

*The Next Stage:  
Delivering Tobacco Prevention  
and Cessation Knowledge  
through Public Health Networks  
Advisors and Partners Meeting*

*Canadian Public Health Association*

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## Opening

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### FACILITATOR

Lise Pigeon  
Lise Pigeon and Associates

### SPEAKER

Debra Lynkowski  
Chief Executive Officer  
Canadian Public Health Association

**Debra Lynkowski** thanked participants for attending and said she is excited about tackling the next stage of tobacco control with the support and advice of this group. She acknowledged Health Canada for its project support, and said while Canada is experiencing a decline in tobacco usage rates, challenges remain, especially with high-risk populations.

Everything about public health is collaborative and consultative, Lynkowski said. “That’s the way we work—we know CPHA can’t tackle this alone. We need to work with a broad collection of advisors.” The Canadian Public Health Association (CPHA) has a long history in tobacco control, with policies dating back to a 1959 resolution urging health agencies to support anti-tobacco education campaigns.

As part of its centenary 12 Great Achievements campaign, CPHA has dedicated the month of May to the recognition of tobacco use as a health hazard. “We want to eliminate this forever,” said Lynkowski. “It has not been without all of your continued perseverance, energy, and enthusiasm that we’ve made such an impact already.”

Facilitator **Lise Pigeon** asked participants to introduce themselves and discuss what they see as the biggest challenges for the public health community in the next phase of tobacco control. Participants identified a range of issues, with several participants emphasizing the importance of reaching youth:

- Balancing a population public health approach with a social determinants of health approach
- Enhancing knowledge transfer and communication
- Creating a portal repository of well-evaluated interventions
- Disseminating information on successful programs
- Using the public health forum to set a short-term agenda to address high smoking rates in Canadian Aboriginal communities
- Maintaining momentum

- Reaching mental health clientele
- Reaching youth
- Determining public health's role in overcoming current tobacco control challenges such as contraband
- Creating culturally appropriate messages for greater results
- Convincing all levels of decision makers and funders that the burden of tobacco has not lifted—five million people currently smoke
- Countering the popular myth that tobacco is “done” because so much progress has been made
- Overcoming “tobacco fatigue” and politicians' lack of interest
- Planning the eradication of tobacco from a public health frame of reference
- Denormalizing tobacco
- Securing funding for nicotine replacement therapy (NRT)
- Challenging the integration of tobacco control into a chronic disease prevention strategy
- Deciding between a greatest impact or disparity lens—two very different approaches
- Understanding CPHA's role as a national public health organization over the next few years
- Adapting different programs and policies to avoid averaging in favour of developing initiatives for a specific context
- Retaining expertise in the tobacco control field and ensuring renewal in the field

## The Context

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### Overview of “The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks”

#### SPEAKER

Greg Penney  
Director, National Programs  
Canadian Public Health Association

**Greg Penney** said CPHA is looking to define the particulars of their involvement in this area. “We’re not trying to be unique and say we’re going to do something different. Our role has been to bring people together and find out how we’re going to move forward. The general rates are going down, but it’s masking the problem and affecting the perception of it,” he said.

CPHA aims to understand public health colleagues' connectivity and its own role in re-engaging the public health community to identify pan-Canadian perspectives and practices. It also seeks to mobilize and facilitate the expansion of existing networks.

Given that this is a national project, CPHA aims to generate information from a broader perspective regarding which types of programs and approaches are working in Canadian communities, rather than focus on a particular area. Penney cited the example of examining a successful outdoor smoking ban. "Those are the nuggets that most of us don't get on a daily basis."

CPHA is also exploring the issues of determining public health priorities, identifying a coordinated and national public health approach, and the parameters of CPHA's responsibility to advocate for and foster change.

Penney said the development of an online knowledge centre to exchange basic information and feedback is part of the current project, but noted that CPHA does not want to reinvent the Canadian Council for Tobacco Control's (CCTC) work. CPHA is examining curricula as another component of the Next Stage project. "We're not looking to say the schools aren't doing anything, but how do we continue to make that a priority?" he asked.

CPHA is working to mobilize the public health workforce to engage frontline staff as well as decision makers, Penney said. "We're working with provincial public health associations so that we can make those connections. If it's not a priority for provincial public health associations, it will be hard to make it a priority elsewhere."

This meeting and the upcoming CPHA conference in June are part of a process to bring people together to explore future actions. Penney noted the importance of this dialogue, given the absence of a formulation of strategies. CPHA hopes to learn from existing practices and identify gaps and inconsistencies by asking and applying a social determinants of health lens to the following questions:

- What is working for you?
- Why is it successful?
- How can we make it work here?

## Update on Research Activities

### SPEAKER

Dr. Robert Schwartz  
Director of Evaluation and Monitoring  
Ontario Tobacco Research Unit

At the beginning of this next stage of tobacco control, **Dr. Robert Schwartz** said, he questioned the utility of yet another tobacco control project. “But I think there’s something tremendously important that can come out of this project. The idea here is to get the public health units across the country putting heads together to figure out how to work best at that level.” In Ontario, 10 out of 36 health units are at about 30% prevalence and this has not decreased over the past 10 years. Some public health units have done tremendously well, with local level initiatives making the difference.

Schwartz identified four main projects for this fiscal year. CPHA is conducting a literature review and synthesis from the local perspective to identify public health successes. The interest extends beyond identifying successful initiatives to explore what is working for whom, when, and why. While scientific literature readily offers black and white answers, more can be learned from this kind of review, he said.

A second project involves searching websites across Canada to study policy and prevention at national, regional, and local agencies. Another project involves collaboration with CCTC to review its database.

