameworks to guide evidence uptake and sustainability (see **Figure 1**). They can be used together to maximize and accelerate change.

Figure 1: *Leading Change Toolkit*™ **Two Complementary Frameworks to Accelerate your Success**

The Social Movement Action Framework (136) is descriptive and identifies the defining elements of a social movement for knowledge (e.g., BPGs) uptake and sustainability. It integrates a 'bottom-up', people-led approach to change for a shared concern (or common cause) in which change agents and change teams mobilize individual and collective action to achieve goals. The framework's elements, categorized as preconditions, key characteristics and outcomes, are dynamic, inter-related and develop spontaneously as the social movement evolves.

The Knowledge-to-Action Framework uses a process model of action cycle phases to systematically guide the adaptation of the new knowledge (e.g., BPG) to the local context and implementation. This framework suggests identifying and using knowledge tools/products, such as guidelines, to determine gaps and begin the process of tailoring the new knowledge to local settings.

The *Leading Change Toolkit*™ is based on emerging evidence in health and social sciences that successful uptake and sustainability of best practice in health care is more likely when:

- BPGs are selected for implementation through a participatory process led by change agents and change teams;

- The selected BPGs reflect priority areas for a shared concern that is credible, valued and meaningful, or an urgency for action;

- Stakeholders are identified and engaged throughout implementation to engage in individual and collective action;

- Receptivity for implementing BPGs, including environmental readiness, is assessed;

- Implementation strategies are tailored to the local context and designed to address barriers;

- Use of the BPG is monitored and sustained;

- Evaluation of the BPG's impact is embedded in the process to determine if the goals and outcomes have been met;

- There are adequate resources to complete all aspects of the uptake and sustainability of the BPG; and,

- The BPG is scaled up, out, or deep, where possible, to widen its influence and create lasting health improvements.

RNAO is committed to widespread deployment and implementation of our BPGs. We use a coordinated approach to dissemination, incorporating a variety of strategies, including the following:

1. The Nursing Best Practice Champion Network®, which develops the capacity of individual nurses and other heath care provider to foster awareness, engagement, and adoption of BPGs.

2. The BPG Order Sets™ provide clear, concise and actionable intervention statements derived from practice recommendations. BPG Order Sets™ can be readily embedded within electronic records, but they can also be used in paper-based or hybrid environments.

3. The BPSO® designation supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate and sustain multiple RNAO BPGs.

In addition, we offer annual capacity-building learning institutes on specific BPGs and their implementation.

Information about our implementation strategies can be found on our website:

- RNAO Best Practice Champions Network®

- RNAO BPG Order Sets™

- RNAO BPSO®

- RNAO capacity-building learning institutes and other professional development opportunities

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Appendix A: Glossary of Terms

Aboriginal: The term used to collectively describe the first inhabitants in what is now Canada, and includes First Nations, Inuit and Métis peoples and their descendants. These are separate and distinct groups, with each having unique and diverse heritage, language, cultural practices and spiritual beliefs (137). The term became commonly used following the inclusion of this definition in the Canadian Constitution Act of 1982 (14). This term is frequently used to identify the First Peoples (inhabitants) in Australia (14).

Best practice guideline: "Best practice guidelines are systematically developed, evidence-based documents that include recommendations for nurses and the interprofessional team, educators, leaders and policy-makers, persons and their families on specific clinical and healthy work environment topics. BPGs promote consistency and excellence in clinical care, health policies and health education, ultimately leading to optimal health outcomes for people and communities and the health system" (138).

CERQual: The Confidence in the Evidence from Reviews of Qualitative Research (CERQual) is a methodological approach to assess the amount of confidence that can be placed in findings from a body of qualitative evidence about an outcome of interest. The assessment provides a transparent means to decide if the review finding reasonably represents the phenomenon under study, which can facilitate guideline panels to make health recommendations (139).

See *CERQual criteria*

CERQual criteria: When using CERQual, four components contribute to the assessment of confidence in the evidence for each finding:

1. *Methodological limitations*, which look at issues in the design of the primary study or problems in the way it is conducted.
2. *Relevance*, whereby primary studies that support a finding are assessed together and a decision is made regarding the applicability of the findings to the population, phenomenon and setting outlined in the research question.
3. *Coherence*, whereby an assessment is made of whether the primary studies provide sufficient data and a convincing explanation for the review findings.
4. *Adequacy of data,* whereby an overall assessment is made about the richness and quantity of the data that support the review finding and phenomenon of interest (139).

See *CERQual*

Circle of care: A team comprised of community members and/or multiple health providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health care and services with people within, between and across health and wellness settings (6). Key interprofessional team members supporting Indigenous community members may include: Traditional Healers, Elders and Knowledge Keepers, midwives, doulas, Aunties, nurses, community health workers, social workers, physicians and pharmacists.

Circle of support: Healing supports include instrumental, informational, emotional and therapeutic categories. Pregnant or postpartum Indigenous women and parents can find support from a circle of immediate and extended family members, community members, friends and peers, supportive health providers and other significant people in that person's community (140).

Clinical immersion: An educational method with a goal of increasing cultural knowledge and sensitivity (141). A clinical immersion provides the opportunity for transformational learning through direct interactions with culturally diverse populations (141).

Community of practice: An online social learning environment that uses technology to support strong participation and mutual engagement among practitioners who are geographically dispersed (142). Participants engage in a process of collective learning in a shared domain, share a common goal and learn how to do a practice more effectively as they interact regularly. Design methods included are consistent facilitation, guiding questions and collaborative assignments that promote the creation and sharing of knowledge amongst the participants over time (142).

Consensus: A process used to reach agreement among a group or panel during a Delphi or modified Delphi technique (143). A consensus of 70 per cent agreement from all panel members was required for the strength of recommendations within this BPG.

Colonization: European settlers seized the traditional lands and territories of many First Nations for settlement, trade, and military reasons and for natural resource extraction on land now known as Canada (144). The Government of Canada then forced the relocation and settlement of many Indigenous communities and the signing of treaties and passed the Indian Act, legislation that led to a catastrophic impact on the cultural, social and political distinctiveness of Indigenous Peoples (144).

Commercial tobacco: Commercial tobacco is manufactured for recreational and habitual use in cigarettes, smokeless tobacco, chewing tobacco, pipe tobacco, cigars and hookah. Commercial tobacco is produced and sold for profit. It contains thousands of chemicals and produces chemical compounds, many of which are carcinogenic and contribute to cardiovascular disease, chronic obstructive pulmonary disease, emphysema, asthma, diabetes, cancer (lung, colorectal, cervical, kidney, liver and stomach) and can lead to premature death (2). Commercial tobacco use also poses risks to the fetus such as low birth weight and increasing likelihood of sudden infant death syndrome (SIDS) (3). Second hand commercial tobacco smoke exposure also causes acute lower respiratory infections in infants and young children (3). Nicotine is the primary addictive substance contained in commercial tobacco (2).

See *Traditional tobacco*

Community-led: Where the community is involved in the development or the implementation of services in collaboration with other stakeholders such as community leaders, Knowledge Keepers, community health workers or health providers.

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Critical reflexivity: Critical reflexivity involves the health student or health provider being able to connect with their own internal assumptions, values and biases that influence their decision-making and the delivery of health care. Reflexivity involves the ability to critically reflect and understand how one's social locations (belief systems) and experiences of privilege or disadvantage shape how we understand the world and produce knowledge (145). For clinicians to understand and address health inequities it is crucial that they have insight into their relation to structures of privilege and oppression (146). Reflexivity is a skill that requires practice and ongoing learning across a career. The capacity for reflexivity is critical because it informs clinical decisions, which can lead to improvements in service delivery and patient outcomes (145).

Cultural safety: Cultural safety is an outcome that is based on respectful engagement that recognizes and aims to address power imbalances inherent across the health system (4). Cultural safety creates an environment that is free of racism and discrimination, where people feel safe when receiving health care. Indigenous people, families and communities should be able to share their perspectives, ask questions, and be respected by health care providers on their beliefs, behaviors and values (4).

De-linked: The health provider working with the woman and the partner or family member separately, to explore individual smoking behaviour and approaches to smoking cessation (147).

Direct evidence: In this BPG, direct evidence refers to findings from the systematic review that pertain to Indigenous populations.

Downgrade: When limitations in the individual studies potentially bias the results in GRADE and GRADE-CERQual, the certainty of evidence will decrease (148). For example, a body of quantitative evidence for one priority outcome may begin with high certainty, but due to serious limitations in one or more of the five GRADE criteria, it will be rated down by one or two levels (148).

Education recommendation: Recommendations that are directed to those responsible for the education of nurses and the interprofessional team. Responsible parties include educators, quality improvement teams, managers, administrators, academic institutions (settings), and health service organizations.

Engagement: In this BPG, the outcome "engagement" refers to the number of people who stay and complete a program.

Ethical space: A partnership formed when two societies with differing worldviews are poised to engage with one another. An ethical space of engagement proposes a framework as a method of examining the diversity and positioning of Indigenous Peoples and Western society in the pursuit of relevant discussions on Indigenous legal issues and the intersection of Indigenous laws and the Canadian legal systems (13).

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Evidence-based nursing practice: The integration of research evidence with clinical expertise and patient values. It unifies research evidence with clinical expertise and encourages the inclusion of patient preferences (149).

Evidence-to-Decision (EtD) frameworks: A table that helps guideline panels make decisions when moving from evidence to recommendations. The purpose of the EtD framework is to summarize the research evidence, outline important factors that can determine the recommendation, inform panel members about the benefits and harms of each intervention considered, and increase transparency about the decision-making process in the development of recommendations (10).

First Nations: A term used to describe First Peoples and their descendants, who do not self-identify as Inuit or Métis in what is now known as Canada (14). There are currently more than 600 distinct First Nations communities in Canada and over 200 First Nation communities (reserves) in Ontario (150). These communities are diverse and distinct from each other, and represent many Indigenous Peoples in Canada.

Good practice statement: A statement directed primarily to nurses and the interprofessional teams who provide care to persons and their families across the spectrum of care, including (but not limited to): acute care, long-term care, primary and community care, or rehabilitation. It refers to a practice already accepted as beneficial or practical advice.

In the case of this BPG, the good practice statement is believed to be so beneficial that conducting a systematic review to prove its efficacy would be unreasonable. These statements are not based on a systematic review and do not receive a rating of the certainty or confidence in the evidence or strength (i.e., conditional or strong) (9).

GRADE: The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) is a methodological approach to assess the certainty of a body of evidence in a consistent and transparent way, and to develop recommendations in a systematic way. The body of evidence across identified important and/or critical outcomes is evaluated based on the risk of bias, consistency of results, relevance of studies, precision of estimates, publication bias, large effect, dose-response, and opposing confounding (10).

When using GRADE, five components contribute to the assessment of confidence in the evidence for each outcome. These components are as follows:

1. *Risk of bias*, which focuses on flaws in the design of a study or problems in its execution.

2. *Inconsistency*, which looks at a body of evidence and assesses whether the results point in the same direction or if they are different.

3. *Imprecision*, which refers to the accuracy of results based on the number of participants and/or events included, and the width of the confidence intervals across a body of evidence.

4. *Indirectness*, whereby each primary study that supports an outcome is assessed and a decision is made regarding the applicability of the findings to the population, intervention and outcome outlined in the research question.

5. *Publication bias*, where a decision is made about whether the body of published literature for an outcome potentially includes only positive or statistically significant results (10).

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Health provider: Refers to both regulated workers (e.g., nurses, physicians, dietitians and social workers) and unregulated workers (e.g., community health workers) who are part of the circle of care.

Regulated health provider: In Ontario, *the Regulated Health Professional Act, 1991* (RHPA) provides a framework for regulating 23 health professions, outlining the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (7).

Unregulated health provider: These providers fulfill a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (e.g., the College of Nurses of Ontario). Unregulated health providers fulfill a variety of roles and perform tasks that are determined by their employer and employment setting. Unregulated health providers only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (8).

Immersion experience: A form of clinical, experiential learning that involves the health profession student both living and working (study) in a practice setting such as a rural Indigenous community (RefID 57). Immersion in the community provides rich opportunities for teaching and learning for educators and students in understanding the role culture has in health care. An immersion experience can provide students with a powerful, life-changing learning experience (citation 114)) as they can gain an understanding of, and experience and confidence with developing relationships and providing culturally safe services (citation 114).

Indian: *The use of this term in Canada is considered outdated and offensive when used by non-Indigenous people.* It is a legal term used to represent a First Nations person with status who is registered under the Indian Act (14). This term may still be in use in other international jurisdictions.

Indian Act: Canadian federal government legislation (law) pertaining to matters of Indian status, bands and reserve communities (18). It grants the Canadian government the right to regulate and administer various affairs and day to day lives of registered Indians and reserve communities (18). This includes overarching political control such as determining who is deemed to be a First Nations person or have Indian status, the imposing of governing structures such as band councils and controlling the rights of First Nations peoples to practice their cultures and traditions (14). In addition, the Indian Act gives the Canadian federal government the rights to determine the land base such as reserves (14). The Indian Act was enacted in 1876 and has undergone multiple amendments, however this Act remains with much of its' original content and form (14).

Indigenous determinants of health: Indigenous health is influenced by complex, intersecting and interrelated Indigenous determinants of health that lead to health inequities. They are structural, historical and contemporary in origin and influence Indigenous health and wellness. Indigenous determinants of health are more than social determinants alone. Structural determinants of Indigenous health can be proximal, intermediate and distal and all interconnect.

Proximal determinants: include the social determinants of health and wellness, such as early childhood development, income, social status, education and literacy, support network, employment, housing, working conditions, culture and gender identity. Experiences of social disadvantage can impact Indigenous health.

Intermediate determinants: are those that can impede or facilitate health through systems that connect proximal and distal determinants such as health-care and education, but also Indigenous-specific determinants that include relationship with the land, kinship networks, traditional languages and ceremonies and knowledge sharing.

Distal determinants: the largest impact, and represent historical, political, ideological, economic and social foundations such the ability to access health-care services, for e.g. First Nations living in reserve communities. Distal determinants also include worldviews, spirituality and self-determination) (22).

Indigenous-led or community led: involves Indigenous community membership that can include Elders, Knowledge Keepers, community leaders, health providers, health workers and community members in the development, planning, implementation and evaluation of a smoking reduction and cessation intervention. This is to ensure that the intervention is respectful, culturally safe and tailored to the needs of their community (79-82).

