A COMMUNITY-INFORMED APPROACH TO
CANNABIS PUBLIC EDUCATION
AND AWARENESS

UNE APPROCHE COMMUNAUTAIRE DE
L'ÉDUCATION ET DE LA SENSIBILISATION
DU PUBLIC AU CANNABIS

A Community-Informed Approach to Cannabis Public Education and Awareness

National Engagement Session

Millbrook, Nova Scotia

Native Women's Association of Canada

L'Association des femmes autochtones du Canada

Introduction

The Native Women's Association of Canada (NWAC) is a National Indigenous Organization representing the political voice of Indigenous women, girls, and gender-diverse people in Canada, inclusive of First Nations on and off reserve, status and non-status, disenfranchised, Métis, and Inuit. An aggregate of 13 Indigenous women's organizations from across the country, NWAC was founded in 1974 on the collective goal to enhance, promote, and foster the social, economic, cultural and political well-being of Indigenous women within their respective communities and Canadian societies.

A Community-Informed Approach to Cannabis Public Education and Awareness is an initiative funded by Health Canada's Substance Use and Addictions Program (SUAP). The project aims to identify cannabis needs and priorities of Indigenous women, girls, and gender-diverse people through community engagement and to create public education resources that are reflective of these needs. This will ensure that the public education and awareness resources that are created will be culturally-safe, distinctions-based, gender-based, and trauma-informed.

Creating culturally-safe, and distinctions-based resources means that they will be reflective of the lived experiences, histories, values, and cultures of status and non-status First Nations, Métis, and Inuit women, girls, and gender-diverse people. A trauma informed approach means taking into account the trauma of Canada's colonial history, but not focusing on or reliving a trauma experience. It is about taking an approach that focuses on empowerment, safety, collaboration, and the strengths and cultural/individual resources an individual or community has. Taking a gender-based approach means considering the gendered impacts of colonization, how this contributes to current issues that affect Indigenous women, girls, and gender-diverse people. For this project, it also means considering how the effects of cannabis and cannabis consumption patterns differ for individuals based on sex and gender.

One of the key objectives of the project is to increase the cannabis literacy of the target population by including culturally-safe and gender-specific, evidence based assessments of risk in a format that is accessible and follows harm reduction principles. Taking a harm reduction approach means including both information on the risks of problematic cannabis use, and information about what safe recreational use looks like for the target population. The creation of these resources will enable Indigenous women, girls, and gender-diverse people to make informed decisions about cannabis use that best suit their circumstances (both as an individual and within a community context) and needs.

The key activities to be undertaken in the proposed project are:

- An engagement session conducted with Indigenous women and gender-diverse people in leadership to discuss cannabis public education and awareness priorities.
- A national online survey to gauge community perspectives, knowledge of- and concerns about cannabis as well as what kinds of educational resources would be beneficial for the target population.

- Four regional in-person engagement sessions to get an understanding of region-specific cannabis needs and concerns. The sessions will be hosted through NWAC's Provincial/Territorial Member Association (PTMAs) to bring together grassroots Indigenous women from various communities across Canada. The purpose of these engagement sessions will be to get a better understanding of the distinct cannabis needs, concerns and priorities of Indigenous women and gender-diverse people in each region.
- Development of culturally-safe and gender-specific resources and educational materials that can be adapted to communities' individual needs. The format that these resources take will be determined by the information collected through the proposed engagement activities.

NWAC staff will then analyze and synthesize the knowledge, evidence and perspectives gained through these engagement activities, and apply them to create a series of culturally-safe, gender-based, trauma-informed cannabis public education and prevention resources for Indigenous women, girls, and gender-diverse people.

NWAC's Cannabis Project held its first national engagement session in Millbrook, Nova Scotia. The engagement sessions brought together Indigenous women, two spirit and gender-diverse people from a wide range of professional and personal experiences regarding cannabis from across Canada. Participants touched upon a wide variety of topics throughout the day leaving staff with a better sense of the distinct cannabis health education needs, barriers, and priorities of Indigenous individuals and their communities. This report will provide an overview of the discussion and key recommendations heard during the engagement session.