The fourth CPHA project is a survey of public health units. Schwartz noted that a web-based survey may not be the best source of information, but can supply the project with some broad information as a starting point. More work will be completed after the survey. CPHA plans to administer the survey through public health associations with the goal of one survey completed per health unit, using a survey response team representing a range of regional perspectives.

## Project Area 1: Mobilizing and Strengthening Public Health Networks

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### FACILITATOR

Lise Pigeon  
Lise Pigeon and Associates

### Introduction

#### SPEAKER

Randi Goddard  
Project Coordinator  
Canadian Public Health Association

**Randi Goddard** outlined the initiative's three project areas. Project area 1 aims to generate information on "what works" with respect to prevention and cessation among youth and adults, particularly in vulnerable populations. Project area 2 seeks to engage Canada's public health community in formulating future strategies and interventions for tobacco control. Project area 3 involves working with schools of public health to review curricula and tobacco control to put forth recommendations. CPHA plans to engage a consultant to examine those programs shortly. The entire project runs until March 2011. This meeting examines project areas 1 and 2.

Goddard identified the project's three key elements: to engage the public health community in knowledge exchange activities, to identify and disseminate information, and to inform the next generation of Canadian tobacco control policy. CPHA designed the three project areas to support these goals.

Goddard listed specific activities CPHA plans to carry out as part of project area 1, including:

- Conducting a literature review of programs and policies at the provincial and local level
- Collaborating with CCTC to examine their database information
- Collaborating with provincial and territorial public health associations to roll out the survey to gain insights on successes, challenges, gaps, and inconsistencies at the local level
- Developing an online public health knowledge centre as a virtual meeting place for practitioners and other public health professionals in the tobacco control community
- Disseminating case studies
- Providing public health information resources
- Providing access to continuing professional development to meet the needs of practitioners in tobacco control
- Undertaking approximately 20 key informant interviews over the next month, including

some participants at this meeting as well as Canadian medical officers of health

- Gathering CPHA members' perspectives and feedback regarding tobacco control and the future of tobacco control in Canada

CPHA will deliver and discuss the results of these activities at future meetings and at CPHA's centenary conference to be held in Toronto on June 13–17, 2010. This conference will include a pre-conference session dedicated to this topic. CPHA will also share the results of face-to-face discussions, such as the conference workshop.

The expected results from these activities include increased connectivity between researchers, practitioners, and other professionals; documented successes and identification of gaps, challenges, and inconsistencies; and a careful examination of vulnerable populations and strategies to address their needs.

CPHA will seek the advisory committee's input over the next few months and plans to reconvene this group to gain insights that will inform the next generation of tobacco control policy.

Lise Pigeon summarized the big project deliverable as the compilation of knowledge ready for exchange in an online knowledge centre.

### **Discussion**

A participant asked whether CPHA had considered looking at vulnerable populations' points of view, specifically special populations' self-definition and perception of a program's impact. He cited H1N1 focus groups' findings that vulnerable populations do not refer to themselves as such. He asked whether the CPHA project was open to this perspective. Goddard said the survey has some specific questions on vulnerable populations for frontline practitioners.

Another participant asked whether CPHA plans to consider the general population's point of view, including those with special needs, in addition to public health practitioners' perspective. Penney said improving CPHA access to that population is the issue. He cited the stigma that continues to attach to mental health such that people do not readily self-identify as members of this group.

A participant said he understood from the project overview that the project would result in public health recommendations regarding tobacco control. Goddard clarified that this deliverable was part of project area 2.

A participant noted the lack of information on Aboriginal smoking patterns and questioned the viability of a literature review within the timeframe. Dr. Robert Schwartz said looking for emerging practices in the field is the best CPHA can do. Ultimately, CPHA will identify gaps in the knowledge base for further study.

One participant said, “What I feel is that you’re trying to create communities of practice for health professionals.” Penney said CPHA has discussed that term extensively. He said some people feel communities of practice cannot be national in scope and must be local. “What we know is that within local settings, there are lots of organizations working together. Once you start moving across borders, you hear little snippets of projects, and that’s part of our goal—sharing that kind of information.”

A participant asked for more discussion of potential challenges for the literature review, which focuses on the public health unit level and local programs. She said health units’ success with pulling practitioners into their process is worth examining, noting the importance of clinician intervention.

Dr. Schwartz said that kind of learning will not come out of the literature review, but he agreed that CPHA could learn more about public health unit operation as these units continue to learn. The review may begin to foster an understanding of why certain public health units are functioning very well and others are struggling.

Another participant asked about the difference between this project and the CCTC’s work. Penney said the literature review’s purpose is to ensure CPHA understands the grey literature existing at the local level. The CPHA online knowledge centre is a gathering place rather than a repository. “Lots of times, what you do on the ground hasn’t been reviewed, but when people start sharing that information, you can begin to create a base. It’s not to compete with the CCTC, but to add another exchange piece.” Those with questions can post them and get feedback from a larger network.

“That’s what we’re trying to do at the local level with our community of practice. People want information and if you have a site I can direct them to, that’s useful,” said one participant.

Penney said, “We see the knowledge centre as an airport hub. We don’t want to be the pilots or the manufacturer,” noting that CPHA does not want to take away from CCTC or National Collaborating Centres (NCCs).

Noting that much public health work is done in partnership, a participant said it appears the survey’s purpose is firmly placed in the public health context. In Nova Scotia, and other provinces, public health has no responsibility for smoking cessation. She said Nova Scotia is “doing a lot of amazing work and public health is a piece of that work. If public health colleagues complete this survey as an organization, and not a partner, a lot of great work might be lost.”