Indigenous Peoples and communities: The Canadian Constitution recognizes three groups of Indigenous Peoples: First Nations, Inuit and Métis. These are three distinct peoples with unique histories, languages, cultural practices and spiritual beliefs (18). In a 2016 census, more than 1.67 million persons in Canada, self-identified as First Nations, Inuit or Métis (18). The actual Indigenous population is likely relatively higher, as some individuals and families do not have access or choose not to participate in government or census data collection.

Indigenous Peoples in Canada are the fastest growing and youngest populations in Canada (increasing by 42.5 per cent between 2006 and 2016, and with 44 per cent under the age of 25 in 2016) (18).

Indirect evidence: In this BPG, indirect evidence refers to findings from the systematic reviews that pertain to non-Indigenous populations. However, it is believed by the panel that this literature is applicable to interventions with Indigenous populations.

Inuit: First Peoples who now reside in approximately 51 communities spread across Inuit Nunangat, the Inuit homeland in Canada's north that includes 35% of Canada's land mass and 50% of Canada's coast line (151). Nunangat spans four regions: Nunavut, Nunavik in Northern Quebec, Nunatsiavut in Northern Labrador and the Inuvialuit region of the Northwest Territories (151). Inuit are distinctively unique with regard to their history, language, culture, cultural practices and spiritual beliefs. The term Inuit is plural for people, and an individual is referred to as Inuk (person).

Māori: Indigenous first peoples of New Zealand with distinct Māori descent and ancestry (152).

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Meta-analysis: A systematic review that uses statistical methods to analyze and summarize the results of the included studies (153).

See *systematic review*

Métis: The origin of Métis people dates to the 17th century with the intermarriage of the early European men (mostly from Scotland and France) and First Nations women in the western regions of Canada (42). Over the next 200 years the Métis nation birthed a distinctive culture and language (Michif) and occupied a strategic role in the fur trade (42).

Nicotine replacement therapy: Nicotine replacement therapy is an alternate, medicinal form of nicotine intake (e.g., transdermal patches or lozenges) that does not include harmful toxins, which would have otherwise been inhaled with commercial tobacco smoke (106).

Nurse: Refers to registered nurses, licensed practical nurses (referred to as "registered practical nurses" in Ontario), registered psychiatric nurses and nurses in advanced practice roles, such as nurse practitioners and clinical nurse specialists (7).

Outcomes: A dependent variable, or the clinical and/or functional status of a patient or population, that is used to assess if an intervention is successful. In GRADE, outcomes are prioritized based on if they: (a) are critical for decision making; (b) important but not critical for decision making; or (c) not important. Use of these outcomes helps make literature searches and systematic reviews more focused (10).

Pathologize: A health provider pathologizes an Indigenous person when they believe a stereotype that an Indigenous Peoples' health status, and any health inequalities they may experience, are predominately related to personal choices or as a result of genetic weaknesses (30).

Perinatal: Refers to the period of time that includes pregnancy, birth and the postpartum period.

PPC research question: A framework to outline a qualitative research question. It specifies three components:

1. The population that is being studied.
2. Phenomena of interest that relates to a defined event, activity, experience or process.
3. Context, which is the setting or distinct characteristics (154).

PICO research question: A framework to outline a focused question. It specifies four components:

1. The *patient or population* that is being studied
2. The *intervention* to be investigated
3. The alternative or **comparison** intervention
4. The *outcome* that is of interest (10).

Postpartum: The six-month period after giving birth.

Practice recommendation: Recommendations that are directed at nurses and the interprofessional team who provide direct care to persons, and support for their families, in primary care, community care and maternal/child settings.

Qualitative research: An approach to research that seeks to convey how human behaviour and experiences can be explained within the context of social structures, and through the use of an interactive and subjective approach to investigate and describe phenomena (155).

Quantitative research: An approach to research that investigates phenomena with tools that produce statistical measurements/numerical data (156).

Quasi-experimental study: A study that estimates causal effects by observing the exposure of interest (i.e. before-and-after designs) but in which the experiments are not directly controlled by the researcher and lack randomization (157).

Quit rates: An outcome measured in tobacco cessation that represents the rate or proportion (%) of people who stop using commercial tobacco such as cigarettes. When measured, there is a numerator and a denominator. The numerator represents the number of people who have quit or ceased smoking after participating in a smoking cessation intervention and the denominator represents the total number of people who participated in the intervention. This measure is commonly used to evaluate the effectiveness of smoking cessation interventions (158).

Randomized controlled trial (RCT): An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (receives intervention) or the comparison (conventional treatment) or control group (no intervention or placebo) (153).

Reach: In this BPG, the outcome reach refers to how many people are enrolled in a program.

Reconciliation: An ongoing process where non-Indigenous Canadians must recognize and acknowledge the harmful events of the past and the devastating impact these have had and continue to have, on Indigenous Peoples in Canada. For that to happen, there needs to be awareness of the past, acknowledgment of harm that has been inflicted, atonement for the cause, and a commitment to action and to change behavior. This process involves establishing and maintaining mutually respectful relationships with Indigenous Peoples going forward (34).

Recommendation: A course of action(s) that directly answers a recommendation question (also known as a PICO research question). A recommendation is based on a systematic review of the literature and is made in consideration of its: (a) benefits and harms; (b) values and preferences; and (c) health equity. All recommendations are given a strength —either *strong* or *conditional*—through panel consensus.

It is important to note that recommendations should not be viewed as dictates, because recommendations cannot take into account all of the unique features of individual, organizational and clinical circumstances (10).

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Recommendation question: A priority research area of practice, policy or education identified by panel members that requires evidence to answer. The recommendation question may also aim to answer a topic area around which there is ambiguity or controversy. The recommendation question informs the research questions, which guides the systematic review.

Reflective practice: An intentional process of thinking, analyzing and learning, identifying one's learning needs and committing to a plan of action (159). In many jurisdictions, reflective practice is a legislated expectation and health professionals engage annually in reflective practice and development of a learning plan (159). This demonstrates a commitment to lifelong learning and continuing competency (159).

Self-determination: The ability of First Nations, Métis and Inuit peoples in Canada to determine their future. This requires confronting and reversing the legacies of colonization discrimination and cultural suffocation (16, 34). Self-determination builds a social and political order using processes of mutual understanding and respect (34). The protection of the rights of Indigenous Peoples in Canada and ability to exercise their right to self-determine is the best way forward and 'strongest antidote' to further violation of Indigenous Peoples' human rights (34).

Settler: For the purpose of this BPG, a settler in Canada means that you are, or your ancestors are not Indigenous and that you or your ancestors entered Canada for the purpose of permanently settling or inhabiting land that was previously inhabited by Indigenous Peoples.

Sixties Scoop: A term that refers to the apprehension and removal of Indigenous children from their families without parental or community consent by government child protection services during the 1960s, and the subsequent placement of the children into the child welfare system across Canada. This removal of Indigenous children from their homes and communities was disproportionately higher compared to the removal of non-Indigenous children. Most Indigenous children were placed with non-Indigenous families, where many had their heritage denied and their identity suppressed. Please refer to reference for further details (14).

Smoking: For the purposes of this BPG, smoking refers to all forms of commercial tobacco use including but not limited to cigarettes, cigars, cigarillos, chewing tobacco, dissolvables, hookah/water pipe/shisha, snuff, roll-your-own cigarettes and pipes. In this BPG, recommendations do not apply to electronic nicotine delivery systems (ENDs) as there is a lack of current research.

Social movements in a context of evidence uptake and sustainability: Individuals, groups and/or organizations who, as voluntary and intrinsically motivated change agents, mobilize to transform health outcomes (160).

Stakeholder: An individual, group, or organization that has a vested interest in the decisions and actions of organizations, and which may attempt to influence decisions and actions (161). Stakeholders include all of the individuals and groups that will be directly or indirectly affected by the change or the solution to the problem.

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Support network: Those individuals whom the person identifies as significant in their life. This network can include individuals who are related (biologically, emotionally, or legally) and/or those with close bonds (friendships, commitments, shared household and child-rearing responsibilities, and romantic attachment) (5).

System, organization and policy recommendations: Recommendations may apply to a variety of audiences including nurses, the interprofessional team, managers, administrators and policy-makers. These audiences are responsible for policy development and securing supports required within organizations and/or the broader community, including workplaces, for the purpose of implementing best practices.

Systematic review: A comprehensive review of the literature that uses clearly formulated questions and systematic and explicit methods to identify, select and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (153).

See *meta-analysis*

Traditional tobacco: Traditional tobacco is a natural plant that is considered one of four sacred medicines (tobacco, sage, cedar and sweetgrass) for some First Nations and Métis communities. It is grown and used by many First Nations and Métis populations for medicinal, sacred and ceremonial purposes. Traditional tobacco is not inhaled, but is burned to create smoke used in ceremony such as smudging. In some First Nations, traditional tobacco is also used as an cultural offering for giving thanks (35).

United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP): The General Assembly of the United Nations adopted the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) on September 13, 2007. This document is the most comprehensive international instrument on the inherent rights of Indigenous Peoples (16). The UNDRIP declaration outlines a universal framework that states the minimum standards for the survival, dignity, and well-being of Indigenous Peoples of the world and elaborates on the existing human rights standards and fundamental freedoms as they apply to specific situations of Indigenous Peoples (16).

Wholistic: includes balancing the mental, emotional, spiritual and physical aspects of health. The term wholistic is used by many Indigenous communities to reflect the wholeness of the person, and a focus on wellness of the person rather than focusing on an illness or disease. This can include relationships with a person's family, community, spirituality, culture and the land (182).

Women and persons: Term used to acknowledge that not everyone who is able to become pregnant identifies as a "woman". It is important to note that gender is not a binary assignment; it can refer to the individual and/or social experience of being a man, a woman, both or neither. Social norms, expectations, and roles related to gender vary across time, space, culture and individuals.

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Appendix B: RNAO Guidelines and Resources That Align with this BPG

The following are some topics and suggested Registered Nurses' Association of Ontario (RNAO) guidelines and resources from other organizations that align with this best practice guideline (BPG).

TOPIC	RESOURCE(S)
Breastfeeding	■ Registered Nurses' Association of Ontario (RNAO). Breastfeeding – Promoting and supporting the initiation, exclusivity, and continuation of breastfeeding in newborns, infants and young children [Internet]. Toronto (ON): RNAO; 2018. Available from: RNAO.ca/bpg/guidelines/breastfeeding-promoting-and-supporting-initiation-exclusivity-and-continuation-breast
Client centred learning	■ Registered Nurses' Association of Ontario (RNAO). Facilitating client centred learning [Internet]. Toronto (ON): RNAO; 2012. Available from: RNAO.ca/bpg/guidelines/facilitating-client-centred-learning
Implementation science, implementation frameworks and resources	■ Registered Nurses' Association of Ontario in partnership with Healthcare Excellence Canada. *Leading Change Toolkit*™ (3rd ed.). Toronto (ON): RNAO; 2021 Available from: RNAO.ca/leading-change-toolkit ■ The (U.S.) National Implementation Research Network's Active Implementation Hub. Get Started [Internet]. [place unknown]: AI Hub; c2013–2018. Available from: http://implementation.fpg.unc.edu/ ■ Canadian Patient Safety Institute. Improvement frameworks: getting started kit [Internet]. [place unknown]: safer healthcare now!; 2015 Aug. Available from: http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Documents/Improvement%20Frameworks%20GSK%20EN.PDF ■ Dissemination & Implementation Models in Health Research & Practice [Internet]. [place unknown]: The Center for Research in Implementation Science and Prevention; [date unknown]. Available from: http://dissemination-implementation.org/content/resources.aspx
Interprofessional collaboration	■ Registered Nurses' Association of Ontario (RNAO). Developing and Sustaining Interprofessional Health Care: optimizing patients/clients, organizational, and system outcomes [Internet]. Toronto (ON): RNAO; 2013. Available from: RNAO.ca/bpg/guidelines/interprofessional-team-work-healthcare

TOPIC	RESOURCE(S)
Perinatal depression	■ Registered Nurses' Association of Ontario (RNAO). Assessment and Interventions for Perinatal Depression, Second Edition [Internet]. Toronto (ON): RNAO; 2018. Available from: https://rnao.ca/bpg/guidelines/assessment-and-interventions-perinatal-depression
Person- and family-centred care	■ Registered Nurses' Association of Ontario (RNAO). Person- and Family-Centred Care [Internet]. Toronto (ON): RNAO; 2015. Available from: RNAO.ca/bpg/guidelines/person-and-family-centred-care
Tobacco interventions	■ Registered Nurses' Association of Ontario (RNAO). Integrating Tobacco Interventions into Daily Practice. [Internet]. Toronto (ON): RNAO; 2017. Available from: RNAO.ca/bpg/guidelines/integrating-tobacco-interventions-daily-practice ■ Additional RNAO learning opportunities on tobacco interventions are available here: RNAO.ca/bpg/courses

Appendix C: Best Practice Guideline Development Methods

This appendix presents an overview of the RNAO guideline development process and methods. RNAO is unwavering in its commitment that every BPG be based on the best available evidence. The Grading of Recommendations Assessment, Development and Evaluation (GRADE) and the Confidence in the Evidence from Reviews of Qualitative Research (CERQual) methods have been implemented to provide a rigorous framework and meet international standards for guideline development.

Scoping the Best Practice Guideline

The scope sets out what an RNAO BPG will and will not cover (see **Purpose** and **Scope**). To determine the scope of this particular BPG, the RNAO best practice guideline development and research team conducted the following steps:

1. **An environmental scan of guidelines.** One guideline development methodologist and an implementation science manager searched an established list of websites for guidelines and other relevant content published between January 2000 and September 2018. The purpose of the environmental scan of guidelines was to gain an understanding of existing guidelines on commercial tobacco interventions in prenatal and postnatal Indigenous women and their families, in order to identify opportunities to develop the purpose and scope of this BPG. The resulting list was compiled based on knowledge of evidence-based practice websites and recommendations from the literature. RNAO panel members were asked to suggest additional guidelines (see **Appendix D**). Please see the search strategy for existing guidelines which includes the list of websites searched and the inclusion criteria used for more detailed information.

The guidelines were reviewed for content, applicability to nursing scope of practice, accessibility, and quality. The guideline development methodologist and implementation science manager appraised five international guidelines using the AGREE II tool (162). Guidelines with an overall score of 6 or 7 (on a 7-point Likert scale) were considered to be of high quality.