National Engagement Session in Millbrook, Nova Scotia
March 5, 2020
Summary Notes

Discussion Part One: Understanding Our Target Audience

1. What are some of the strengths that the target population already has regarding sharing knowledge of healthy living?

Participants agreed that Indigenous women, girls and gender diverse people have many strengths but perhaps the biggest two include their ability to connect with others and their traditional knowledge that applies a holistic perspective to plant medicine and health. Indigenous women and gender diverse people have reclaimed their culture and their traditional way of life; participants concurred that rematriation was an important value and strength. Furthermore, participants touched on Indigenous resiliency, they explained that resilience gives Indigenous communities the ability to hold multiple levels of trauma and still be able to connect and take care of each other. Storytelling and ceremonies were expressed as important ways of connecting knowledge keepers with community members to share valuable ancestral knowledge and lived experiences. Similarly, grassroots movements connecting peers provides opportunities to share and exchange knowledge, network and empower one another. Therefore, Indigenous women and gender diverse people's connections with Elders and knowledge keepers are important strengths that provide access to traditional knowledge.

Participants explained that despite Indigenous communities' diverse backgrounds, they can still connect and share with each other because they are open-minded and recognize each other's differences in culture and tradition. There are different types of healers and Elders with vast knowledge of wellness, especially with plant medicines like cannabis. Participants explained that Indigenous people need to take advantage of their natural strengths in the use of traditional healing methods and follow their natural intuitions and experiences with ceremony, plant medicines, and connection to the spirit to support all forms of health.

2. What are the stigmas creating a barrier to a better understanding of cannabis use?

Participants cited multiple sources of stigma that may create barriers to a better understanding of the effects of cannabis use, including stigma from within one's own community, stigma as a result of media representation of cannabis and its consumers, stigma stemming from Canada's previous prohibition and stigma rooted in the current medical system. Participants explained that the current lack of cannabis education and resources greatly contribute to the existing stigma as the majority of people are uninformed or misinformed about the substance. Participants elaborated that stigma from within their own communities can often be due to Christian presence and the effects of colonialism. They cited examples of people being removed from their religious group or even evicted from their reserve due to cannabis use. Religious institutions and Elders in some communities can share fear-based information about cannabis which contributes to stigma making it difficult and risky for people to identify themselves as

users. Furthermore, participants felt that physicians prioritized synthetic pharmaceuticals and medications over cannabis and cannabinoids further contributing to stigma.

Prohibition was also discussed during the engagement session. Participants expressed that the actual cause of prohibition is unknown to the general public causing them to think of cannabis with a negative connotation. This greatly contributes to the stigma surrounding the pant. Participants felt that historically, cannabis and hemp were used frequently across different industries but due to stigma and lack of education, they are not used to their full potential today. Participants thought the negative effects of stigma can be resolved with better cannabis education. Participants felt that it's inaccurate to put cannabis in the same conversation as alcohol and illicit drugs as may people utilize it as medicine. When cannabis is regulated in this way it increases the stigma for people that need cannabis as part of their healing.

Participants discussed how Non-Insured Health Benefits (NIHB) does not fund medical cannabis nor has it taken enough action leaving a great financial burden on Indigenous people that require cannabis to manage their health issues. They recalled incidents in the healthcare system where physicians appeared to be uneducated on medical cannabis, others explained that their physicians weren't even willing to discuss cannabis during their encounters. Participants acknowledged the importance of health providers' roles in reducing stigma since many people rely on them for information about managing their personal health. Participants expressed how they fear disclosing their cannabis use to their healthcare providers as they worried they would be seen as bad/unfit parents and risk having their children taken away. Further, they explained that current methods of harm reduction frequently excluded cannabis, while the idea of harm reduction is being institutionalized and used as a novel buzzword. They explained that it was in fact a concept that has existed in traditional Indigenous wellness teachings for generations.

Finally, participants felt that media coverage of cannabis and its users greatly contributed to stigma. Cannabis users are often portrayed as being lazy individuals who can't be good students, employees, friends, or parents. The lack of education in general, promotes misinformation as many theories tied to stigma have been disproven repeatedly. For example, the idea that cannabis is a "gateway drug" or that it is dangerous and addictive like other street drugs has no backing or evidence. Participants felt that there is a lot of fearmongering in media and current education about cannabis. They agreed that cannabis education needs a more balanced approach with more practical information for people to be able to make better decisions about their situation. They expressed a desire to see more positive media campaigns that show different cannabis users and dispel these misconceptions.