Penney said CPHA has discussed this aspect, but is unclear as to what exists at the public health level. He said CPHA’s goal is not to gather everything anyone is doing with tobacco control in a community.

Another participant said CPHA will discover that different jurisdictions operate differently with community partners—it may not be that they are failing to do something well, but rather that it is simply not within their scope.

A participant asked about the projected launch date for the knowledge centre, whether the knowledge centre will link to other organizations, and whether an analysis of knowledge centre users will be conducted.

Penney said the launch date would coincide with the upcoming CPHA conference. CPHA is considering the long-term strategy for the knowledge centre and has discussed profiling and linking to organizations. “We don’t want to house everything and be the ‘Google’ of public health.” He said the analysis will include questions looking at the number of people using the knowledge centre, whether users are engaging in discussions, user characteristics, and topics of discussion.

Dr. Schwartz identified an underlying assumption that public health is what happens in the 117 public health units across Canada. However, public health is organized differently within jurisdictions and even within a single province. While the survey can “scratch the surface” and capture some of this information, it is not likely the best way to learn about it, he said. He asked participants for ideas for gathering information regarding local level initiatives and actors in tobacco control.

### **Small group report backs**

Pigeon asked participants to break into smaller discussion groups to identify their top two or three knowledge needs regarding tobacco control.

One group said they focused on the management of youth tobacco patterns. They chose the term “management” to demonstrate a concern with all phases of cessation in addition to the prevention of uptake. The group identified a need to understand youth in context as young people faced with peer pressure to smoke, groups of kids forming communities of smokers outside schools, and the concept of recreational smoking. They also noted the interconnectedness of mental health issues and poverty.

Another group discussed the challenge of translating local successes with participatory research to get decision makers’ attention. “We’re dealing with populations and unless you can track that success, it doesn’t count when the researchers or decision makers look at it. It doesn’t translate into evidence that’s going to impress decision makers,” said a participant. The group identified the population versus the individual approach as a key issue.

One participant said the challenge is to diffuse the huge database of knowledge into the community such that knowledge translates into practice. Another participant raised the issue of broader community engagement beyond the core public health people.

A participant said cessation should be seen as an output rather than an input. "If you ask three quarters of people how they quit, they'll say they quit on their own, cold turkey. How can we figure out our role in bumping that number up? How do we maximize that?"

A participant said public health's central role is to change public policy and practice. "When you consider tobacco cessation as an input, what are you going to do to help individuals? That's clinical practice. But this is public health and that means much more on policy change that will create a climate where people want to change their individual behaviour." Globally, smoke-free workplaces and public places have resulted in a 10% decrease in tobacco consumption on average, and an immediate improvement in sudden cardiac death rates for the whole population. The participant called this a public health success story.

Pigeon said if the premise becomes that public health is about policy, the project deliverable might need to change.

A participant said, "We would see working with a client on cessation as a primary care role. We see public health not only as public policy, but as a way to influence practice and service delivery. We see our role in public health as working with other sectors so the health system understands the process of behaviour change."

Another participant said public policy must change to obtain funding. The public and advocacy groups control the politicians, who control the funds. "I believe it won't work with tobacco very well because people are complacent about tobacco. A good plan requires evidence pulled together in a coherent package," she said. Referencing Dr. Nancy Edwards' work on achieving policy change, she said public policy change is unlikely to happen in the absence of evidence, but also in the absence of a crisis. "How do we do some out-of-the-box thinking to remind people that this still is a crisis?"

A participant identified the issue of strategically reaching different populations with social media such as Twitter, noting the issue is not simply understanding how to reach the target populations, but determining the appropriateness of using those outlets. She cautioned against assuming that everyone likes these social media sites and has access to them.

Penney asked participants whether certain settings or populations should be a priority for policy, rather than thinking about policy in general. He said the struggle "is that public health is everything, so in some ways we have to be a bit narrow to keep the parameters. We have to keep some scope and management level. We're not trying to get into the physicians' offices."

A participant asked how CPHA could incorporate a social determinants perspective in public health practice, saying that CPHA should determine which tools they need to influence policy and decision makers.

Dr. Schwartz discussed the need for a common understanding regarding the definition of public health policy. "Sometimes we think of public health policies as protection policies, but we need to understand whether public health has a comprehensive role that includes all of the elements in tobacco control. You may be promoting policies that have clinical applications."

A participant noted that while this group has been using the term "knowledge," project staff must be cognizant that both information and knowledge are being discussed.

A participant referred to a presentation on the accountability of public health given at a recent tobacco control meeting. "To what level do you take accountability for lack of services or programs provided? Over 65% of Inuit people smoke in my region. Politicians ignore this, but at some point, someone has to take accountability for that. What role does public health play in this area?"

## **Morning Plenary: Responses to Draft Survey Questionnaire**

### **SPEAKER**

Dr. Robert Schwartz  
Director of Evaluation and Monitoring  
Ontario Tobacco Research Unit

Dr. Schwartz introduced the context and intent of the survey. He said CPHA "is committed to learning what is happening at the level of public health units, so we need to have some further discussion about what we mean by that."

He said Ontario Tobacco Research Unit (OTRU) staff have already talked about whether a public health unit is defined by a geographic area, the people who work within its formal structure, or more broadly by its partners and collaborators. In its current form, the survey focuses on the health unit as a formal administrative authority. "Having said that, there's room for some discussion about how we're going to address that," he said. "The important thing is to find out what's happening locally and how well it's working."