The following guidelines were appraised as indicated:

- Gould, G., Bittoun, R. & Clarke, M. A Pragmatic Guide for Smoking Cessation Counselling and the Initiation of Nicotine Replacement Therapy for Pregnant Aboriginal and Torres Strait Islander Smokers. The Journal of Smoking Cessation. 2014; 1-10.
  - Score: 3 out of 7. This guideline was not used in this BPG.

- National Institute for Health and Care Excellence (NICE). Smoking: acute, maternity and mental health services [Internet]. London (UK): NICE; 27 Nov 2013. Available from: https://www.nice.org.uk/guidance/ph48/chapter/1-Recommendations
  - Score: 6 out of 7. This guideline was not used in this BPG as it was not specific to the Indigenous population.

- National Institute for Health and Care Excellence (NICE). Smoking: Stopping in pregnancy and after childbirth [Internet]. London (UK): NICE; 23 Nov 2010 Update 2015. Available from: https://www.nice.org.uk/guidance/ph26
  - Score: 6 out of 7. This guideline was not used in this BPG as it was not specific to the Indigenous population.

- World Health Organization (WHO). WHO recommendations for the prevention and management of tobacco use and second hand smoke exposure in pregnancy. Geneva (Switzerland): WHO; 2013. Available from: https://www.who.int/tobacco/publications/pregnancy/guidelinestobaccosmokeexposure/en/
  - Score: 7 out of 7. This guideline was not used in this BPG as it was not specific to the Indigenous population.

- Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment (CAN-ADAPTT), Centre for Addiction and Mental Health. Canadian smoking cessation clinical practice guideline. Toronto, Canada: CAN-ADAPTT, CAMH; 2011. Available from: https://www.nicotinedependenceclinic.com/en/canadaptt/PublishingImages/Pages/CAN-ADAPTT-Guidelines/CAN-ADAPTT%20Canadian%20Smoking%20Cessation%20Guideline_website.pdf
  - Score: 3 out of 7. This guideline was not used in this BPG.

- Ordean A, Wong S, Graves, L. No. 349-substance use in pregnancy. J Obstet Gynaecol Can 2017;39(10): 922–937.e2
  - Score: 5 out of 7. This guideline was used as a supporting resource for a non-Indigenous population specific recommendation.

2. **A review of the literature.** A literature review was undertaken to determine available commercial tobacco interventions in Indigenous perinatal populations and to explore the relevant contextual factors that influence commercial tobacco intervention programs in Indigenous communities.

3. **Telephone key informant interviews.** Nineteen interviews were conducted with experts in the field—including people with lived experience, direct care health providers and researchers—to understand the needs of nurses, members of the interprofessional health team, and people with lived experience.

4. **Site visits.** There was an on-site visit with an urban Indigenous health team and on-site visit with an Indigenous midwifery practice setting. The purpose of the site visits was to have an immersive experience in Indigenous specific health settings and speak to health providers to understand both health provider and patient perspectives regarding care.

Assembly of the Panel

RNAO aims for diversity in membership of a panel; this aligns with its Organizational Statement on Diversity and Inclusivity, which is part of the RNAO Mission and Values (Registered Nurses' Association of Ontario, date unknown). RNAO also aims for persons impacted by BPG recommendations, especially people with lived experiences and families, to be included as panel members.

There are numerous ways in which RNAO identifies and selects members of a panel. These include:

- searching the literature for researchers in the topic area;

- soliciting recommendations from key informant interviews;

- drawing from established professional networks, such as RNAO Interest Groups, the Nursing Best Practice Champions Network® and Best Practice Spotlight Organizations® (BPSOs®); and

- contacting other nursing and health provider associations, topic-relevant technical associations or organizations, and advocacy bodies.

For this BPG, the RNAO best practice guideline development and research team assembled a panel of people from nursing practice, research, education and policy, as well as other members of the interprofessional team, and people with lived experience representing a range of sectors and practice areas (see the **RNAO Best Practice Guidelines Panel** on page 19).

The panel engaged in the following activities. The panel:

- developed and approved the purpose and scope of this BPG;
- determined the recommendation questions and outcomes to be addressed in this BPG;
- participated in a **consensus**[G] development process to finalize recommendation statements;
- provided feedback on the drafting of this BPG;
- participated in the development of evaluation indicators; and
- identified appropriate stakeholders to review the draft guideline prior to publication.

In addition to the above, the panel co-chairs also:

- participated in monthly meetings with the guideline development methodologists and guideline development project coordinator;
- facilitated panel meetings;
- provided in-depth guidance on clinical and/or research issues; and
- moderated voting processes.

Declaration of Conflict of Interest

In the context of RNAO BPG development, the term "conflict of interest" (COI) refers to situations in which a panel member's or RNAO staff's financial, professional, intellectual, personal, organizational or other relationships may compromise their ability to conduct panel work independently. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the panel prior to their participation in guideline development work using a standard form. Panel members also updated their COI at the beginning of each in-person guideline meeting and prior to guideline publication. Any COI declared by a panel member was reviewed by both the RNAO best practice guideline development and research team and by panel co-chairs. No limiting conflicts were identified. See Declarations of Conflicts of Interest Summary.

Identifying Priority Recommendation Questions and Outcomes

RNAO systematic review questions are developed in accordance with the PICO format (population, intervention, comparison and outcomes) and PPC format (population, phenomenon of interest and context).

In February 2019, the RNAO best practice guideline development and research team and the panel convened in person to determine the priority recommendation questions and outcomes for this BPG. A comprehensive list of recommendation questions that the BPG could potentially address was developed at the meeting. This was informed by:

- the environmental scan of guidelines,

- the review of the literature,

- key informant interviews; and

- panel discussion at the in-person meeting.

This comprehensive list of potential recommendation questions was presented to the panel in an online survey. Panel members were asked to rank order the recommendation questions, from highest to lowest priority. A live rank ordering was completed and the results were presented to the panel. The top eight recommendation questions were deemed to be the final recommendation questions. Panel co-chairs did not participate in the rank ordering, but facilitated the voting process.

Following this initial vote—and in alignment with GRADE standards for assessing and presenting the evidence— outcomes were identified and prioritized per recommendation question. A comprehensive list of outcomes per recommendation question (that was quantitative in nature) was developed at the in-person meeting, informed by a review of the literature, key informant interviews and panel discussion at the in-person meeting. It was deemed feasible to have three to five outcomes per recommendation question.

Revisions to the Original Recommendation Questions and Outcomes

There were eight original recommendation questions. All recommendation questions and outcomes were reviewed by an external GRADE expert. Outcomes that were considered unrealistic to measure were brought to the attention of the RNAO development team by the GRADE expert. Feedback was taken into consideration and presented to the panel. Outcomes were refined based on the feedback and consultation with the panel.

For recommendation question 1, the panel revised the outcomes and limited interest to only reach and engagement. In addition, the panel suggested conducting a search for indirect evidence in the broader pregnant population for recommendation question 1 as the impact of smoking cessation counselling in the broader population would be very relevant to the Indigenous population. For question 1 and 5 in which indirect evidence was sought, the prioritized outcomes were determined by what was prominent in the included studies.

Test searches were completed for all recommendation questions. However, no literature was identified that could answer two of the original recommendation questions. In consultation with the panel co-chairs, it was determined that a recommendation question on conducting culturally safe smoking cessation assessment would be more appropriately answered as a good practice statement. For recommendation question 4, the external GRADE expert suggested conducting a case series study, systematically gathering observational data from panel members. In addition, the panel suggested conducting a search for indirect evidence in the broader population in relation to embedded smoking cessation intervention within broader health and wellness programs, to support answering recommendation question 4. More information on the good practice statement and conducting the case series study is described on pages 115-116.

For **Recommendations 3** and **7**, based on external GRADE review, a PICO format was developed based on the recommendation question, in order to identify quantitative evidence.

The remaining 7 recommendation questions and their respective PICO and PPC research questions were renumbered and are presented below.

Revised Recommendation Questions

Recommendation Question #1: Should smoking reduction and cessation counselling be recommended for Indigenous women and persons during pregnancy and the post-partum period?

> **PICO Research Question #1:**
> *Direct search*
> **Population:** Indigenous women and persons during pregnancy and the post-partum period
> **Intervention:** All forms of smoking reduction cessation counselling (individual, group-based, multifaceted, etc.) provided by any health providers in the circle of care
> **Comparison:** No counselling or usual care
> **Outcomes:** Reach and engagement, smoking rates (prevalence (not found within this literature), amount smoked (not found within this literature)
>
> *Indirect Search*
> **Population:** Women and persons during pregnancy and the post-partum period
> **Intervention:** All forms of smoking reduction and cessation counselling (individual, group-based, multifaceted, etc.) provided by any health provider in the circle of care
> **Comparison:** Usual care and less intensive interventions
> **Outcomes:** Abstinence late in pregnancy, abstinence 6-11 months postpartum

Recommendation Question #2: What needs (social, cultural, environmental supports) and opinions (with respect to barriers and facilitators) do Indigenous women and persons of reproductive age, their support network and community, express about smoking cessation interventions?

> **PPC Research Question #2:**
> **Population:** Indigenous women of reproductive age, their families and communities
> **Phenomenon of Interest:** Needs (social, cultural, environmental supports) and views (barriers and facilitators)
> **Context:** When seeking access to smoking reduction and cessation resources
>
> **PICO Research Question #2:**
> **Population:** Indigenous Peoples of reproductive age, their partners & their family members
> **Intervention:** smoking reduction and cessation services
> **Comparison:** usual care available/accessible
> **Outcomes:** reach and engagement, quit rates, quit attempts

Recommendation Question #3: Should smoking reduction and cessation interventions embedded within broader health and wellness programs be recommended?

> **PICO Research Question #3**
> *Case series*
> **Population:** Indigenous women and persons during pregnancy and the post-partum period, their families and communities
> **Intervention:** Smoking reduction and cessation embedded within broader health and wellness programs
> **Comparison:** No intervention
> **Outcomes:** Reach, engagement and acceptability
>
> *Indirect search*
> **Population:** Persons who use commercial tobacco
> **Intervention:** Smoking reduction and cessation embedded within broader health and wellness programs
> **Comparison:** No intervention
> **Outcomes:** Quit rates

Recommendation Question #4: Should culturally appropriate and trauma-informed smoking reduction and cessation services be recommended?

> **PICO Research Question #4**
> **Population:** Indigenous women and persons during pregnancy and the post-partum period, their families and communities
> **Intervention:** Culturally appropriate and trauma-informed smoking reduction and cessation services
> **Comparison:** No culturally appropriate and trauma-informed commercial tobacco reduction and cessation services
> **Outcomes:** Reach, engagement, quit rates and quit attempts

Recommendation Question #5: Should pharmacotherapy (nicotine replacement therapy, bupropion, varenicline) be recommended for smoking cessation in pregnant and post-partum women and persons?

> **PICO Research Question #5**
> **Population:** Women and persons who are pregnant or breastfeeding
> **Intervention:** Pharmacotherapy (nicotine replacement therapy, bupropion, varenicline)
> **Comparison:** No pharmacotherapy
> **Outcomes:** quit rates, miscarriage & spontaneous birth, mean birth weight

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Recommendation Question #6: Should Indigenous community-led smoking reduction and cessation approaches be recommended?

> **PICO Research Question #6**
> **Population:** Indigenous women and persons during pregnancy and the post-partum period, their families and communities
> **Intervention:** Indigenous community-led smoking reduction and cessation approaches
> **Comparison:** No intervention
> **Outcomes:** Reach, engagement, quit rates and quit attempts

Recommendation Question #7: Should undergraduate education for nurses and the interprofessional team and/or continuing professional development for health providers on Indigenous health be recommended?

> **PICO Research Question #7**
> **Population:** Students in professional health programs, nurses, members of the interprofessional team
> **Intervention:** Professional development and/or undergraduate education regarding Indigenous health
> **Comparison:** No professional development and/or undergraduate education regarding Indigenous health
> **Outcomes:** Cultural safety, attitude, knowledge and change in practice (not found within this literature)

Systematic Retrieval of the Evidence

RNAO BPGs are based on a comprehensive and systematic review of the literature.

For this BPG, RNAO's best practice guideline development and research team and a health sciences librarian developed a strategy for the aforementioned research questions. A search for relevant research studies for research questions 1 (direct evidence), 2, 4 and 6 published in English between January 2009 and March 2019 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Medline, Epub Ahead of Print, Cochrane Controlled Trials Register, Cochrane Database of Systematic Reviews, Emcare, PsychInfo and Biblio of Native North Americans.

For the additional search for indirect evidence for research question 1, an update to an existing high quality systematic review (published in 2017) was completed. For research question 1, a search for relevant randomized controlled studies published in English between January 2017 and April 2020 was applied to the following databases: Medline, Embase, Central Register of Controlled Trials, and CINAHL.

A search for relevant research systematic reviews for research question 3 (indirect evidence) published in English between January 2009 and May 2020 was applied to the following databases: Medline, Embase, Cochrane Database of Systematic Reviews, PsychInfo, CINAHL, ProQuest Theses, CMA Infobase, and National Institute for Clinical Excellence.

For research question 5, a recent high quality systematic review (published March 2020) was identified. Therefore, a further search was not completed.

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A search for relevant research studies for research question 7 published in English between January 2010 and December 2019 was applied to the following databases: Medline, Epub Ahead of Print and In-Process, Emcare, CINAHL, ERIC and Open Gray.

Systematic review search dates were limited to the last 10 years in order to capture the most up-to-date evidence. All study designs were included. Panel members were asked to review their personal libraries for key studies not found through the above search strategies. For more information please review the detailed search strategy for the systematic reviews, including the inclusion and exclusion criteria and search terms.

All studies were independently assessed for relevance and eligibility by two guideline development methodologists based on the inclusion and exclusion criteria. Any disagreements were resolved through consensus.

All included studies were independently assessed for risk of bias by study design using validated and reliable tools. **Randomized controlled trials**[G] were assessed using the Risk of Bias 2.0 tool (163); **quasi-experimental studies**[G] and other non-randomized studies were assessed using the ROBINS-I tool (164); systematic reviews were assessed using the ROBIS tool (165); and qualitative research studies were assessed using a modified CASP qualitative checklist (166). The two guideline development methodologists reached consensus on all scores through discussion.