3. How can we reduce stigmatization and shame for those that choose to use cannabis?

When discussing ways of reducing the existing stigma, participants' responses involved four main areas:

1. Creating safe spaces;
2. Improving the language used regarding people who use substances;
3. Better public health education, and
4. Better support from policy and medical systems.

Participants discussed the importance of creating safe spaces where people who use cannabis and/or other substances can connect with others and improve their wellness through traditional

medicines, ceremony, diet and exercise. Some participants felt that they needed better access to traditional ceremonies since often these are not accessible for people who use cannabis and other substances. Often, people who use cannabis or other substances are denied ceremony until they abstain from using for at least 4 to 7 days. Participants explained that it forces them to choose between using their plant medicine or drug that helps them cope with their trauma and the ceremony and connection that helps with their healing. By removing the barriers to access traditional healing ceremonies, participants explained that more people could get the help they need to live healthier lives and connect with community support systems.

Participants expressed a desire to comfortably speak about their lived experiences with cannabis and increase dialogu5e without feeling shamed, stigmatized and marginalized. Participants emphasized the importance of language referencing cannabis and other drugs. They expressed preference to destigmatizing, person-centered language such as, “plant medicine” vs “drug”, and “de-prescribing”.

Education was an important topic of the day’s discussion and participants acknowledged that there are many ways to improve currently available resources. Participants highlighted the importance of positive role-models and strength-based focus in education for all Indigenous groups. For example, campaigns showing different people that may not fit the typical stereotype for people using substances sharing their experiences, why they choose to use cannabis and their advice for people to make better decisions. Participants stressed the importance of incorporating cannabis education into school curriculums targeting both youth and teachers. They also suggested educational programming for health care providers, and policy makers. Participants felt that this approach will reach a wider audience and empower people with knowledge to help others while stopping the pattern of stigmatization. They expressed a desire to see a more balanced approach to cannabis education rather than abstinence-only messaging and fear mongering. Participants felt that current public health messaging failed to acknowledge the medicinal uses and benefits of cannabis. Engagement session attendees emphasized the value of exploring traditional cannabis use and its role in certain ceremonies and tribes. They stressed the importance of having a broader understanding of the context of traditional cannabis use and the history of prohibition in education.

Further, garnering support from policy makers and health systems was equally important. Some participants perceived an overall lack of support for people that use cannabis from medical service providers, child and family services, and government policy. Some participants saw physicians as “gate-keepers” who didn’t support access to medical cannabis and its role in reducing reliance on pharmaceuticals for their chronic health issues enough. Failing to involve Indigenous people in policy and research will continue to perpetuate misconceptions, stigma and prejudice and their respective burdens on Indigenous communities.

4. What does a harm reduction approach look like in the context on cannabis?

Participants used Ekosi Health’s cannabis harm reduction approach where cannabis is being used to support people in reducing their dependence on opioids and more harmful pharmaceuticals as a model for best practice. They expressed a desire for more physicians to adopt this model and utilize an evidence-based advice model similar to the one Dr. Shelley Turner uses. Participants discussed harm reduction recommendations such as encouraging people to choose smokeless options for consuming cannabis and using cannabis as a tool to

help lessen withdrawal symptoms from opioids and alcohol. They also expressed the importance of including people who use poly-substance in harm reduction.

Participants explained that there are many sweat lodge keepers require 4 to 7 days of sobriety in order to participate, therefore stressed the need for Elders who are taught harm reduction approaches. This could be done by connecting Elders together in a council where knowledge of harm reduction can be shared.

5. What are some of the barriers when it comes to resources being accessed by Indigenous women, girls, and gender-diverse people? Does this differ for rural and remote communities?

Participants' highlighted two main barriers with respect to the current education available:

1. Difficulty accessing education and
2. Existing education doesn't meet the needs of all Indigenous women, girls, and gender-diverse people.