Schwartz outlined the structure of the survey and the process for administering it through provincial public health associations. He said the section on how local tobacco control efforts are organized could be expanded to include questions on the role of the public health unit relative to other local and provincial government and non-government players. The survey will also look at changes in the level of tobacco control activity, and whether the issue is front and centre for different health units. Schwartz noted that the survey will "scratch the surface" of what is happening at the local/regional level and suggested that, following the survey, CPHA

consider what else is needed to be known and seek that information through face-to-face discussions such as the pre-conference session scheduled during CPHA's conference in June.

The sections on cessation, prevention, protection, and enforcement are the heart of the survey, Schwartz said. Through a mix of closed and open questions, the survey is structured to determine what is happening through local programs and interventions, what advocacy the health units are doing, where the successes have occurred, and how they can be explained.

"My approach to planning and evaluation is very much a realist approach, which means we need to understand what works in what context," he said. "It's looking at the relationship between context, mechanisms, and outcomes." A mechanism that succeeds in a rural community may not be effective in an urban centre, and an intervention that reaches young adults may not serve people suffering from mental illness. "That's what we're going to try to understand from asking these questions about what's working, when, and why."

The survey also deals with barriers—organizational, financial, capacity, or knowledge—that stand in the way of effective tobacco control programs.

One of CPHA's objectives through this project is to increase connectivity among public health units—to create a network where local practitioners can share ideas and success stories. He said it would be useful to add survey questions on the forms of connectivity that exist, including formal structures like Ontario's tobacco control area networks as well as less formal linkages.

Dr. Schwartz invited comments on "whether there are general things we're missing to support this process, and whether some of the things we're doing are off in the wrong direction." He added, "We know how to do this. There are ways of measuring. This survey may not be the ideal channel, but it will start us off in that direction."

## Discussion

A participant said the survey as structured would make it very difficult to describe the extensive tobacco control work her health unit has put in place across her district. She recommended reframing the preamble to refer to health units' roles as catalysts, facilitators, and supporters of tobacco control initiatives in their districts, regions, provinces, and beyond. As the text is currently written, "you're not allowing me to answer what public health is doing in a province, the way our province is structured. I think this is pivotal to moving forward."

Dr. Schwartz agreed, saying "We can't miss that. The trick is to frame it in such a way that a person like yourself answering the survey will understand that the intent is to capture what's going on, rather than what the public health unit is formally doing. It is a little bit fuzzy here, because what's going on may or may not have anything to do with the public health unit. Lots of things happen because the province has mandated them, and they fund non-government

organizations to make them happen at the local level. So it's a good question for CPHA—in that situation, what do you want? . . . It's a dilemma in this whole project, where public health has been defined as the local health unit."

The participant suggested phrasing that would draw out activities within a health unit over the last two or three years that had resulted in action on the ground. For example, "we do have a role in cessation. We often provide the evidence that drives the system to change. But we do it because we're public health practitioners, working within a comprehensive strategy. No one tells us it's our job."

A participant suggested adapting the questions to the structures in each province and territory and conducting the research via focus group.

Another participant echoed the need for more flexible questions, noting that even within a province like Ontario it would be difficult for the provincial public health association to get a sense of the variety of local strategies for operationalizing tobacco control. She cited the example of Toronto Public Health, which has not provided direct cessation services for many years, but does a lot of advocacy through community health centres, hospitals, and other organizations. Toronto "failed miserably on a lot of these questions," the participant said, but the same survey would generate a different response from other public health units in Ontario that involve themselves in direct service delivery.

Participants discussed the value and feasibility of a second survey of provincial associations to determine the structure of tobacco control programs across the country. Penney said one of the survey's goals is to help provincial associations inventory the activity in their own jurisdictions, including the roles played by community partners and the effectiveness of different strategies in specific contexts.

Dr. Schwartz asked participants whether they agreed that local public health units have a responsibility to ensure that comprehensive tobacco control is happening, whether or not they deliver it directly. "If we have that, then the ideal might be to get at the gaps in tobacco control from the local perspective," he said. "If the public health unit is not the doer, it should be the one that advocates for things to happen."

No one disagreed with Schwartz's statement; one participant commented that health units are mandated to provide services, either in silos or in community partnerships. The participant who raised the original question said the assumption that comprehensive tobacco control is the role of public health would be a great output for the project as a whole, and "a huge gift for the business I'm in."

A participant said the survey should include questions on health units' tobacco control mandates, and whether they originate with the province or have been articulated locally.

A participant thanked OTRU for addressing many of the issues she had raised after reviewing an earlier draft of the survey, but expressed concern that the current version still reinforced a bias in favour of segmenting tobacco control by target age group and population. “I know Health Canada loves this,” she said, but the resulting program criteria make it more difficult to measure the impact of population-based efforts like the Heather Crowe Campaign—which received a poor evaluation from a federal funder, despite a powerful impact on the ground.

“There’s a difference between measures aimed at youth and measures that are effective with youth, and sometimes the broader measures are much more effective,” said the participant. The jury is still out on whether school-based measures work, and even on whether they are counterproductive. By segmenting the audience, “you’re implicitly endorsing this choice, which is not necessarily the right way to go for a lot of people working in tobacco control,” she said. Dr. Schwartz agreed.

A participant said the survey should be completely redesigned to capture the real mission of public health. Questions on policy change should be sharpened and moved from the back of the survey to the front, and the entire questionnaire should be “built around the idea of leadership, rather than followership.”

“You have to ask questions about how public health units are driving change rather than bringing up the rear,” he said. “Programs are all well and good. We need programs. But the real responsibility is to make sure they happen, not to actually do them.” Health units in some jurisdictions might take on direct delivery, “but the real job of public health is to make sure clinical services get delivered, as well as many other aspects of public health change.”