For data extraction, the included studies were divided equally between the guideline development methodologists. Each guideline development methodologist extracted information from their assigned studies and this information was reviewed by the other guideline development methodologist for accuracy. For the assigned qualitative studies, each guideline development methodologist extracted and organized data into codes using the NVivo software. The codes were cross-checked by the guideline development methodologists and consensus was established through discussion.

In May 2021, the health science librarian conducted an update search for the relevant research studies published in English between the end of the original search dates (March 2019) and May 2021 and that answered revised research questions 2, 3, 4, 6 and 7. The update search was applied to the following databases: Cumulative Index to Nursing and allied Health (CINAHL), Medline, Medline in Process, Cochrane Central, Cochrane Database of Systematic Reviews, PsycINFO, Embase and Emcare. Results from 10 studies were incorporated into the discussions of evidence across all the Recommendations. See the PRISMA diagram in **Appendix D** for studies included in the update search.

Determining Certainty and Confidence of Evidence

Certainty of Evidence

The certainty of quantitative evidence (i.e., the extent to which one can be confident that an estimate of an effect is true) is determined using GRADE methods (10). First, the certainty of the evidence is rated for each prioritized outcome across studies (i.e., for a body of evidence) per recommendation (10). This process begins with the study design and then requires an examination of five domains—risks of bias, inconsistency, imprecision, indirectness, and publication bias—to potentially **downgrade**[G] the certainty of evidence for each outcome. See **Table 11** for a definition of each of these certainty criteria.

Table 11: GRADE Certainty Criteria

CERTAINTY CRITERIA	DEFINITION
Risk of bias	Limitations in the study design and execution that may bias study results. Valid and reliable quality appraisal tools are used to assess the risk of bias. First, risk of bias is examined for each individual study and then examined across all studies per defined outcome.
Inconsistency	Unexplained differences (heterogeneity) of results across studies. Inconsistency is assessed by exploring the magnitude of difference, and possible explanations in the direction and size of effects reported across studies for a defined outcome.
Indirectness	Variability between the research and review question and context within which the recommendations would be applied (applicability). There are four sources of indirectness which are assessed: ■ differences in population ■ differences in interventions ■ differences in outcomes measured ■ differences in comparators.
Imprecision	The degree of uncertainty around the estimate of effect. This is usually related to sample size and number of events. Studies are examined for sample size, number of events and confidence intervals.
Publication bias	Selective publication of studies based on study results. If publication bias is strongly suspected, downgrading is considered.

Source: Reprinted from: The GRADE Working Group. Quality of evidence. In: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Table 5.1, Quality of evidence grades. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.wsfivfhuxv4r. Reprinted with permission.

Following the initial consideration for rating down the certainty of quantitative evidence, three factors are assessed that can potentially enable rating up the certainty of evidence for observational studies:

1. **Large magnitude of effect**: If the body of evidence has not been rated down for any of the five criteria and a large estimate of the magnitude of intervention effect is present, there is consideration for rating up.

2. **Dose–response gradient**: If the body of evidence has not been rated down for any of the five criteria and a dose–response gradient is present, there is consideration for rating up

3. **Effect of plausible confounding**: If the body of evidence has not been rated down for any of the five criteria and all residual confounders would result in an underestimation of treatment effect, there is consideration for rating up (10).

GRADE categorizes the overall certainty of evidence as high, moderate, low or very low. See **Table 12** for the definitions of these categories.

For this BPG, the five GRADE quality criteria for potentially downgrading quantitative evidence—and the three GRADE quality criteria for potentially rating up evidence—were independently assessed by the two guideline development methodologists. Any discrepancies were resolved through consensus. An overall certainty of evidence per recommendation was assigned based on these assessments. The certainty of evidence assigned to each recommendation was based on the certainty of prioritized outcomes in the studies that informed the recommendation.

Table 12: Certainty of Evidence

OVERALL CERTAINTY OF EVIDENCE	DEFINITION
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Source: Reprinted from: The GRADE Working Group. Quality of evidence. In: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Table 5.1, Quality of evidence grades. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.wsfivfhuxv4r. Reprinted with permission.

Confidence in Evidence

Similar to GRADE, there are four **CERQual criteria**[G] to assess the confidence in qualitative findings related to a phenomenon of interest:

1. Methodological limitations
2. Relevance
3. Coherence
4 Adequacy of data.

See **Table 13** for a definition of each of these criteria.

Table 13: CERQual Quality Criteria

CRITERIA	DEFINITION
Methodological limitations	The extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding.
Coherence	An assessment of how clear and cogent the fit is between the data from the primary studies and a review finding that synthesizes that data. By "cogent," we mean well supported or compelling.
Adequacy of data	An overall determination of the degree of richness and quantity of data supporting a review finding.
Relevance	The extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question.

Source: Reprinted from: Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQUAL to qualitative evidence synthesis findings: introduction to the series. Implement Sci. 2018;13(Suppl 1):1-10. Table 2, Definitions of the components of the CERQual approach; p. 5. Reprinted with permission.

For qualitative findings, these four criteria were independently assessed by the two guideline development methodologists. Discrepancies were resolved through consensus. An overall judgment of the confidence in each review finding was made based on these assessments. (See **Table 14** for the confidence of evidence judgments.) Recommendations that included qualitative evidence were assigned an overall confidence in evidence based on the corresponding review finding.

Table 14: Confidence in Evidence

OVERALL CONFIDENCE OF EVIDENCE	DEFINITION
High	It is highly likely that the finding is a reasonable representation of the phenomenon of interest.
Moderate	It is likely that the finding is a reasonable representation of the phenomenon of interest.
Low	It is possible that the review finding is a reasonable representation of the phenomenon of interest.
Very low	It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Source: Reprinted from: Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQUAL to qualitative evidence synthesis findings: introduction to the series. Implement Sci. 2018;13(Suppl 1):1-10. Table 3, Description of level of confidence in a review finding in the CERQual approach; p. 6. Reprinted with permission.

Formulating Recommendations

Summarizing the Evidence

The guideline development methodologists analyzed all studies pertaining to each quantitative research question and drafted recommendations that answer the questions accordingly. For qualitative studies, the review findings were used to inform draft recommendations. For each draft recommendation, GRADE and/or GRADE-CERQual evidence profiles were constructed by the two guideline development methodologists. GRADE and/or GRADE-CERQual evidence profiles are used to present decisions on determining the certainty and/or confidence of evidence, and to present general information about the body of research evidence, including key statistical or narrative results (10).

The evidence profiles for the body of quantitative studies presented the decisions made by the two guideline development methodologists on the five key GRADE certainty criteria for rating down the population included in the studies, countries where the studies were conducted, key results, and transparent judgments about the certainty underlying the evidence for each outcome (10). For this BPG, **meta-analyses**[G] were not performed; therefore, results were synthesized using narrative.

CERQual evidence profiles were created for the body of qualitative evidence for each draft recommendation, when applicable. Similar to the GRADE evidence profiles used for **quantitative research**[G], the CERQual evidence profiles presented the body of evidence supporting each theme related to the outcomes for every recommendation. These evidence profiles presented the decisions made by the two guideline development methodologists on the four key CERQual criteria and the transparent judgements about the confidence underlying the evidence for each theme.

For more detail, please see the GRADE and CERQual evidence profiles for each recommendation, organized per outcome.

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Evidence-to-Decision Frameworks

Evidence-to-Decision (EtD) frameworks[G] outline proposed recommendations and summarize all necessary factors and considerations based on available evidence and panel judgement for formulating the recommendation statements. EtD frameworks are used to help ensure that all important factors (i.e., certainty or confidence of the evidence, benefits/harms, values and preferences, and health equity) required to formulate recommendation statements are considered by the panel (10). Both quantitative and qualitative evidence are incorporated into the frameworks. The guideline development methodologists draft the EtD frameworks with available evidence from the systematic reviews.

For this BPG, the EtD frameworks included the following areas of consideration for each drafted recommendation statement (see **Table 15**):

- Background information on the magnitude of the problem.
  - Includes the PICO question and general context related to the research question.
- The balance of benefits and harms of an intervention.
- Certainty and/or confidence of the evidence.
- Values and preferences.
- Health equity.

Decision Making: Determining the Direction and Strength of Recommendations

Panel members were provided with the EtD frameworks to review prior to a scheduled two-day in-person meeting to determine the direction (i.e., a recommendation for or against an intervention) and the strength (i.e., strong or conditional) of the BPG's recommendations. Panel members are also given access to the complete evidence profiles and full-text articles.

The panel co-chairs and the two guideline development methodologists facilitated the in-person meeting to allow for adequate discussion for each proposed recommendation.

The decision on the direction and strength of each recommendation statement was determined by discussion and a consensus vote of at least 70 per cent of voting panel members. The voting process was anonymous and was moderated by the panel co-chairs and guideline development methodologists. In determining the strength of a recommendation statement, the panel was asked to consider the following (see **Table 15**):

- the balance of benefits and harms of an intervention;
- certainty and/or confidence of the evidence;
- values and preferences; and
- health equity.

Table 15: Key Considerations for Determining the Strength of Recommendations

FACTOR	DEFINITION	SOURCES
Benefits and harms	Potential desirable and undesirable outcomes reported in the literature when the recommended practice or intervention is used. "The larger the difference between the desirable and undesirable effects, the higher the likelihood that a strong recommendation is warranted. The narrower the gradient, the higher the likelihood that a conditional recommendation is warranted" (167).	Includes research exclusively from the systematic review.
Certainty and confidence of evidence	The extent of confidence that the estimates of an effect are adequate to support a recommendation. The extent of confidence that a review finding is a reasonable representation of the phenomenon of interest (168). Recommendations are made with different levels of certainty or confidence; the higher the certainty or confidence, the higher the likelihood that a strong recommendation is warranted (167).	Includes research exclusively from the systematic review.
Values and preferences	The relative importance or worth of the health outcomes of following a particular clinical action from a person-centred perspective. "The more values and preferences vary or the greater the uncertainty in values and preferences, the higher the likelihood that a conditional recommendation is warranted" (167).	Includes evidence from the systematic review (when available) and other sources, such as insights from the panel.
Health equity	Represents the potential impact of the recommended practice or intervention on health outcomes or health quality across different populations. The greater the potential for increasing health inequity, the higher the likelihood that a conditional recommendation is warranted (169).	Includes evidence from the systematic review (when available) and other sources, such as insights from the panel.

Source: Adapted by the RNAO panel from: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.svwngs6pm0f2

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Developing Good Practice Statements

The panel was sent a survey asking them to respond to five questions pertaining to the good practice statement on culturally safe smoking status assessment:

1. Is this statement clear and actionable?

2. Is the message really necessary in regards to actual health practice?

3. After consideration of all relevant health outcomes and potential downstream consequences, will implementing the good practice statement result in large net positive consequences?

4. Is a systematic review of the evidence necessary or required for this statement?

5. Is there a clear and explicit rationale to support this good practice statement?

Eight out of thirteen panel members completed the survey on the good practice statement for culturally safe smoking status assessment, and their results are as follows:

- For the first question, 8 of 8 respondents answered "yes."

- For the second question, 8 of 8 respondents answered "yes."

- For the third question, 8 of 8 respondents answered "yes."

- For the fourth question, 7 of 8 respondents answered "no."

- For the fifth question, 8 of 8 respondents answered "yes."

Conducting a Case Series

In the absence of direct evidence for research question 3, a case series was conducted to answer the recommendation question "should smoking cessation interventions embedded within broader health and wellness programs be recommended?" An electronic systematic observation form was drafted and circulated to panel members. The purpose of the form was to gather panel members' observations about integrating nicotine cessation interventions within broader health and wellness programs in an effort to inform a recommendation. Open-ended questions were posed regarding the types of cessation supports, its estimate of reach and engagement and its general impact (benefits and harms) and, person's values and preferences. Out of 13, four panel members provided observational data based on their experiences. The case series was quality appraised using ROBINS-I and a certainty of evidence was determined by the two guideline development methodologists. The results of the systematic observation form and the certainty of evidence was presented to the full panel. This direct evidence was used alongside indirect evidence found in the literature to support the development of **Recommendation 7**.

Supporting Resources and Appendices

Panel members and stakeholders submitted content for the supporting resources and appendices throughout the guideline development process. The two guideline development methodologists reviewed the content based on the following five criteria:

1. **Relevance**: Supporting resources and appendices should be related to the subject of the BPG or recommendation. In other words, the resource or appendix should be suitable and appropriate in relation to the purpose and scope of the BPG or the specific recommendation(s).

2. **Timeliness**: Resources should be timely and current. Resources should be published within the last 10 years or in line with current evidence.

3. **Credibility**: When assessing credibility, the trustworthiness and expertise of the source material's author or authoring organization is considered. Potential biases are also assessed, such as the presence of advertising or the affiliation of the authors with a private company selling health-care products.

4. **Quality**: This criterion assesses the accuracy of the information and the degree to which the source is evidence-informed. The assessment of quality is in relation to the subject of the resource. For example, if a tool is being suggested, is that tool reliable and/or valid?

5. **Accessibility**: This criterion considers whether the resource is freely available and accessible online.

Drafting the Guideline

The guideline development methodologists wrote the draft of this BPG. The panel reviewed the draft and provided written feedback, which was incorporated into a subsequent draft. The BPG then proceeded to external stakeholder review.

Stakeholder Review

As part of the guideline development process, RNAO is committed to obtaining feedback from: (a) nurses and other health providers from a wide range of practice settings and roles; (b) knowledgeable administrators and funders of health services; and (c) stakeholder associations.

Stakeholder reviewers for RNAO BPGs are identified in two ways. First, stakeholders are recruited through a public call issued on the RNAO website. Second, individuals and organizations with expertise in the guideline topic area are identified by the panel and the RNAO best practice guideline development and research team, and directly invited to participate in the review.

Stakeholder reviewers are individuals with subject matter expertise in the guideline topic or those who may be affected by its implementation. Reviewers may be nurses, members of the interprofessional team, nurse executives, administrators, research experts, educators, nursing students, or people with lived experience and their family members.

Reviewers are asked to read a full draft of the BPG and participate in a review of the draft prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire.

The stakeholders are asked the following questions about each good practice statement:

- Is this statement clear?

- Do you agree with this statement?

- Is there a clear and explicit rationale to support this good practice statement?