Participants acknowledged that there are many barriers to accessing cannabis health education. One of which is cost. Funding for public health resources like cannabis education are given to a region or province, but not specifically dedicated specifically to First Nations, Inuit, or Metis peoples. Participants explained that the way funding is allocated often leaves many people without equal access to resources especially those that live in remote communities. Further, while telemedicine provides an opportunity to obtain a medical cannabis license, connect with experts, obtain health advice, services and education, certain regions, specifically rural and remote communities, don't have the technology necessary for telemedicine making it inaccessible.

Participants explained that limited access to healthcare services on reserve and in remote communities greatly impacted accessibility to health education resources. Further, those incarcerated or those attending school on reserve similarly struggle to access resources. Participants explained that the existing resources regarding cannabis education are not always applicable to Indigenous women, girls and gender diverse people. They acknowledged that existing cannabis evidence and research does not encompass Indigenous women, Indigenous gender diverse people, Indigenous pregnancies, or Indigenous breastfeeding mothers. As a result, education created from current evidence is inapplicable to Indigenous populations and can perpetuate harmful myths. Participants felt that current information can be inaccurate and fear-based especially in resources given to Indigenous youth. Additionally, participants explained that print materials can often be inaccessible to those with lower literacy, especially those whose first language isn't English.

Finally, participants stressed the problematic lack of people with lived experience working in public health to create resources on substance use which ultimately leads to resources that are irrelevant, invalid and may perpetuate myths and harm.

6. What is the best way to reach our target populations? (Indigenous women, girls, and gender diverse people) Who is our <u>priority</u> population?

Participants discussed the possibility of digital methods to reach Indigenous women, girls, and gender diverse people such as social media campaigns, smartphone applications, websites, and online learning courses. They also discussed how community-based events, storytelling, sharing circles, and medicine gatherings could be used to raise awareness about the health impacts of cannabis. Some cited First Nations Health Authority's (FNHA) very successful bus poster campaign and radio public service announcements as a successful model. Improved curriculum for students, parents, and teachers to be taught strengths-based information about substance use and Indigenous people was also suggested. Media such as infographics, posters, billboards, music, videos, and acting performances were also proposed as a way to communicate cannabis health education to Indigenous women, girls and gender diverse people. Finally, some participants suggested that these public service announcements should, amongst other places, be placed near liquor stores in the communities.

When asked to identify the target population, participants were divided. Most agreed that a target shouldn't be chosen at all and instead, all Indigenous people need to be considered for better accessibility to relevant health information on cannabis. Others felt that youth, Elders, parents, and health professionals should be prioritized.

Discussion Part Two: Considerations for Education

1. What does trauma informed care look like when looking at cannabis education?

Participants discussed tools for dealing with trauma in a culturally safe way such as, providing safe spaces, acknowledging colonial trauma, sharing circles, and empowerment through empathy and healing support. They also stressed the importance of focusing on the potential healing properties of cannabis including its role in treatment for posttraumatic stress disorder (PTSD), a significant issue in Indigenous populations. Erasure of stigma was an essential step outlined by the participants for achieving a more holistic approach to trauma informed education around substance use. Furthermore, respect for individual experiences, differences in culture, and providing truthful accurate information that is appropriate for someone's age and situation were highlighted as important elements to trauma informed care and resources to Indigenous people.

Participants discussed usage of traditional language regarding public health education. They stated that words like "plant" (vs. drug), "mother earth", "healing" and "spirit of the plant" can help in conferring information around health and cannabis. Participants discussed that language used for resources on cannabis should include perspectives from people with lived experience, have open dialogue, intergenerational knowledge sharing and story-telling.

Participants explained that trauma informed education should include information about the history of criminalization and its disproportionate effects on Indigenous people. Along with development of cannabis education, participants stated that being trauma informed also includes taking direct actions to address the consequences of Canada's previous prohibition and fighting for people who are still incarcerated for cannabis-related crimes.