The participant said the survey, in its current form, treats public health units “as the caboose of the train of public health policy, when it’s really the engine.” He said, “I’m looking for public health improvement through policy change and social change, and that’s the real nub of public health work. Whatever questionnaire you come up with has to tap into that dimension, because that’s the very important work of public health. There are many things about this CPHA project that trouble me greatly, but there are other things that excite me.” He noted the project’s great potential, particularly because of CPHA’s ability to mobilize through 117 public health units and every other element of the Canadian public health community.

Noting that another participant had mentioned tabling a tobacco control petition with 12,000 signatures in her provincial legislature, he said “Just imagine if she thought that part of her team was all the other 116 health units, and instead of 12,000 names, you had 120,000 names. How much faster would the legislature sit up and take notice? What if that were the same for every health unit? And what if every health unit in every province could contribute to public policy change in every province and at the national level, and even international change?”

A participant said the section on public health policy referred to delivery, but not to advocacy or policy change. “Yes, some of us are very delivery-based, but I look at other organizations and they’re more about the broader picture,” he said. “I didn’t see anything about really influencing what we’re doing around contraband, which is really around policy change” and is a current focus for many health units.

A participant suggested focusing on the role of public health in policy and advocacy, influence, community development, and capacity-building first, then moving down from there to the more tactical roles the health units sometimes take on. That kind of question would make sense at the team level, and CPHA could keep the survey within limited bounds by asking respondents to identify a couple of key partners, rather than providing a complete inventory.

### Table Reports

Following a round of table discussions, participants recommended specific revisions to the questionnaire:

- The section on cessation should be rephrased to emphasize interventions, rather than programs.
- The reference to age groups in the cessation section should separate youth under 18 from young adults aged 18–24.
- In the opening section of the questionnaire, the question on number of dedicated staff should distinguish people with a lead role in tobacco control from the 60 nurses who might be dealing with the dossier on a daily basis.
- Question #3 should include a reference to denormalization as a pillar of tobacco control.
- On prevention, the age breakdowns in question #38 will vary by geographic region. The focus should be when a student begins high school, not a specific age. Penney explained that CPHA had been mandated to focus on the 18 - 24 population, but a participant said the prevention literature emphasizes developmental stage, specifically the year when a student goes from being in the oldest age group at one school to the youngest age group at another school.
- In questions #44-47, vulnerable groups should be defined earlier, and specific populations should be identified.
- The survey should address provincial efforts to address ceremonial use of tobacco in Aboriginal communities, as well as jurisdictional responsibilities for on- and off-reserve populations.
- Question #50 should be reframed. No one will respond that scientific evidence is unimportant, but it would be more useful to ask how readily respondents can find the evidence and research they need: easily, sometimes, or rarely.

- Question #56 should:
  - Provide separate boxes to distinguish smoke-free outdoor spaces from municipal facilities (for example, arenas)
  - Distinguish smoke-free vehicles by whether children are in the vehicle
  - Address two different issues for multi-unit dwellings: smoking/non-smoking apartment lobbies and a total ban on smoking
  - Flag policies to protect against all kinds of second-hand smoke, including hookahs and herbal cigarettes
- Participants discussed whether Question #56 should refer to “tobacco-free,” rather than “smoke-free,” since youth have picked up that smoke-free products include chewing tobacco. A participant said “smoke-free” is the right reference for protection initiatives focused on second-hand smoke, but “tobacco-free” is appropriate for prevention.
- Rather than asking what successes a health unit has achieved, question #57 should ask what activities they have carried out to promote and implement healthy laws (give examples). The time frame should be five years, since that is when most relevant activity has occurred.
- Question #58 should be followed by a question on how respondents identify champions within health units to move policy forward.
- Question #59 should ask for examples of barriers, obstacles, and challenges that health units have encountered, particularly institutionalized limits on public health engagement in the political process.
- Question #61 is unclear and might benefit from examples.
- The section on enforcement should ask what respondents are doing about contraband, what works, and whether the issue is important in their jurisdictions. An important question is whether enforcement is carried out by a public health officer (generalist) or a tobacco specialist.
- Question #72 should segment partnerships by purpose (cessation, prevention, protection, etc.), and should include advocacy and evaluation.
- Questions #71-73 should include references to active local coalitions and councils.
- Questions #75 and #76 should be asked separately for federal and provincial programs.
- Question #79 should ask about respondents’ business requirements, but should not list specific options.
- To address the problem with segmentation, the survey should begin with a question about whether the health unit orients its services to the general public or specific populations.
- To support ongoing development of the CPHA knowledge centre, the survey should include a question about respondents’ knowledge needs and the information tools they

would use.

The group considered whether a survey with 100 or more questions would make health units less likely to respond. A participant said public health practitioners are deluged with research requests, and recommended a directive from medical officers of health to emphasize the importance of completing this survey.

One of the tables proposed a new preamble for the questionnaire: “The role of public health is to ensure there are policies and programs at local, provincial, and federal levels to reduce the use of tobacco products and their impacts. In light of the work your public health unit or region is engaged with as a catalyst, facilitator, partner, supporter, or direct service delivery provider, what is working well, what is not working well, and why, to reduce the use of tobacco products within your district, region, province, and beyond?”

To complete the reframe, the table recommended opening each section of the questionnaire by asking respondents to describe their organizations’ specific contributions, rather than assuming the public health units’ role is direct delivery. The section on protection should refer to tobacco control policies and legislation, rather than smoke-free policies, and the grids in the survey should include a column for services “provided by others.”

Dr. Schwartz echoed concerns about the length of the survey, but agreed that the revisions were doable. A participant said some of the group’s suggestions should make it possible to shave about 20 questions from the questionnaire.