The stakeholders are asked the following questions about each recommendation:

- Is this recommendation clear?

- Do you agree with this recommendation?

- Is the discussion of evidence for this recommendation thorough and clear, and does the evidence support the recommendation?

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In addition, the stakeholders are asked:

- Do you have any additional comments/suggestions about the background section of this guideline?
- Do you agree with the wording of the key concepts and accompanying definitions?
- Are the supporting resources and appendices included in this guideline appropriate?

With respect to the evaluation indicators, the stakeholders are asked:

- Are these indicators relevant to your practice setting?
- Do you have suggestions for other indicators and/or measures?

The RNAO best practice guideline development and research team compiles the survey submissions and summarizes the feedback. Together with the panel, the team reviews and considers the survey results, modifying BPG content and recommendations prior to publication to reflect the feedback.

For this BPG, the stakeholder review process was completed throughout 2020 and 2021. Diverse perspectives provided feedback (see **Stakeholder Acknowledgement**).

As part of the stakeholder review process, the guideline development methodologists shared the draft guideline with representatives from Indigenous-focused BPSOs who will be implementing this BPG in their practice settings. Participants ranged from Traditional Healers and Elders, to frontline nursing staff and social service providers. The BPSO participants shared both written and verbal feedback. Guideline development methodologists reflected on the feedback received and areas for revision that addressed areas of concern were brought forward to the BPSO representatives for discussion, further feedback and consensus.

Critical Reflexivity

Critical reflexivity requires that a person connect with the assumptions, values and biases that direct their decision-making. Reflexivity involves the ability to critically reflect and understand how our social locations (belief systems) and experiences of privilege or disadvantage shape how we understand the world and produce knowledge (146). For clinicians to understand and address health inequities it is crucial that they have insight into their relation to structures of privilege and oppression (146). It was important for the guideline development methodologists (GDMs) developing this BPG to actively engage in ongoing critical reflexivity. Moreover, critical reflexivity is an important aspect of enacting cultural safety and humility. As such, it was necessary for GDMs to critically reflect upon their social locations and experiences of privilege or disadvantage throughout the development of this BPG. The two GDMs that co-led this BPG identified as settlers. Critical reflexivity required a commitment to self-directed and lifelong learning. During BPG development, GDMs completed the Sanyas Cultural Safety Course, participated in the Kairos Blanket Exercise, engaged in a number of diverse webinars pertaining to Indigenous health and wellness, and completed additional readings on colonialism and impact on health and wellness by Indigenous authors. The GDMs will continue to participate in ongoing learning about Indigenous history, health and well-being.

APPENDICES

Procedure for Updating the Guideline

The RNAO commits to updating all BPGs, as follows:

1. Each BPG will be reviewed by a team of specialists in the topic area every five years following publication of the previous edition.

2. RNAO International Affairs and Best Practice Guidelines Centre staff regularly monitor for new systematic reviews, randomized controlled trials and other relevant literature in the field.

3. Based on that monitoring, staff may recommend an earlier revision period for a particular BPG. Appropriate consultation with members of the original panel and other specialists and experts in the field will help inform the decision to review and revise the BPG earlier than planned.

4. Three months prior to the review milestone, the staff begin to plan for the review. They:

   a. Compile feedback received and questions encountered during the implementation, including comments and experiences of BPSOs® and other implementation sites regarding their experiences.

   b. Compile a list of new clinical practice guidelines in the field and refine the purpose and scope.

   c. Develop a detailed work plan with target dates and deliverables for developing a new edition of the BPG.

   d. Identify potential BPG panel co-chairs with RNAO's CEO.

   e. Compile a list of specialists and experts in the field for potential participation on the panel. The panel will be comprised both members of the original panel and new members.

5. New editions of BPGs will be disseminated based on established structures and processes.

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Appendix D: PRISMA Diagrams for Guideline Search and Systematic Reviews

Guideline Review

Figure 2: Guidelines Review Process Flow Diagram
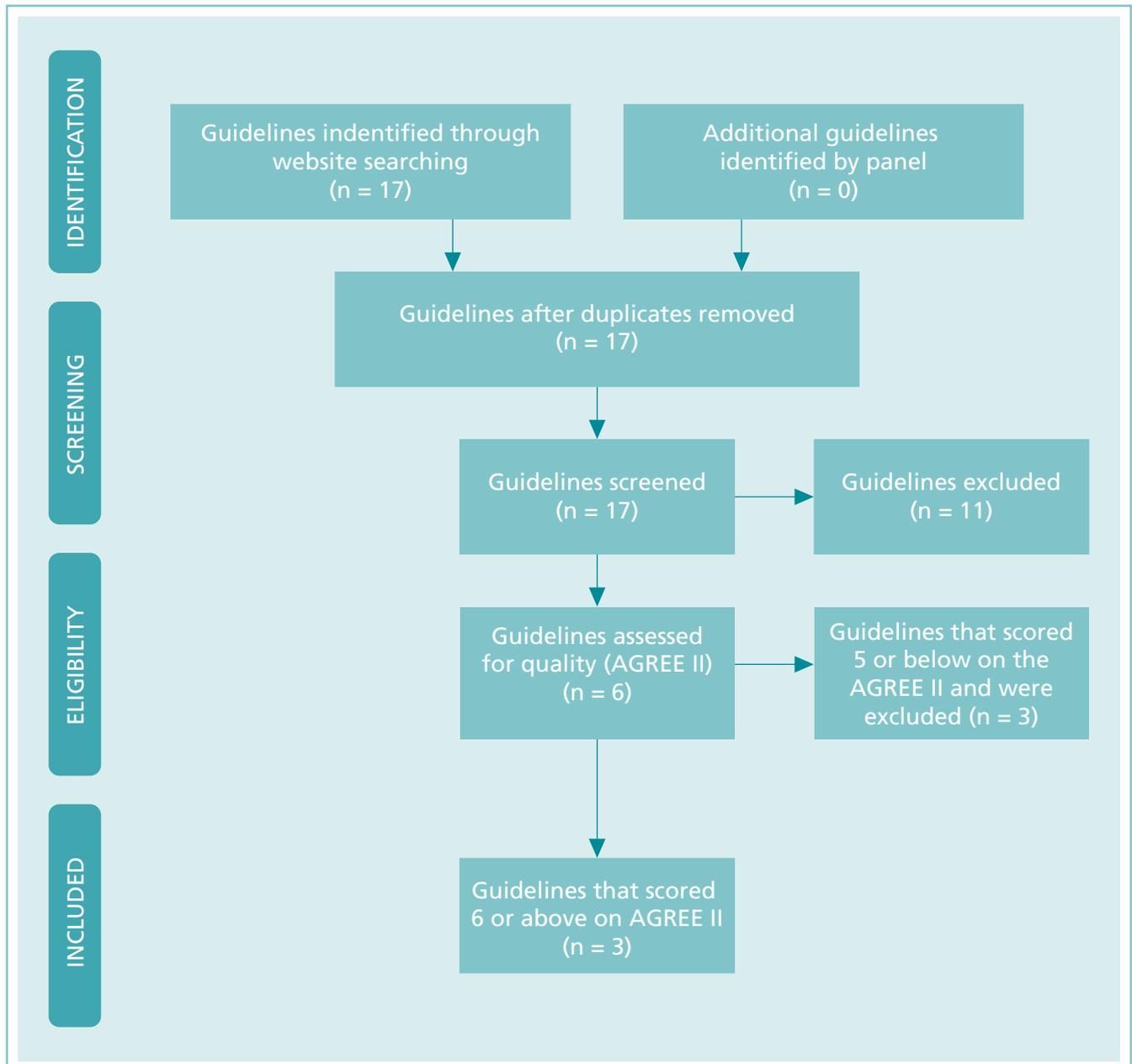
Included guidelines were considered for GRADE-ADOLOPMENT and required to have an overall AGREE II score of 6 or more (out of 7) (Schunemann et al., 2017). However, none of the guidelines were used for GRADE-ADLOPMENT as they were not relevant to the Indigenous context.

Source: Adapted by the RNAO panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 3: Article Review Process PRISMA Diagram for Recommendation Question #1 (Direct Search)

Recommendation Question #1:

Should smoking reduction and cessation counselling be recommended for Indigenous women and persons during pregnancy and the post-partum period? (direct search)

Outcomes: Reach and engagement
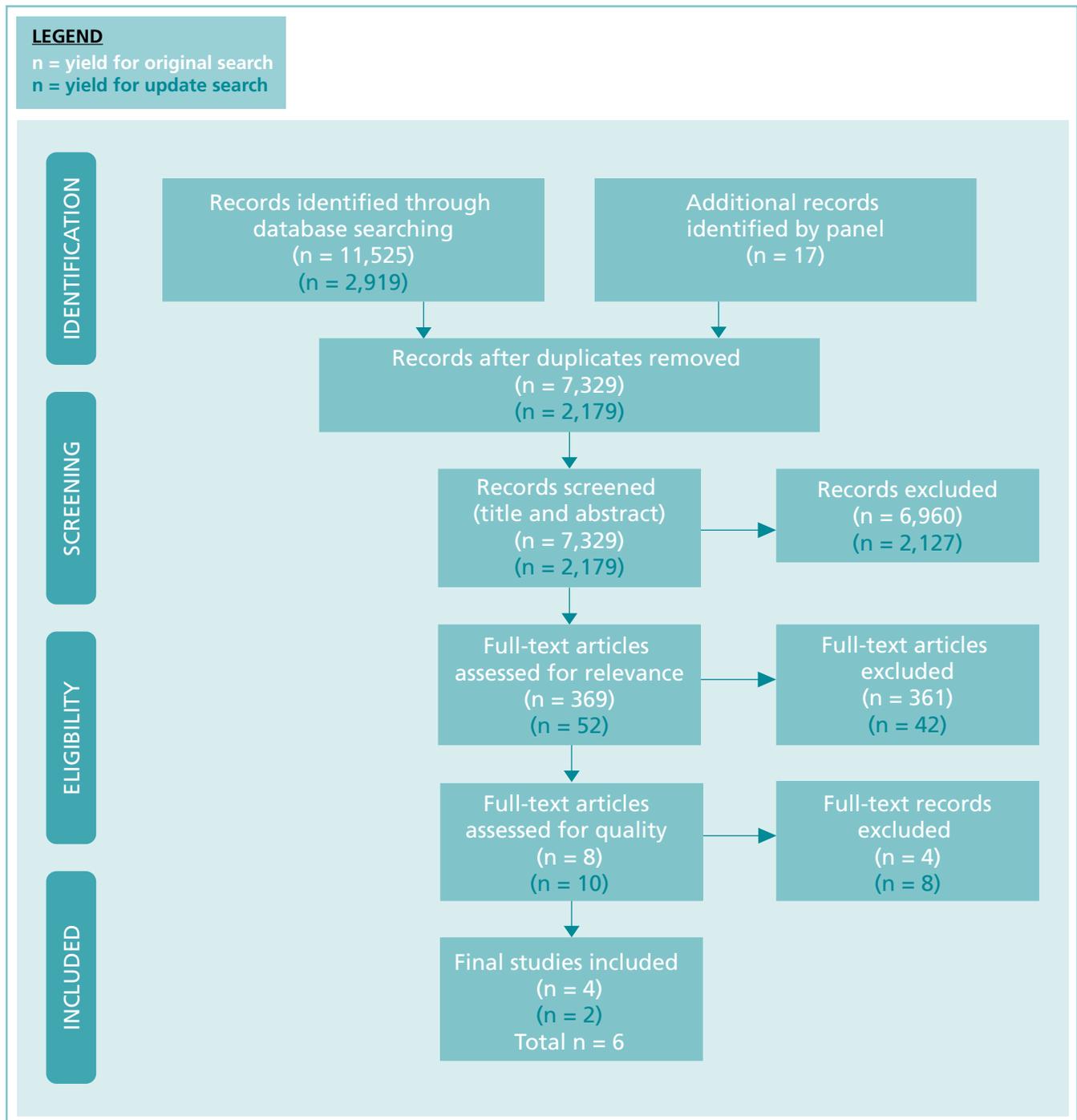
LEGEND
n = yield for original search
n = yield for update search

IDENTIFICATION

Records identified through database searching
(n = 11,525)
(n = 2,919)

Additional records identified by panel
(n = 17)

Records after duplicates removed
(n = 7,329)
(n = 2,179)

SCREENING

Records screened (title and abstract)
(n = 7,329)
(n = 2,179)

Records excluded
(n = 6,960)
(n = 2,127)

ELIGIBILITY

Full-text articles assessed for relevance
(n = 369)
(n = 52)

Full-text articles excluded
(n = 361)
(n = 42)

Full-text articles assessed for quality
(n = 8)
(n = 10)

Full-text records excluded
(n = 4)
(n = 8)

INCLUDED

Final studies included
(n = 4)
(n = 2)
Total n = 6

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Figure 4: Article Review Process PRISMA Diagram for Recommendation Question #1 (Indirect Search)

Recommendation Question #1:

Should smoking reduction and cessation counselling be recommended for Indigenous women and persons during pregnancy and the post-partum period? (indirect search)

Outcomes: Quit rates

IDENTIFICATION

Records identified through database searching
(n = 811)

Additional records identified by panel
(n = 0)

Records after duplicates removed
(n = 679)

SCREENING

Records screened
(title and abstract)
(n = 679)

Records excluded
(n = 620)

ELIGIBILITY

Full-text articles assessed for relevance
(n = 59)

Full-text articles excluded
(n = 55)

Full-text articles assessed for quality
(n = 4)

Full-text articles excluded
(n = 3)

INCLUDED

Final studies included
(n = 1)

Source: Adapted by the RNAO panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ. 2009;339:b2535. doi: 10.1136/bmj.b2535

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2222222222

Figure 6: Article Review Process PRISMA Diagram for Recommendation Question #3 (Direct Search)

Recommendation Question #3:

Should smoking cessation interventions embedded within broader health and wellness programs be recommended?