Finally, participants discussed the importance of collaborating with health care service providers to discuss and enhance their role in providing trauma informed education relating to cannabis. Health care service providers are often a primary source of health education (including cannabis) to people and are typically trusted to provide accurate information. Participants want to see service providers take their time to care for each patient, implement active listening, and provide safe environments without barriers to access. Many participants recalled having very difficult experiences in institutionalized spaces, such as clinics, and stated that the care they received was not trauma informed or culturally safe. As explained by the participants, trauma informed education and care means that safe spaces are provided for everyone including Indigenous women and gender diverse people where healthy relationships can be built between service providers and those seeking help. Participants stated that cannabis' role in dealing with trauma as a medicine should be available as an option for those that want to use it and health care settings should be able to provide accurate information on this topic in a form that is understandable for the individual in need.

2. What does distinctions-based education look like when looking at cannabis education?

Participants discussed important focuses for distinctions-based education including an individualized approach for different people, differences between forms of cannabis,

cultivars/strains of the plant, differences in ways people consume cannabis, and differences in the reasons people chose to use cannabis. They also discussed community-based differences in cannabis perceptions and in what situations it might be appropriate to consume. They went on to explain that Elders are the best source of knowledge when it comes to Indigenous communities and their view of cannabis. Understanding these differences is key in taking a distinctions-based approach. They also highlighted specific considerations including timing, subject matter, access to healthcare, unique needs and perceptions of cannabis.

Participants also discussed the topic of inclusivity in culturally safe cannabis education. They felt that being inclusive means that everyone, including youth, 2SLGTBQ+, and Elders need specific resources and that education must be accessible for all to be considered culturally safe. Participants explained that these specific groups of people must be included throughout the entire development of resources to ensure that all voices are heard. Participants also discussed the issues around "Pan-Indigenous" education, where resources are created without proper input from the target audiences and the resources end up not being effective at addressing the unique needs of everyone. Participants explained that to avoid this issue and be more inclusive, there should be committees and open dialogue between different groups who are able to provide informed consent to use their cultural information.

Participants discussed that using adaptable resources for addressing the need for distinctions-based education where a "skeleton model" could be created then modified for the community that needs it. To adapt a resource to a specific community Elders are important to include because they will understand the needs of their community.

3. Do we need targeted education for Elders? Youth? Gender diverse people? Pregnant individuals? Health care providers? If so, what does that look like?

Participants agreed that targeted cannabis education for different audiences was vital. Overall, the discussion around targeted education was focused around education specific to Elders as they are prone to spreading misinformation based on outdated opinions or stigmas and can be the most resistant to learning more about cannabis. Additionally, Elders can potentially benefit greatly from medicinal application of cannabis while also be at high risk for side effects. Participants stressed the necessity of utilizing simple language, visual resources, in-person education, story-telling or peer-based forms of educational programming for Elders. They acknowledged that Elders can face communication barriers related to language and understanding of health information. Some participants suggested a "train the trainer" model where Elders in different communities are informed utilizing toolkits. They can then provide better quality education and support to others in the community around cannabis.

When discussing educational content, participants agreed that resources should contain accurate, evidence-based, consistent information regardless of how cannabis education is provided to different audiences. They stressed the importance of tailoring the education to meet the needs of Indigenous people of varying levels of literacy. Additionally, participants felt that education must include information about cannabidiol (CBD) because this will help lower misconceptions about cannabis. They also felt this will help provide balanced education that differentiates between medicinal and recreational use and help people understand responsible consumption while utilizing a harm reduction approach.

Participants felt that peer-based education would be very helpful in reaching everyone. For example, youth would have access to conversations with other youth regarding cannabis within a safe and inclusive environment. In fact, participants stressed that providing education in a safe and inclusive environment where conversations can occur without fear, stigma or judgement was important to all subgroups including gender diverse people, parents, and pregnant and breastfeeding individuals. Finally, participants explained that health care providers, Indigenous service providers and on reserve services need to be involved in order for targeted education to be effective for all groups.

4. What does culturally safe cannabis education look like?

When discussing what culturally safe cannabis education, participants' responses could be summarized in four main themes:

1. Transparency,
2. Traditional knowledge,
3. Inclusivity, and
4. The differentiation between medicinal and recreational usage.