## **Project Area 2: Priorities for Public Health and its Approach to Tobacco Control**

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### **FACILITATOR**

Lise Pigeon  
Lise Pigeon and Associates

### **SPEAKER**

Greg Penney  
Director, National Programs  
Canadian Public Health Association

Greg Penney began the conversation around project area 2 deliverables by asking participants to specify the policy areas that CPHA should focus on, and discuss approaches for engaging certain populations. CPHA has traditionally used the language of a public health approach and Penney asked whether this approach is unique. Although CPHA’s goal is a national coordinated approach, he noted that “we can only link everybody to an extent . . . we want a direction we can focus on.”

### Facilitated brainstorm session

Lise Pigeon asked participants to identify agenda priorities, or “big ticket items,” that should drive public health practitioners and decision makers in the future. During a brainstorming session, participants recommended a wide range of priorities that were loosely categorized into six groups:

#### *Flipchart 1*

- Find effective ways to reach hard-core or hard-to-reach smokers—group interventions have not been reaching their targets
- Develop culturally appropriate and relevant public health interventions
- Coordinate programs to address multiple addictions (tobacco, substance abuse, gambling)
- Target prevention and cessation for young adults
- Advocacy in smoke-free movies targeting youth
- Decrease social exposure, including exposure in movies and outdoor bans, so people are less exposed and see fewer tobacco products
- Provide accessible smoking cessation services for hard-to-reach populations
- Target vulnerable populations with unique interventions
- Decrease availability of tobacco products
- Ban all new tobacco products
- Minimize diversity of tobacco products

#### *Flipchart 2*

- Subsidize NRT
- Drive cessation
- More research in youth cessation issues
- Change the profit motive of the tobacco business (for example, performance regulations, government interface)
- Phase out tobacco—make tobacco industry responsible for tobacco supply and demand reduction by reversing incentives for profit-making, obliging tobacco industry to meet annual targets for supply and demand reduction leading to a virtual phase-out of tobacco in 25 years
- Advocate for the discussion of the end of tobacco use in Canada, similar to New Zealand and Finland

***Flipchart 3***

- Maintain the “science” of tobacco control—for example, in Nova Scotia, therapeutic dose needed in climate of integration
- Prevent the removal of a dedicated budget for tobacco control in favour of an overall budget for general public health
- Ensure tobacco control initiatives are not lost within chronic disease prevention integration
- Find effective ways to denormalize tobacco products among youth
- Canadian sport and recreation organizations support tobacco-free policy
- Support other primary health care providers in integrating smoking cessation into their practice (for example, dentists, pharmacists, asthma, diabetes)
- Continue to raise the issue that tobacco is not “done”
- Ensure tobacco control is kept on decision makers’ radar screen
- Identify medical officers of health and public health units that are innovators and early adopters in tobacco control in Canada

***Flipchart 4***

- Advocate for next steps in policy and legislation for each jurisdiction, such as tobacco-free patios and entrances to public buildings, that would have the most evidence of effectiveness
- Establish tobacco-free outdoor spaces (parks, beaches, playgrounds, recreation)
- Establish tobacco-free school legislation
- Tackle contraband
- Plain and standardized packaging
- Product control, including physical appearance and additives (for example, flavours)
- Price controls: maximum price for industry, high prices for retail (using taxes)
- Total ban on advertising (for example, no money to retailers, imported magazines, industry public relations, messages on packaging)
- Harmonize anti-tobacco legislation at the highest political level, based on established legislation

***Flipchart 5***

- Implement a coordinated approach that tobacco cessation intervention becomes “standard of care” by all health professionals
- Funding to support training in 5A’s brief intervention
- Incorporate tobacco education in all levels of coaching certification

- Incorporate tobacco control and cessation intervention in curricula of colleges of medicine, dental, nursing, pharmacy, and others
- Tobacco industry products are designed to addict and kill long-term users: convince public health practitioners and decision makers to commit to tobacco control as an effective way to decrease disability and death across population
- Facilitate capacity building for health professionals and systems to ensure clients are routinely assessed regarding smoking and follow-up
- Maintain funding

### *Flipchart 6*

The last flipchart contained priority issues that lie outside the scope of CPHA's role, including:

- Licence all tobacco retailers and work to decrease number of licences issued
- Put provincial 1-800 lines prominently on all cigarette packs
- Reinstate Aboriginal tobacco funding
- Increase taxation on reserve tobacco

### **Discussion: A national coordinated approach?**

Pigeon asked participants to identify those priorities that would benefit from a national coordinated approach.

A participant asked for clarification of the term "national coordinated approach." Noting the approach is within a CPHA context, Penney said the question is: "If we had to look at all of these priorities, are there some things that we could take and really focus on nationally from a public health unit level to say these are public health priorities and advocate on those?" He said CPHA is not trying to move all public health units to the same level, but to target those areas in which people are most interested.

Penney noted that CPHA cannot be everywhere on the ground, and must first ascertain a starting point. CPHA has areas to work on as an organization going forward, even without project funding, and certain topics may recur year after year. "Hopefully the survey will give us some of that other connection too. We might see a lot of consistency across jurisdictions nationally," he said.

One participant said England's National Health Service (NHS) offers NRT to every citizen. In her rural community, people are looking for a NRT subsidy, not programming. Penney said practitioners on the ground are "evaluating, but mostly they're doing. If NRT is supported by evidence and people across Canada, then we could look at that."

Another participant said CPHA must define some of these issues itself, such as determining whether its goal is to be a coordinating place for national policies. Penney said CPHA serves its members and this process should help inform them. “We had a consultation, we had a process, and this is what they’re saying. Our goal is to figure out where we should be in tobacco and what our role is for the future,” he said. “There are lots of people doing work in it. We’ve been around for 100 years and we’re still trying to find our way into certain topics. We’re trying to find that bigger picture and work through it.”