Outcomes: Reach, engagement, quit rates and quit attempts

LEGEND
n = yield for original search
n = yield for update search

IDENTIFICATION

Records identified through database searching
(n = 11,525)
(n = 2,919)

Additional records identified by panel
(n = 17)

Records after duplicates removed
(n = 7,329)
(n = 2,179)

SCREENING

Records screened (title and abstract)
(n = 7,329)
(n = 2,179)

Records excluded
(n = 6,960)
(n = 2,127)

ELIGIBILITY

Full-text articles assessed for relevance
(n = 369)
(n = 52)

Full-text articles excluded
(n = 369)
(n = 42)

Full-text articles assessed for quality
(n = 0)
(n = 10)

Full-text articles excluded
(n = 0)
(n = 10)

INCLUDED

Final studies included
(n = 0)
(n = 0)
Total n = 0

Source: Adapted by the RNAO panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ. 2009;339:b2535. doi: 10.1136/bmj.b2535

APPENDICES
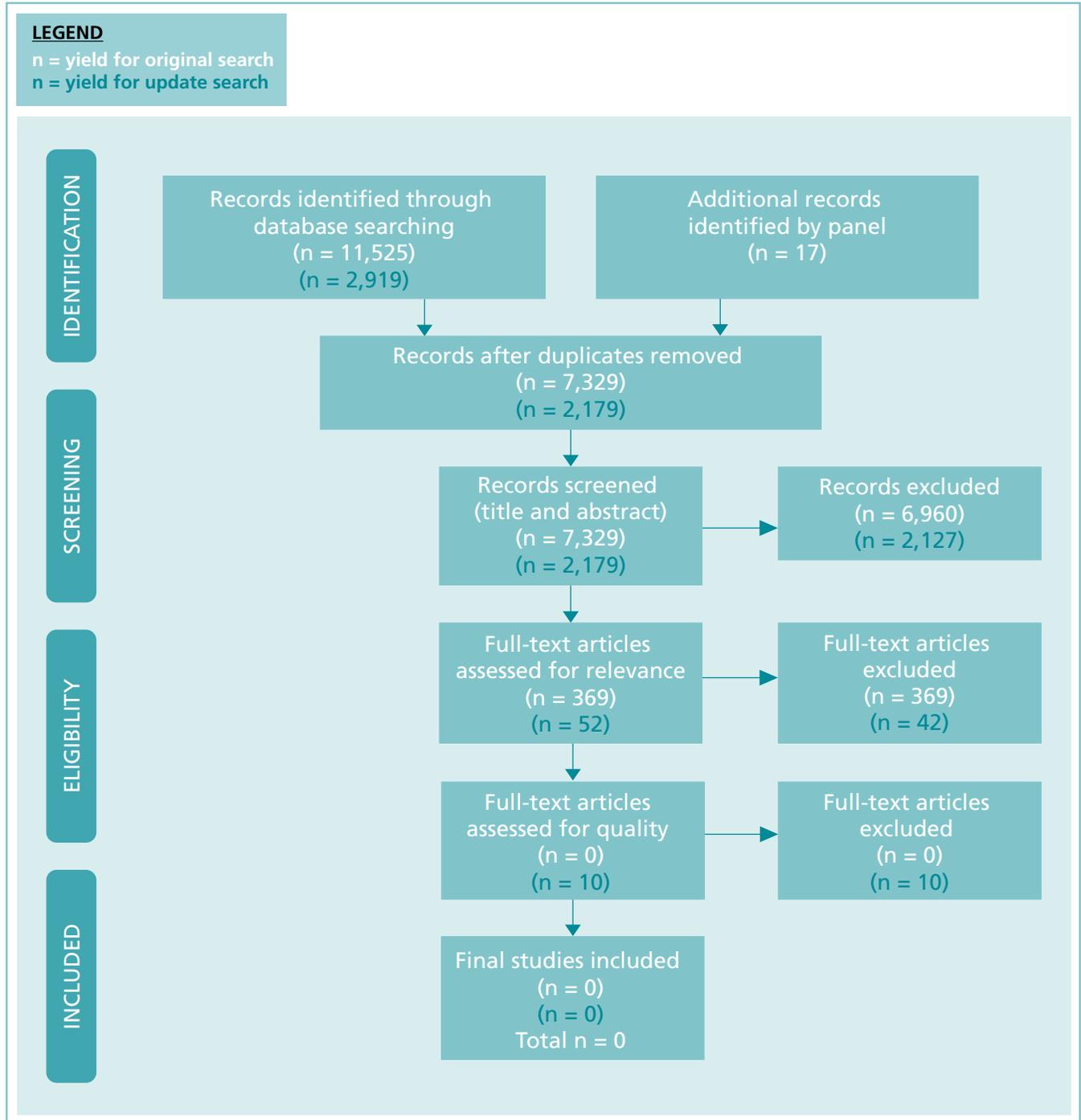
Figure 7: Article Review Process PRISMA Diagram for Recommendation Question #3 (Indirect Search)

Recommendation Question #3:

Should smoking reduction and cessation interventions embedded within broader health and wellness programs be recommended?

Outcomes: Quit rates
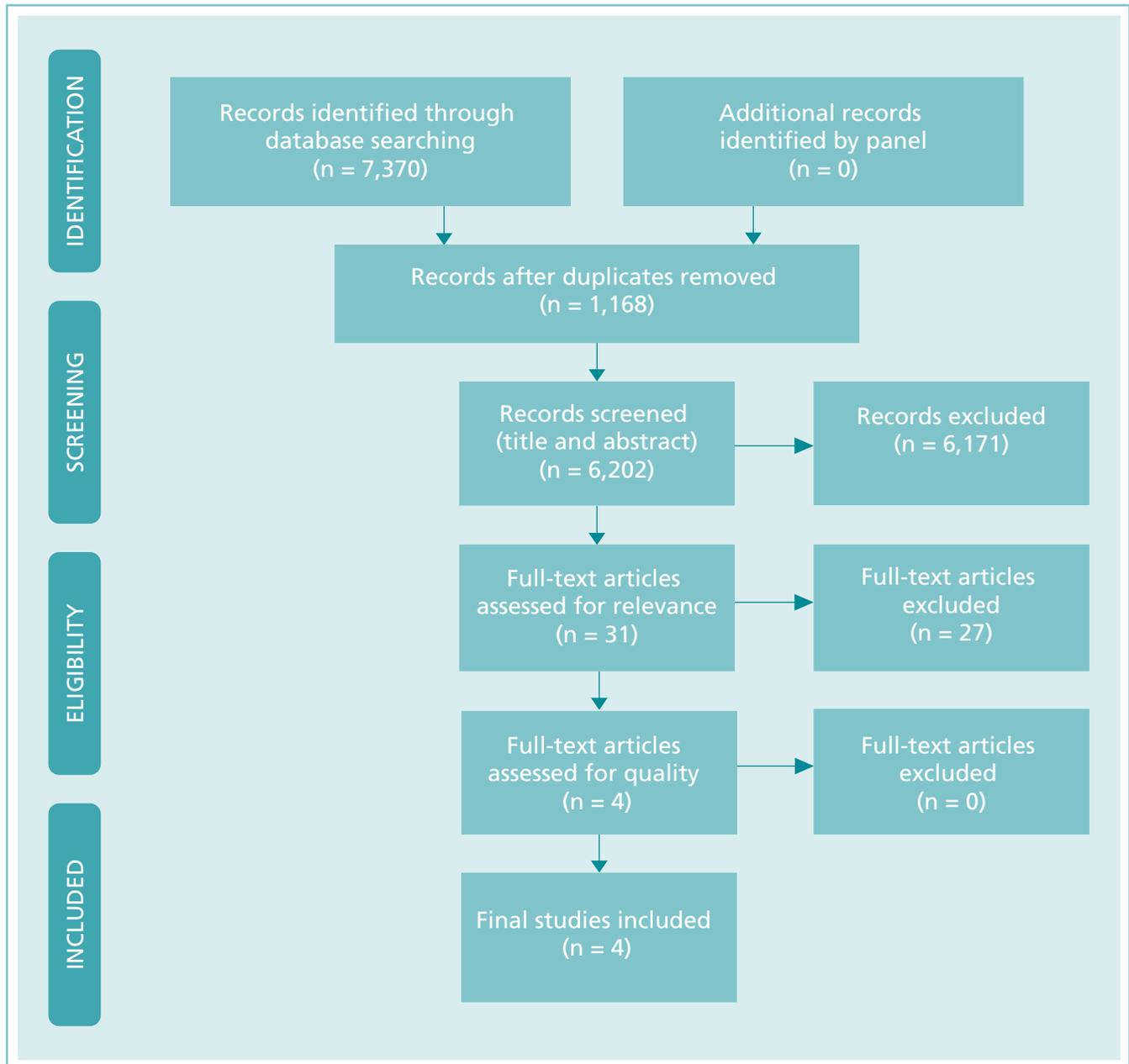
Source: Adapted by the RNAO panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 8: Article Review Process PRISMA Diagram for Recommendation Question #4

Recommendation Question #4:

Should culturally appropriate and trauma-informed smoking cessation services be recommended?

Outcomes: Reach, engagement, quit rates, quit attempts

LEGEND
n = yield for original search
n = yield for update search

IDENTIFICATION

Records identified through database searching
(n = 11,525)
(n = 2,919)

Additional records identified by panel
(n = 17)

Records after duplicates removed
(n = 7,329)
(n = 2,179)

SCREENING

Records screened (title and abstract)
(n = 7,329)
(n = 2,179)

Records excluded
(n = 6,960)
(n = 2,127)

ELIGIBILITY

Full-text articles assessed for relevance
(n = 369)
(n = 52)

Full-text articles excluded
(n = 365)
(n = 42)

Full-text articles assessed for quality
(n = 4)
(n = 10)

Full-text articles excluded
(n = 0)
(n = 3)

INCLUDED

Final studies included
(n = 4)
(n = 7)
Total n = 11
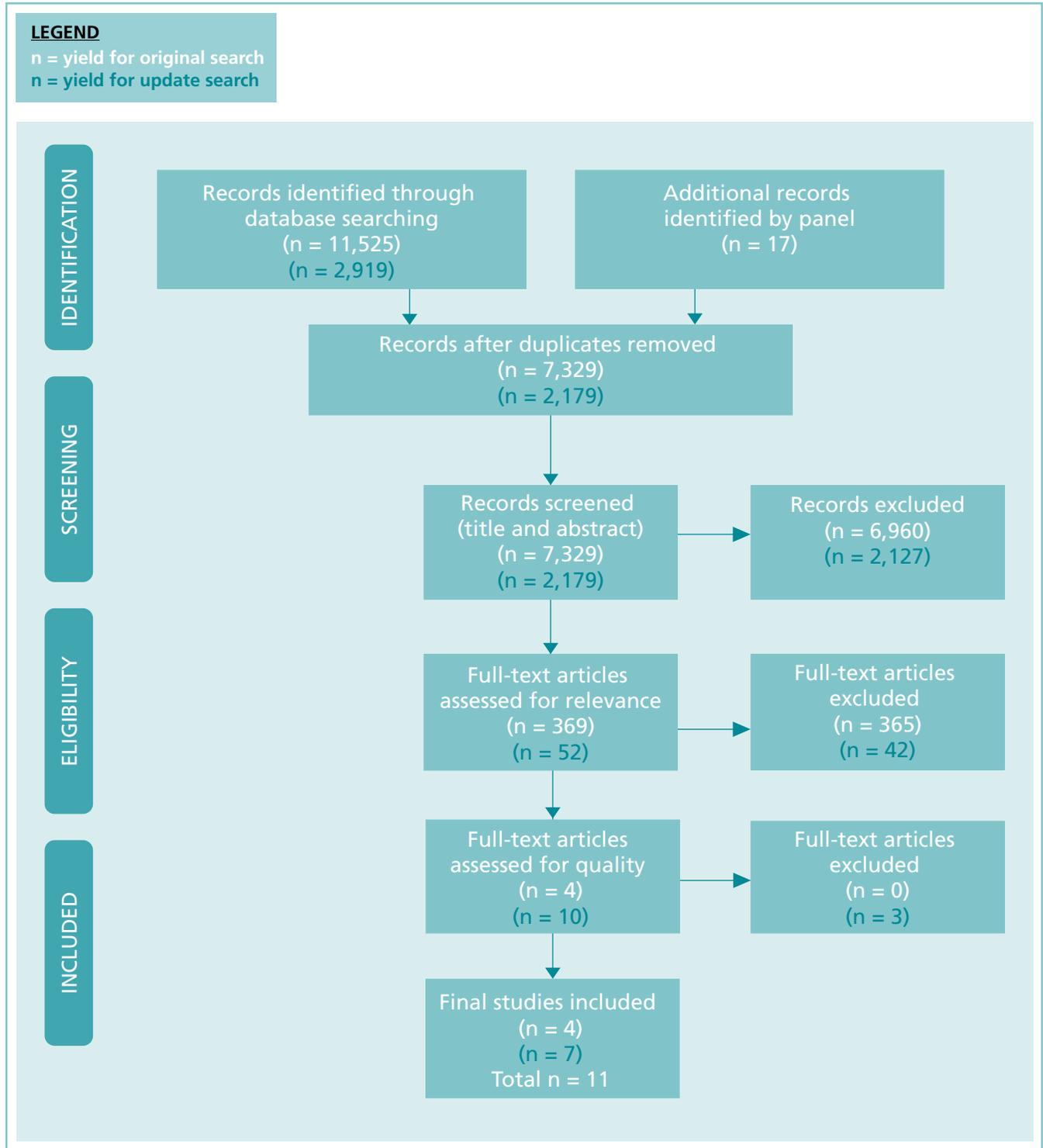
Source: Adapted by the RNAO panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 9: Article Review Process PRISMA Diagram for Recommendation Question #5

Recommendation Question #5:

Should pharmacotherapy (nicotine replacement therapy, bupropion, varenicline) be recommended for smoking cessation in pregnant and post-partum women and persons?