Participants expressed the importance of honest, transparent, evidence-based education that is not fear-based, opinion-driven or patronizing. They explained that culturally safe education needed to include easy to understand information that outlines cannabis production and what chemicals and processing methods are used. Participants felt the inclusion of growing practices can help people realize that cannabis is only a plant that doesn't necessitate fear. Further, they stressed the importance of utilizing education to correct common misconceptions about the plant and its effects on the body.

Participants also expressed interest in including traditional methods for growing cannabis plants that were used historically in Indigenous communities. They recalled ancient trading systems that existed between numerous Indigenous groups across North America that included cannabis and other plant medicines. Participants felt the acknowledgement of the sacred and spiritual nature of plant medicines in education is important for cultural safety and awareness. They highlighted how Elders can be a valuable resource who can provide historical teachings, cultural nuances, Indigenous language, and words for the cannabis plant.

Participants highlighted the importance of including a distinction between medicinal and recreational use for culturally safe cannabis education. Participants acknowledged that often cannabis is included in conversations with alcohol and other substances. However, they felt that it should not be compared to them because it is also used medicinally. Participants explained that it is important to include what responsible cannabis consumption looks like in education and have conversations around this topic.

Participants noted that more collaboration between National Indigenous organizations like NWAC, British Colombia First Nations Health Authority (BC FNHA), Thunderbird Partnership Foundation (TPF), and Assembly of First Nations (AFN) was needed to promote more collaborative outreach events and campaigns that influence sensible drug policy. Participants went on to highlight the large gap in data collection on Indigenous cannabis use habits. For example, some organizations that work with Indigenous people who use drugs don't always ask about cannabis use. Important data that could help identify priorities in health care and cannabis policy is not captured in this methodology. Participants acknowledged that Indigenous people

have the right to self-governance as stated in United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and this includes the regulation around the use and sale of cannabis.

Discussion Part Three: How to Adapt Resources for Our Target Audience

1. **What are some of the contextual factors to consider when making targeted resources regarding cannabis, i.e. Racism, jurisdiction issues, corporatization?**

Participants acknowledged that there are many contextual factors that come into play when making resources specifically for Indigenous people and cannabis. The main themes that emerged from the responses were: stigmatization, discrimination, media representation, and the current cannabis regulations.

With regards to stigmatization, participants explained that there are issues with myths and stigmas about cannabis users parenting ability, women of colour, and the overrepresentation of Indigenous children in institutionalized care. Participants explained that they would like to see more strengths-based messaging while acknowledging intergenerational trauma, the missing and murdered Indigenous women and girls (MMIWG) and avoiding a "pan-Indigenous" approach. Participants acknowledged that there is a need to distinguish between medical and recreational cannabis use and that this is especially an issue in the workplace.

Regarding discrimination and current media representation of Indigenous people and cannabis, participants discussed the issues of high racial tensions, and the overrepresentation of white males dominating the cannabis industry. Participants explained that with the lack of Indigenous consultation from the Canadian government during the creation of cannabis legislation, it left Indigenous people without enough opportunities to participate in the new industry. Participants explained that the media often portrays Indigenous reserve dispensaries as villainous since they are unlicensed by the federal government. There are also First Nations communities that ban cannabis use but participate in production operations for cannabis agriculture. In doing so, participants explained that the media describes them as hypocritical. Participants felt that news media uses biased headlines and articles when referring to Indigenous communities and stories about cannabis. They also acknowledged the often strongly racist opinions that exist in news website comment sections.

Financial barriers also came up in discussion since this is a relevant contextual factor that many Indigenous people deal with. Since medical cannabis is not covered by NIHB, provincial insurance, or most private insurance plans it leaves people that use cannabis as a treatment for various medical conditions at a disadvantage compared to other therapies that are covered by insurance. Another financial barrier for medical cannabis patients is that it can be very costly to obtain a medical grower license. In order to keep the license the individual needs to pay every year to renew the license, however the growing process for cannabis can be that it takes up to 10 months before it's ready for consumption. Participants discussed that the financial barriers to access medical cannabis can be different whether someone lives on or off reserve land. Someone living on reserve or in remote communities may not have access to ordering medical cannabis online due to delivery restrictions or high shipping costs. Dispensaries are not available in all communities.