A CPHA staff member said, “I don’t think we see ourselves as coordinating national policy. We want to be instructed by the public health community on what we can do in tobacco control. It’s coming up from the bottom; it can’t come from the top of CPHA.”

Regarding the issue of determining the most appropriate role for CPHA, Dr. Robert Schwartz said, “The area is pretty crowded with actors at the national and provincial levels. I’m wondering if the niche for being the national coordinating body for local public health could see CPHA involvement.” He said an annual or biannual theme could assist public health units across the country to engage at the provincial level. “There should be a niche and I think CPHA should tread carefully. You don’t want to do things that others are doing,” Schwartz said.

Commending the group for its excellent ideas, Penney noted that part of this process is to revisit the Federal Tobacco Control Strategy (FTCS) concepts, on which CPHA would like to have some impact. A participant suggested using the four pillars of tobacco control as a guide and choosing priorities for each.

Another participant called for a more “tempered understanding of targeted programming. The youth, the poor, First Nations—for whatever group has been identified for targeting, there’s a fundamental misunderstanding about what the data tells us about who is smoking. We should worry about high rates of smoking amongst populations, but in terms of absolute numbers, you don’t conclude that smokers are different, but that they’re the same.” He said the difference between absolute numbers and percentages is key. “If it’s a smallish group with a higher percentage, your impact is not going to be as large if you consider only the smaller group. The impact may be far less than you think it’s going to be.”

A participant said the hard-core or hard-to-reach smokers identified as a priority could encompass any group who smokes, whether it is youth, Aboriginal Canadians, someone with mental health issues, or middle-class smokers. Another participant said vulnerability in tobacco control should be understood differently than vulnerability in a social justice context.

Given the lack of federal surveillance tools, Schwartz said, these connections present an opportunity for additional information sources. He noted that the federal government is no longer conducting much research.

A participant said CPHA should be careful about significant investment in the small portion of people in vulnerable populations because the social determinants of health have a greater impact in these situations. “It may have more to do with improving their standard of life. I wouldn’t suggest abandoning people, but as you drive the middle majority further away from an unwanted cultural adaptation, you drag everyone else along with you. The fewer smokers there are, the easier it is to enact legislation, for example.”

A participant said while certain areas fall naturally under CPHA’s scope, other national level areas are less relevant, and asked CPHA whether it distinguishes between support and engagement. Penny answered in the negative saying “Either way is fine. It would be interesting to see where you see CPHA—in a support role or taking the lead? And inside CPHA, do we have the resources and capacity to do that? Lead, follow, or get out of the way?”

### Clarifying and further refining the priorities

Pigeon asked the group to identify their most important priorities. Following this priority setting exercise, the priorities were rearranged into five areas. For each area, she asked participants to work in small groups to answer three questions:

- What focus should CPHA take on this issue?
- What is the role for CPHA?
- What first steps should CPHA take?

***Priority: Implement a coordinated approach that tobacco cessation intervention becomes “standard of care” by all health professionals***

**Focus:** CPHA could develop a position statement on tobacco cessation related to core competencies directed at professional health organizations. People would need tobacco cessation as a core competency to achieve their certification. A position statement would bring health professionals to the table.

**Role:** CPHA could recommend that the orientation package for new hires such as pharmacists, nurses, and physicians, include a standard of care regarding tobacco cessation.

**First steps:** The group noted the importance of conducting the survey and sharing resources. They noted that Saskatoon requires nurses to complete a tobacco cessation worksheet with every admission order for patients in long-term and acute care. CPHA could share the Saskatoon model and more of these kinds of activities should arise from the survey. The group said much work is already being done in this area, such that CPHA could draw on this work instead of having to take the lead.

***Priority: Decrease availability of tobacco products, ban new tobacco products, and minimize diversity of tobacco products***

**Focus:** In the short term, CPHA could work to reduce the number of tobacco outlets, ban new products, and reduce the number of brand options available. “Instead of brand families, we’ll have brand orphans,” said one participant.

**Role:** Within the current project’s scope, CPHA could produce policy research with options, recommendations, and positions. CPHA could follow up beyond the life of this project and use their networks, including the 117 public health units, teachers, and other professionals, to advocate for the project’s policy positions and recommendations.

**First steps:** Reduce the number of outlets at the municipal level, starting with a demonstration project that involves several municipalities. Outlets could be reduced by category or number using licence fees, conditions of licence to achieve public health objectives through vendor training, and other strategies. The demonstration project could be carried out simultaneously with other work and begin with project design and the identification of interested municipalities. The group noted that evaluating the results might take longer than the initial project’s timeframe.

***Priority: Phase out tobacco; more specifically, make the tobacco industry responsible for supply and demand reduction by reversing incentives for profit making, obliging the industry to meet annual targets for supply and demand reduction leading to a virtual phase-out of tobacco in 25 years.***

**Focus:** Make phase-out of the tobacco industry a mainstream idea.

**Role:** CPHA could officially support this focus and champion this initiative.

**First steps:** CPHA could introduce this priority at its upcoming conference with documented target options. CPHA could help identify and recruit champions through medical officers of health and public health units. These champions would be armed with CPHA credibility and support.

A CPHA staff member asked for clarification of the term industry, citing the example of the informal industry that exists on reserves. A participant said Canada must simultaneously address the issue of contraband, noting the goal is to reduce demand, not ban tobacco. “You put the responsibility on the tobacco industry to do the opposite of what they do. We need to take away the ability of the industry to externalize their costs.”