Outcomes: Quit rates, miscarriage & spontaneous birth, stillbirth, mean birth weight, low birth weight, preterm birth, neonatal intensive care unit (NICU) admissions, neonatal death, congenital abnormalities, caesarean section
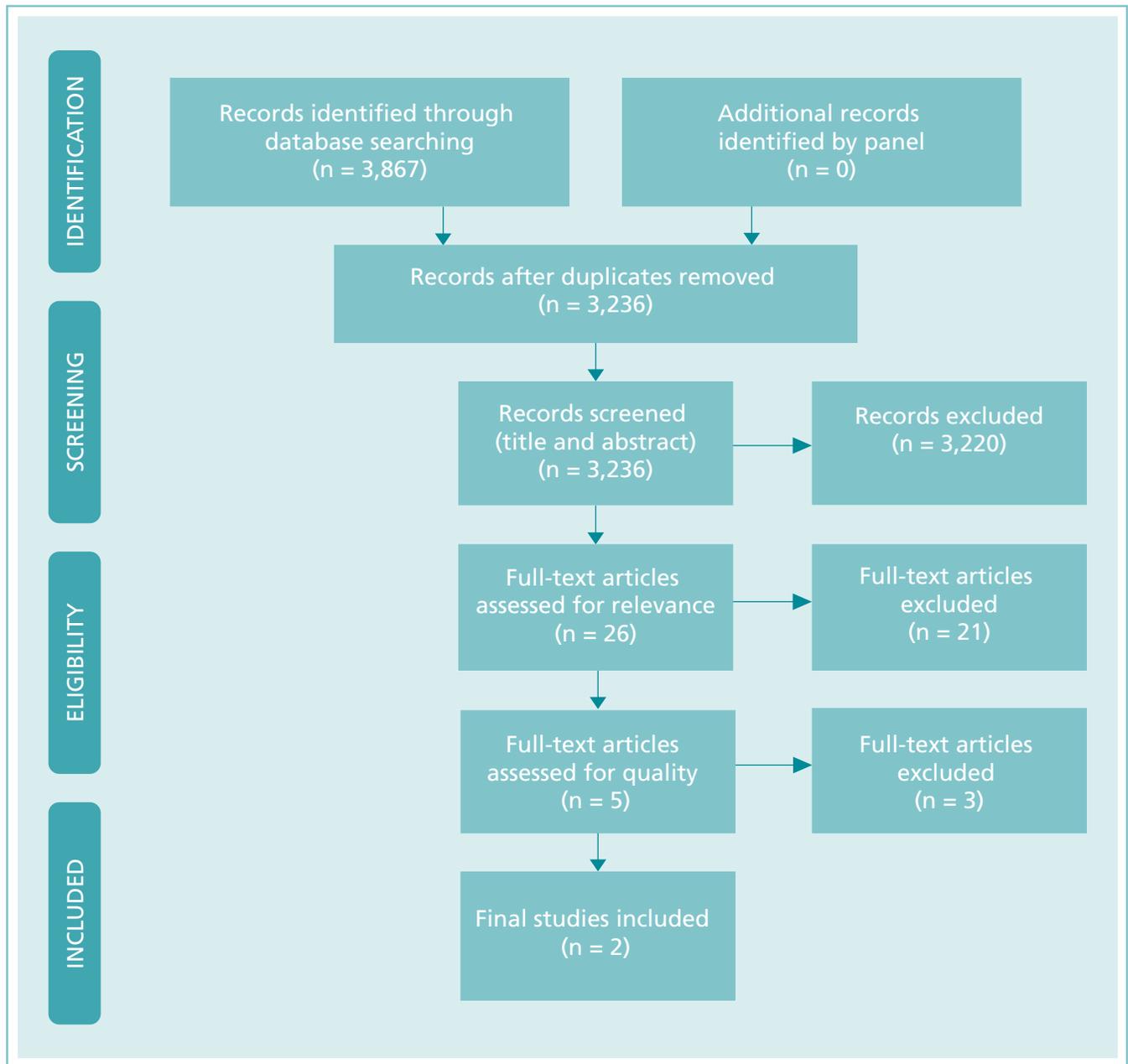
Source: Adapted by the RNAO panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 10: Article Review Process PRISMA Diagram for Recommendation Question #6

Recommendation Question #6:

Should Indigenous community-led smoking cessation approaches be recommended?

Outcomes: Reach, engagement, quit rates, and quit attempts

LEGEND
n = yield for original search
n = yield for update search

IDENTIFICATION

Records identified through database searching
(n = 11,525)
(n = 2,919)

Additional records identified by panel
(n = 17)

Records after duplicates removed
(n = 7,329)
(n = 2,179)

SCREENING

Records screened (title and abstract)
(n = 7,329)
(n = 2,179)

Records excluded
(n = 6,960)
(n = 2,127)

ELIGIBILITY

Full-text articles assessed for relevance
(n = 369)
(n = 52)

Full-text articles excluded
(n = 365)
(n = 42)

INCLUDED

Full-text articles assessed for quality
(n = 4)
(n = 10)

Full-text articles excluded
(n = 0)
(n = 3)

Final studies included
(n = 4)
(n = 7)
Total n = 11

Source: Adapted by the RNAO panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ. 2009;339:b2535. doi: 10.1136/bmj.b2535

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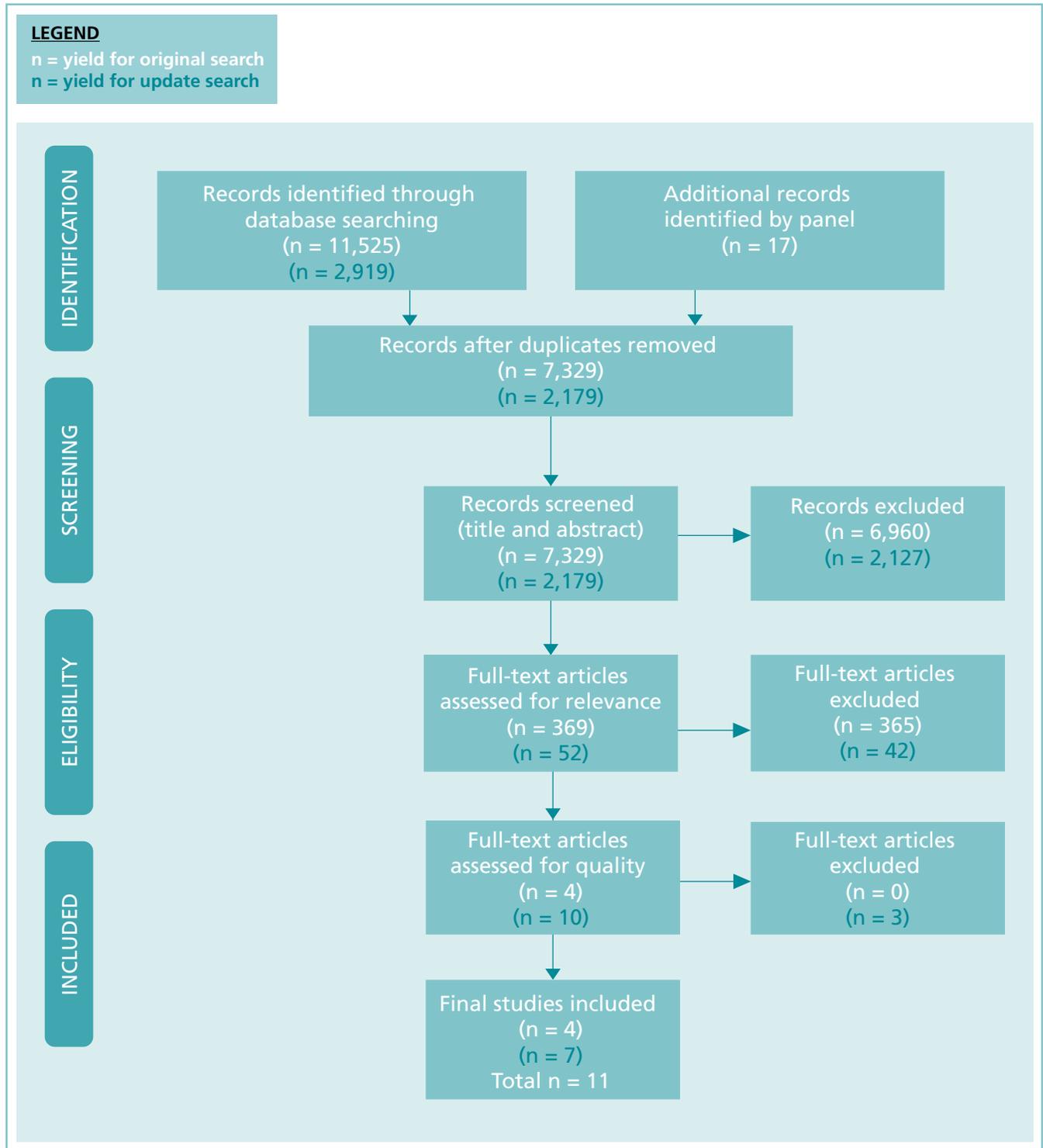
Figure 11: Article Review Process PRISMA Diagram for Recommendation Question #7

Recommendation Question #7:

Should undergraduate education for nurses and the interprofessional team and/or continuing professional development for health providers on Indigenous health be recommended?

Outcomes: Cultural safety, attitude, knowledge, change in practice

LEGEND
n = yield for original search
n = yield for update search

IDENTIFICATION

Records identified through database searching
(n = 2,252)
(n = 295)

Additional records identified by panel
(n = 0)

Records after duplicates removed
(n = 1,891)
(n = 248)

SCREENING

Records screened (title and abstract)
(n = 1,891)
(n = 248)

Records excluded
(n = 1,802)
(n = 227)

ELIGIBILITY

Full-text articles assessed for relevance
(n = 89)
(n = 21)

Full-text articles excluded
(n = 68)
(n = 14)

INCLUDED

Full-text articles assessed for quality
(n = 21)
(n = 7)

Full-text articles excluded
(n = 6)
(n = 2)

Final studies included
(n = 15)
(n = 5)
Total n = 20

APPENDICES
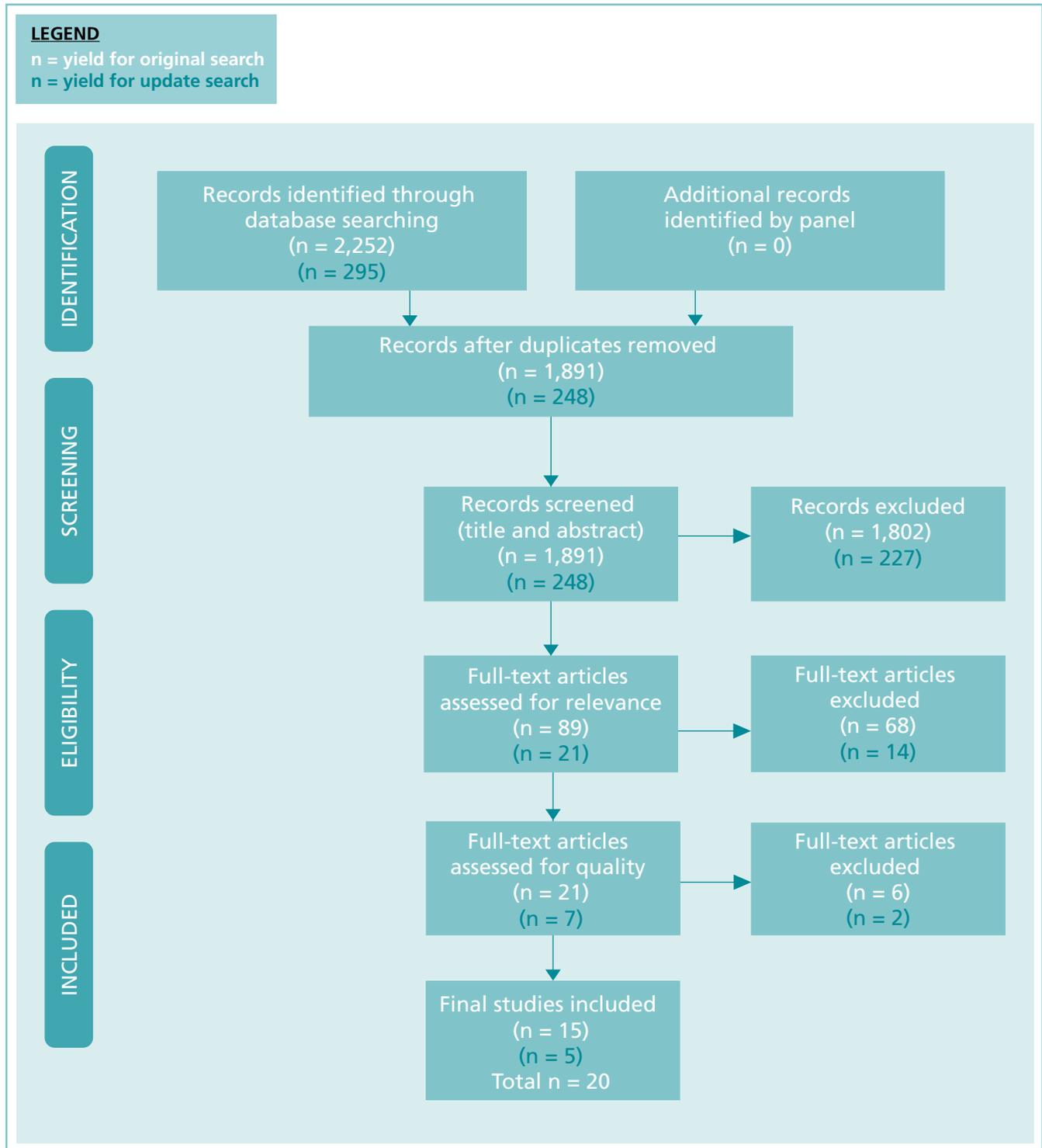
Source: Adapted by the RNAO panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ. 2009;339:b2535. doi: 10.1136/bmj.b2535

Appendix E: Types of Commercial Tobacco Products or Nicotine Delivery System

The following table details different types of commercial tobacco products or nicotine delivery systems.

Table 16: Descriptions of Commercial Tobacco Product or Nicotine Delivery System

COMMERCIAL TOBACCO PRODUCT OR NICOTINE DELIVERY SYSTEM	DESCRIPTION
Cigarettes	"A tube-shaped tobacco product that is made of finely cut, cured tobacco leaves wrapped in thin paper. It may also have other ingredients, including substances to add different flavors. A cigarette is lit on one end (may or may not have a filter) and smoked, and the smoke is usually inhaled into the lungs" (170).
Cigars	"A roll of tobacco wrapped in leaf tobacco or in a substance that contains tobacco. Cigars differ from cigarettes in that cigarettes are a roll of tobacco wrapped in paper or in a substance that does not contain tobacco" (171).
Cigarillos	"A short (3-4 inches) and narrow cigar that typically contains about 3 grams of tobacco and usually does not include a filter" (171).
Hookah	"Water pipes that are used to smoke specially made tobacco that comes in different flavors, such as apple, mint, cherry, chocolate, coconut, licorice, cappuccino and watermelon. Hookah is also called narghile, argileh, shisha, hubble-bubble and gooza. Hookahs vary in size, shape and style. A typically modern hookah has a head (with holes in the bottom), a metal body, a water bowl and flexible hose with a mouthpiece" (172).
Roll-Your-Own Cigarettes	Roll-your-own tobacco is loose tobacco that the user places inside rolling paper and burns" (173).
Pipes	"A device that has a mouthpiece at one end of a tube and small bowl at the other end that is filled with tobacco, which is lit and smoked. The smoke from a pipe is a usually not inhaled into the lungs" (174).