Finally, participants highlighted the issues around cannabis regulation including barriers for funding for Indigenous people in starting cannabis businesses and the taxation of cannabis

products on reserve. Participants explained that there are more financial barriers in place for Indigenous people in the cannabis industry than there are for non-Indigenous people.

2. What resources are you aware of regarding cannabis education for Indigenous people? Specifically, women and gender diverse people?

Many participants discussed Thunderbird Partnership Foundation's resources such as Train the Trainer programs, Let's Talk Cannabis, and Trauma-Informed Care. Some participants discussed their experiences with obtaining information from local cannabis growers and suppliers. Others were aware of Ekosi Health Centres and their resources and services. Some participants discussed various services available in Manitoba such as the Manitoba Harm Reduction Network, and clinics that integrate cannabis education and herbal medicine teachings that help patients on an individual basis. Some participants also mentioned Red Bear Healing Centre in Nova Scotia because they offer traditional medicines as a treatment option to patients. Participants also acknowledged the resources put out by the provincial and federal governments, however, they felt that they are not specific to Indigenous women, girls, and gender diverse people.

Many participants discussed First Nations Health Authority and the resources that this organization has available for cannabis health information. Participants mentioned the FNHA cannabis resources for breast-feeding individuals, pregnancy, and harm reduction. Some participants also mentioned that they have attended conferences on this topic before, such as the National Indigenous Cannabis and Hemp Conference where there was information regarding health and cannabis for Indigenous people available.

3. What are the gaps in resources/education missing with what's currently available?

Participants discussed a number of gaps in the currently available resources and overall, they felt that there is a lack of resources specifically for women, girls, and especially for gender diverse people with regards to cannabis and health. Participants acknowledged that there are many "calls to action" reports produced but the recommendations are never operationalized.

Participants expressed a desire to see harm reduction centers that are cannabis friendly and that can better serve off-reserve populations as well as remote and rural communities. Participants explained that they want these centers to provide health information to Indigenous people, offer a safe space for 2SLGTBQ+ people who use cannabis, assist in treatment of alcohol abuse and be collaborative with other organizations in sharing knowledge and educational tools. Participants acknowledged that there is a lack of individualized information on health and cannabis from knowledgeable health care providers. Individualized health counselling including cannabis should also include information about potential interactions between medications and cannabis.

When discussing content that is missing from current resources, participants expressed that they want more comprehensive information about the growing process of cannabis plants and using plant medicines. Participants want access to indigenized education on cannabis, including names for cannabis in Indigenous languages, historical information about the plant, knowledge of preparing extracts, information about strains and how they affect the body differently.

Participants explained that there is a lack of resources that are specific to different groups, such as youth, Elders, women, and gender diverse people. Participants discussed that they would like to see education that includes information about cannabis culture, myths, and addresses the stigma around people who use cannabis. They mentioned that the information should be understandable for everyone – from basic level to more complex topics about cannabis for specific health issues. Participants also discussed the lack of appropriate cannabis education specific for children. They expressed a desire to see more information and resources available in schools.

Indigenized cannabis education means that women, girls, and gender diverse people will have access to safe spaces to have open conversations with recognized and inclusive Elders who can provide the support in a traditional Indigenous way. Participants explained that the cannabis plant itself is already female and Indigenous, but we need to take it back. Participants want a multi-disciplinary approach with land-based teachings, knowledge keepers, Elders, harm reduction specialists and other advocates for holistic healing through plant medicines.

4. What mediums are best for delivering cannabis public health education to the target audience?

Regarding specific mediums or forms that cannabis public health education should take, participants discussed digital media such as webinars, cartoons, YouTube videos, infographics, PowerPoint presentations, and social media. Traditional mediums were also discussed such as, newspapers, radio, posters and bringing people together with food and music. Participants explained that in-person methods of reaching people to help spread cannabis health information, including making alliances between other organizations like NWAC, and creating workshops or community information sessions. Some form of incentives may also be important to include in dissemination of health information to be able to reach more people. Additionally, reaching out to schools to distribute the media can help with dissemination and reaching a larger audience. Participants agreed that knowing the audience and tailoring the delivery to suit their respective needs is best when deciding on forms of cannabis education.