Another participant noted the “remarkable convergence” between the second and third priorities. “It’s not a brand new wheel that needs to be invented. There is some information that has been written and we’d be delighted to assist in helping get these position papers together.”

**Priority:** *Continue to raise the issue that tobacco is not “done.” Given that tobacco industry products are designed to addict and kill long-term users, convince public health practitioners and decision makers to commit to tobacco control as an effective way to decrease disability and death across the population. Identify medical officers of health and public health units that are innovators and early adopters in tobacco control in Canada.*

**Focus:** The group said tobacco is seen as a moral issue rather than a public health issue. Everyone must understand that tobacco industry products are a public health issue to be eliminated over time to eliminate harm to public health.

**Role:** CPHA could proclaim the message that tobacco control is the top priority to improve population health. CPHA could disseminate this message to those working in the field, politicians, and the public.

**First steps:** The group said the survey is a good starting point. One participant recommended a top-down vision using the survey, promoting synthesis, and engaging the public health community online. CPHA could make a united call to action. “When the tobacco control lobby advocates, they are seen as being interested parties. The CPHA is perfectly positioned to argue the case to all levels of government. Proclamations and advocacy by CPHA would go a lot further than tobacco control groups,” said Dr. Schwartz.

**Priority:** *Harmonize anti-tobacco legislation at the highest political level to the highest standard—not to the lowest common denominator—and advocate for next steps in policy and legislation for each jurisdiction*

**Focus:** The group identified advocacy as the paramount focus, noting that knowledge transfer is important as well. They said the knowledge centre should not try to be everything, likening it to an airport hub. The group also noted the need for CPHA to “keep the momentum going.”

**Role:** CPHA could map current policy and legislation opportunities and connect people who have had success with those who want success. Through resolutions and profiles, CPHA could be the voice advocating for more tobacco legislation. The group noted that advocacy has slowed down, and said now is the time to bring it back.

**First steps:** While harmonizing legislation is a long-term outcome rather than an action, understanding specific policies, such as smoke-free policies, could be a first step. Developing a structure for this exercise would assist CPHA. Sharing survey information with jurisdictions will allow CPHA to connect people with promising practices, and make quicker connections to determine what is happening at the local level that may not be published. If work is not published, “you can’t find it and I can’t prove it,” said a participant.

### *General Discussion*

A participant asked about a media avenue that CPHA could use. "We know the agencies that we can go to, but is there some way to keep up-to-date on a national level on smoke-free policies, for example, to keep the momentum going? If we all can have our finger on the pulse of policies, that would be helpful."

Participants expressed their support for the discussion's focus on public health policy as social change. A participant said the last two priorities are "in the class of 'Let's marshal the troops and strike up the band'" while the first three are "the bandwagons we're going to get on."

Penney asked participants to identify any significant omissions from the priority list. A participant said, "I think we may be doing a disservice to Aboriginal communities. The funding has been cut off, the federal government has not been doing a good job, and neither has Ontario. There may be an opportunity for CPHA to get something going. There may be a connection to contraband." A participant said, "As an Aboriginal person, I would not want to see CPHA leading that. The National Aboriginal Health Organization should be leading that."

Another participant noted that although the government cut the Aboriginal tobacco control program 11 years ago, there is reason for optimism as the current round of funding has awarded \$4 million in grants and contributions for tobacco control in Aboriginal communities, including an Assembly of First Nations project. The federal government awarded a substantial amount of money to territorial governments as well.

A CPHA staff member said CPHA and NAHO have a Memorandum of Understanding. "This could be a topic where we would certainly be willing to work with them to make this a mainstream issue." While territorial public health associations have been very active, NAHO must take the lead.

A participant asked whether the curriculum piece for medical teaching establishments speaks only to cessation. "We talked at one time about having tobacco as a fundamental subject." The group responsible for the first priority clarified that their table had only discussed cessation.

Penney said the education component was a missing piece for him. While the group touched on the subject, part of the CPHA project's mandate is to engage schools of public health. "One of the fundamental things I hear in every meeting is 'What do they learn in tobacco?' The med school curriculum is almost impossible to change. The bigger impact would be in the Masters and undergraduate programs. How do we do that? It's got to be in all the schools. We have to engage the teachers."

A participant said the University of Waterloo integrates the topic in some of its courses, but it is not mandatory and the university could integrate it to a greater extent.

## Summing Up and Next Steps

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### FACILITATOR

Lise Pigeon

Lise Pigeon and Associates

Pigeon asked participants, “What is your sense of the progress made here today and the journey?” A participant said, “It seems like we’ve won the battle with a smoke-free Ontario strategy, so it’s good to have this to re-energize. There are so many new projects in Ontario, but there’s still a lot of work that needs to be done.”

Another participant said she appreciated the opportunity to come and hear about other jurisdictions’ initiatives. She said the size of the group was large enough to be representative, but small enough to hear from everyone.

One participant expressed concern about the timeline for phase 1, noting that March Break accounts for 10 days of a three-week timeline. “Where we’ve landed is much stronger than what I was looking at in my office. I would hate to see the quality of work lost because we are trying to roll it out in a certain timeframe. How we engage public health practitioners is critical and we need traction on that piece.”

Penney thanked the participants for beginning the process. Assuring them the final priority list is not all that CPHA would take away from the discussion, he said CPHA will use all of the original priorities listed by the participants to explore how to stimulate and foster connections.

Penney said a report will follow that captures the discussions from this meeting. As part of its centenary activities, CPHA plans to focus on the health hazards of tobacco in May. After discussions at the CPHA conference in June, CPHA would like to bring people together again in a similar meeting. At the close of the project, CPHA will put forth recommendations to Health Canada.