COMMERCIAL TOBACCO PRODUCT OR NICOTINE DELIVERY SYSTEM	DESCRIPTION
E-cigarettes (also called e-cigs, vapes, e-hookahs, vape pens, and electronic nicotine delivery systems [ENDS])	"A device that has the shape of a cigarette, cigar and does not contain tobacco. Some resemble pens or USB flash drives. Larger devices, such as tank systems or mods, bear little or no resemblance to cigarettes. It uses a battery and contains a solution of nicotine, flavorings, and other chemicals, some of which may be harmful. When electronic cigarettes are used, the nicotine solution turns into a mist that can be inhaled into the lungs. The amount of nicotine in individual e-cigarettes can vary. It is not yet known whether electronic cigarettes are safe or if they can be used to help smokers quit smoking" (175, 176).
Chewing Tobacco (also called Spit Tobacco)	"A type of smokeless tobacco made from cured tobacco leaves. It may be sweetened and flavored with licorice and other substances. It comes in the form of loose tobacco leaves, pellets or "bits" (leaf tobacco rolled into small pellets), plugs (leaf tobacco pressed and held together with some type of sweetener), or twists (leaf tobacco rolled into rope-like strands and twisted). It is placed in the mouth, usually between the cheek and lower lip, and may be chewed" (177).
Dissolvables	"Finely ground tobacco pressed into shapes such as tablets, sticks or strips. Dissolvable tobacco products slowly dissolve in the mouth. These products may appeal to youth because they come in attractive packaging, look like candy or small mints, and can be easily hidden from view" (178).
Snuff	"Finely ground tobacco that can be dry, moist or packaged in pouches or packets. Some types of snuff are sniffed or inhaled into the nose; other types are placed in the mouth" (178).

APPENDICES

Appendix F: Adapted 5 As

The 5 As – ask, advise, assess, assist and arrange – are a well known screening and brief support approach used by health care providers related to tobacco cessation. This adapted, gender-informed version tailors this approach for pregnant women, taking into account: gendered influences on women's smoking and the importance of developing a safe and respectful context for asking about tobacco.

Ask: Given the stigma associated with tobacco use, particularly in pregnancy, discuss commercial tobacco use with all women in open and non-judgemental ways that acknowledge: what women may already know about risks, the stigma they may have encountered, and the changes they have already made.

Advise: Provide and discuss information about healthy choices appropriate to the woman's reproductive stage. Tailor the advice/information provision based on what she already knows.

Assess: Assess level of tobacco use and readiness to reduce or stop. Record level/frequency of use and interest in support so that tailored follow-up can be done throughout the system of care. Discuss related health and social issues that may make it challenging to access support.

Assist: Work with women to set goals based on their situation. Assist with planning change(s), keeping the discussion open, and supporting self-efficacy. Discuss options for support and treatment.

Arrange: Assist women in getting the help they need by making referrals to other agencies or follow-up, depending on their situation.

Adaptation by: Nancy Poole, PhD and Lorraine Greaves, PhD
Centre of Excellence for Women's Health
https://cewh.ca/recent-work/tobacco-girls-and-women/

Note: RNAO respectfully acknowledges that the Adapted 5 As document may need to be further adapted by organizations to be inclusive of all pregnant people, not just those that identify as women.

Appendix G: Cultural Protocols for Offering Traditional Tobacco

When working with many (not all) First Nation or Métis Elders and traditional Knowledge Keepers, offering tobacco (traditional medicine) is a respectful practice when requesting guidance from an Elder or Knowledge Keeper to share their teaching, expertise and knowledge. The following resources are examples and may be used to guide and improve your understanding of traditional tobacco use with some Indigenous communities.

Table 17: Resources to Guide and Improve Understanding of Traditional Tobacco Use With Some Indigenous Communities

RESOURCE	DESCRIPTION
Ontario Federation of Labour Indigenous Circle. Tobacco-offering protocol [Internet]. Toronto. 2018 [cited 2022 January 21]. Available from: https://ofl.ca/wp-content/uploads/2019.06.20-OFL-FNMI-Tobacco-Offering-Protocol.pdf	■ Instructions for offering traditional tobacco as a gift with First Nations ■ Protocols can vary by nation and community ■ Check with a local First Nation, a Friendship Centre or a Health Access Centre for further details on the local protocol for offering traditional tobacco, in particular where an Elder is invited to participate
Cree Board of Health and Social Services of James Bay. Traditional Medicine: Tobacco [Internet]. Chisasibi. 2021 [cited 2022 February 1]. Available from: https://www.creehealth.org/health-tips/traditional-medicine-tobacco	■ Outlines cultural protocols for offering tobacco when harvesting medicine ■ Additional resources on other traditional medicine such as white spruce, balsam fir, sage and cedar
University of Regina. Guideline for practicing Indigenous protocols at the university of Regina [Internet]. Regina. n.d. [cited 2022 February 4]. Available from: https://www.uregina.ca/policy/assets/docs/doc/GOV-040-025-AppendixB-Protocol.docx	■ First Nations and Métis cultural practices ■ See page 3 specific for traditional tobacco cultural practices

Note: All website addresses were active as of March 30, 2022.

APPENDICES

Appendix H: Cultural Safety Terminology

Cultural safety creates an environment for Indigenous community members that is free of racism and discrimination and where community members feel safe and respected when accessing and participating in health services (179). Non-Indigenous health providers who are empathetic and respectful understand the power differentials inherent in the delivery of health services and recognize that lifelong critical reflection of their assumptions and biases is an essential for practicing in a culturally safe way. Person- centred care principles identify the individual at the centre as the expert in their own health and wellness. A variety of terms are used to define various levels of understanding around providing cultural safe care. See **Table 18** for further details:

Table 18: Definitions of Cultural Safety Terminology

DEFINITIONS OF CULTURAL SAFETY TERMINOLOGY	
Cultural Awareness	Having an awareness of the nuances of one's own culture as well as the culture of others.
Cultural Sensitivity	Where health providers recognize differences in cultures and that these differences are important to acknowledge in health services.
Cultural Competency	An approach that focuses on health providers' acquiring knowledge, skills and attitudes to deliver health services in more effective and respectful ways with Indigenous community members and people of different cultures.
Cultural Humility	When health providers are humble and acknowledge that they are learners in understanding a person's lived experiences. This learning is lifelong and involves ongoing self-reflection.
Cultural Safety	An approach that considers how historical and social contexts and structural and interpersonal power imbalances shape health and health service experiences. Health providers are self-reflective and self-aware with regard to their position of power and the impact of this position in relation to people receiving health services. Cultural safety is determined by those who receive health services, not by those who deliver health services.

Adapted from: Ward C, Branch C, Fridkin A. What is Indigenous cultural safety – and why should I care about it? Visions. 2016;11(4):29-32.

Appendix I: Description of the *Leading Change Toolkit*™

BPGs can only be successfully implemented and sustained if planning, resources, organizational and administrative supports are adequate and there is appropriate facilitation. The active engagement and involvement of formal and informal leaders (e.g., change agents, peer champions) are also essential. To encourage successful implementation and sustainability, an international panel of nurses, researchers, patient/person advocates, social movement activists and administrators has developed the *Leading Change Toolkit*™ (1). The *toolkit* is based on available evidence, theoretical perspectives and consensus. We recommend the *Leading Change Toolkit*™ for guiding the implementation of any BPG in health-care or social service organizations.

The *Leading Change Toolkit*™ includes two frameworks—the Social Movement Action (SMA) Framework (160) and the Knowledge-to-Action (KTA) Framework (180)—for the change agents and change teams that lead the implementation and sustainability of BPGs. Both frameworks outline the concept of implementation and its inter-related components. Either framework, the SMA or the KTA, can be used to guide change initiatives, including the implementation of BPGs. The use of both frameworks serves to enhance and accelerate change (136).

The SMA Framework includes elements of **social movements in a context of evidence uptake and sustainability**[G] that have demonstrated powerful impact and long-term effects. Based upon the results of a concept analysis, the framework includes 16 elements categorized as preconditions (i.e., what must be in place prior to the occurrence of the social movement), key characteristics (i.e., what must be present for the social movement to occur), and outcomes (i.e., what will likely happen as a result of the social movement) (136, 181). The three categories and elements of the SMA Framework are shown in **Figure 12**.

**Figure 12: Social Movement Action Framework**

SOCIAL MOVEMENT ACTION FRAMEWORK
FOR KNOWLEDGE UPTAKE AND SUSTAINABILITY

Grinspun, D., Wallace, K., Li, S.A., McNeill, S., & Squires, J. (2020, Spring). Leading change through social movement. *Registered Nurse Journal*, 32(1), 15.

KEY CHARACTERISTICS

- Goals and outcomes are met
- Change is scaled up, out, or deep
- Capacity in leading change is increased

OUTCOMES

PRECONDITIONS
- Change is valued and necessary
- Receptivity to change
- Examples of social movements are recognized

- Urgent need to take action
- Framing
- Emerging leaders
- Intrinsic motivation
- Individual and collective action
- Public visibility
- Collective identity
- Momentum
- Networks of people and resources
- Core leadership structures

The KTA Framework is a planned cyclical approach to change that integrates two related components: the knowledge creation and the action cycle. The knowledge creation process is what researchers and guideline developers use to identify critical evidence results and to create a knowledge product, such as an RNAO BPG. The action cycle is comprised of seven phases in which the knowledge product is implemented, evaluated and sustained (180). Many of the action cycle phases may occur, or need to be considered, simultaneously. The KTA Framework is depicted in **Figure 13** (1).

Figure 13: Knowledge-to-Action Framework
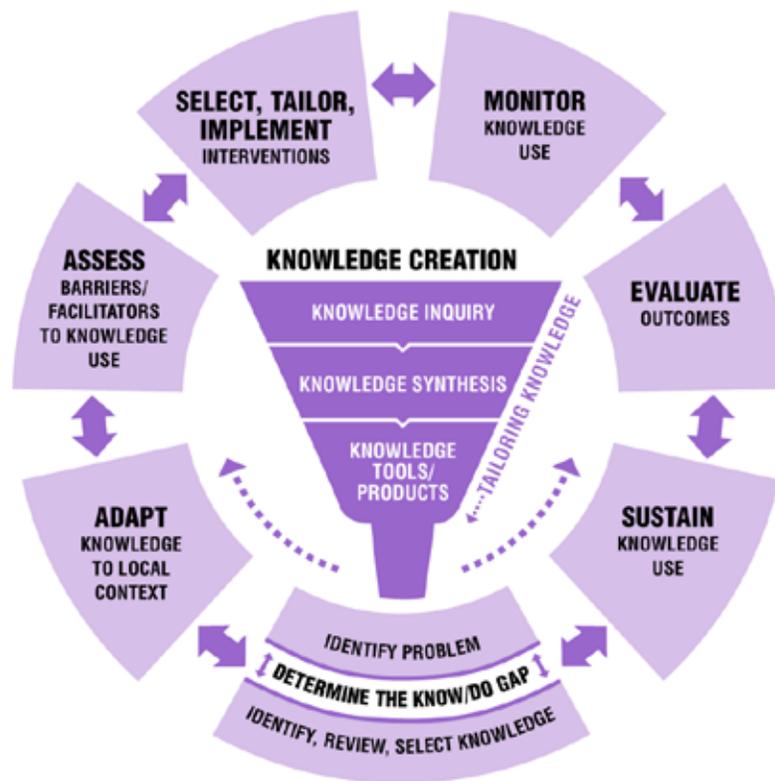
It is a complex undertaking to implement and sustain BPGs to effect successful practice changes and positive health outcomes for patients/persons and their families, providers, organizations and systems. The *Leading Change Toolkit™* is a foundational implementation resource for leading this process.

Endorsements

Association *of*
Ontario Midwives
Delivering what matters.

May 11, 2022

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON, M5H 1L3

Dear Dr. Grinspun,

On behalf of the Association of Ontario Midwives (AOM), we are pleased to convey AOM's endorsement of the Registered Nurses' Association of Ontario's (RNAO) best practice guideline *Promoting Smoking Reduction and Cessation with Indigenous Peoples of Reproductive Age and Their Communities*. With its evidence-based focus on the importance of culturally safe and meaningful ways to promote smoking reduction and cessation with Indigenous peoples, this guideline will benefit pregnant people, their families, communities, nurses and other health-care providers.

The AOM is dedicated to advancing the clinical and professional practice of Indigenous/Aboriginal and Registered Midwives in Ontario. Our vision is for midwives to lead decolonized and anti-racist reproductive, pregnancy, birth, and newborn care across Ontario. The AOM is committed to supporting interprofessional care and maximizing the contribution of midwives in providing primary perinatal care. In addition, one of the AOM's core values is to "promote and support the restoration and renewal of Indigenous midwifery".

The RNAO BPG's evidence-based recommendations addressing smoking reduction and cessation is a knowledge translation document which will facilitate health care providers to provide collaborative, evidence-based and person-centred care. Collaboration among the interprofessional team, person receiving care, their support network and their community is essential for delivering the highest quality of care to all clients.
Sincerely,

Ellen Blais, BSc, BHSc (Midwifery), AM
Director, Indigenous Midwifery

Alexa Minichiello, MSc
A/Director of Clinical Knowledge Translation

365 Bloor St. E., Suite 800 | Toronto, ON M4W 3L4 | T. 416.425.9974 1.866.418.3773 | F. 416.425.6905 | OntarioMidwives.ca

Notes

ia BPG

INTERNATIONAL
AFFAIRS & BEST PRACTICE
GUIDELINES

TRANSFORMING
NURSING THROUGH
KNOWLEDGE

Best Practice Guideline

This project is funded by the Government of Ontario.

RNAO
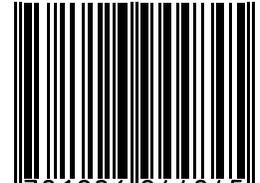
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

Ontario