

THE NEXT STAGE: DELIVERING TOBACCO PREVENTION AND CESSATION KNOWLEDGE THROUGH PUBLIC HEALTH NETWORKS

FINDINGS FROM KEY INFORMANT INTERVIEWS

Prepared for the

Canadian Public Health Association

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Background

In December 2009, Health Canada funded the Canadian Public Health Association (CPHA) to undertake a project to engage Canada's public health community in knowledge exchange activities, identify evidence-informed, practice-based strategies and inform the "next generation" of tobacco control policy in Canada. The project is titled *The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks*.

Aligned to the objectives and strategic priorities of the Federal Tobacco Control Strategy (FTCS), CPHA's *The Next Stage* project is national in scope. The project places an emphasis on best practices and emerging effective approaches, builds on the extensive public health knowledge base accumulated over many years with respect to tobacco control, and leverages the reach and experience of the multidisciplinary public health community.

Acknowledgements

CPHA would like to thank all those who participated in the key informant interviews. Their valuable input on tobacco control policy and programming will be key to informing *The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks*.

Key informants and their affiliations appear in Appendix A – Key Informants.

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Introduction

The goal of *The Next Stage* project is to engage Canada's public health community, including public health teaching institutions and students, in documenting and sharing evidence-informed and practice-based strategies and interventions in tobacco control through a systematic process and by developing recommendations, case samples and intervention strategies for public health and its approach to tobacco control.

The objectives of the key informant interviews were to gain insight and perspectives on:

- successes in tobacco control
- challenges and priorities for the next phase of tobacco control
- mobilizing and strengthening public health networks for knowledge exchange on tobacco control

Approach and Scope of the Report

This report represents a summary of the findings from 28 key informant interviews of 45-60 minutes each, held between April and June 2010. The participants were

representatives from non-governmental organizations, public health and all provincial/territorial governments except Quebec. Quebec's interviews will be undertaken by a French speaking consultant and the results will be included in a separate report.

As part of the process, a list of key informants was generated by CPHA with assistance from *The Next Stage* project Advisory Committee. A snowball technique was also used, in which key informants were asked to recommend others to be interviewed.

An interview guide was used to focus participants on their perceptions about the key themes listed below. Emails and phone calls were then made to obtain consent for interviews and establish a date and time for each interview. A confidential summary chart detailing the individual responses was developed, on which this report is based.

Key Themes

A number of key themes were addressed through the interviews with key informants:

- Successes in Tobacco Control
- Challenges in Tobacco Control
- Vulnerable Populations
- Key Priorities
- Knowledge Development and Exchange/Best Practices
- Potential Role for CPHA

Successes in Tobacco Control

Most respondents agreed that the successes of the national and provincial/territorial tobacco strategies are based on government investment in tobacco reduction strategies and on legislative initiatives. Many participants mentioned the significant drop in prevalence rates that has resulted from these strategies. CTUMS statistics from 2008 show that:¹

- In the last 10 years there has been a decline in the overall smoking rate among Canadians aged 15 and over from 25% in 1999 to 18% in 2008.
- In the same period of time, Canada's population increased by about 12%, while ever smokers (current smokers and former smokers combined) increased by only 4%.

According to key informants from two provinces, publicly funded health promotion resource centres were vital in moving their tobacco control strategies forward. Other provinces benefited from the leadership of and resulting strides made by the non-governmental organizations and coalitions involved. The government worked with these partners and public health authorities to build a movement in tobacco control.

¹ Health Canada (2010). Canadian Tobacco Use Monitoring Survey (CTUMS) 2008. CTUMS – 10 Years of Data, 10 Years of Progress. URL: http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/ctums-esutc_2008-eng.php. Accessed June 12, 2010.

Another benefit to the tobacco strategies has been the partnership forged between the research and practice communities across Canada. For example, partnerships among academics and advocates have resulted in targeted research evidence being used to support public policy. In fact, public policies such as those dealing with taxation and pricing, restrictions on public and workplace smoking, sales to minors, advertising and promotion, and enforcement of these policies, as well as public health programming, have together had a significant impact on smoking rates across Canada.

Additional successes mentioned by key informants include the following:

- The continuity of a core long-term strategy in each province or territory, with periodic renewals of these strategies that provided additional resources
- The Health Canada Grants and Contributions program, especially for smaller provinces and the territories
- The shift in cultural norms from traditional public education to social change approaches to tobacco control
- The national mass media campaign (especially the powerful “Heather Crowe” ads) and local/provincial/territorial smoke-free public places and workplace campaigns that resulted in a shift in public attitudes about protecting non-smokers from secondhand smoke
- Federal and provincial support for the Smokers’ Helpline as an effective cessation resource for smokers across Canada

Challenges in Tobacco Control

A number of significant challenges were identified by key informants. First and foremost, tobacco use remains the most preventable cause of disease, disability and death, and imposes a heavy burden on our health care system. Tobacco is an epidemic, which begs the question how it can not be a top government priority.

It was noted that tobacco control has the biggest return on investment and can be self-funding if taxes raised are targeted to tobacco strategies, as is the case with some provincial gambling strategies.

Although all provinces and territories have tobacco strategies in place, significant political commitment and funding are still required to carry out new and more effective tobacco control initiatives. Several respondents felt that governments at all levels need to treat tobacco control as an imperative public health measure. Enhanced provincial, territorial and Federal collaboration is also of the utmost importance, given the enormous cost of tobacco to society.

The provinces and territories look to the federal government for a national strategy in which all jurisdictions can participate. However, some respondents commented that there is no national focus or clear direction in tobacco control.

It was acknowledged that tobacco control public policy has been very effective in reducing tobacco use in the general population. What is not working well, according to some key informants, is the advancement of social policy vis-à-vis the tobacco control

agenda. We need to examine the unintended consequences of tobacco policies and how they may affect vulnerable populations by considering social justice and equity issues when formulating such policies. For example, some key informants noted that increased tobacco taxes have created unintended hardships among smokers in low SES groups and have led to food insecurity. Smokers living on low incomes often continue to purchase cigarettes in the same quantity despite higher taxes, as they are addicted and usually have no access to free smoking cessation aids. We therefore need to look at issues with a social equity lens (e.g., using a gender based analysis) and examine the differential effects from interventions on vulnerable populations.

It was also suggested that we need to consider a model whereby government oversees both the tobacco industry and the production, advertising and sale of tobacco products. Respondents also felt that Health Canada needs to make a commitment to and take action on policies that were to be considered last year, e.g., plain packaging, 1-800 number on tobacco packages, etc.

Vulnerable Populations

The following vulnerable populations were identified the most often:

- Aboriginal people including First Nations, Inuit and Métis
- Women and their families
- People with mental health issues and co-morbidities
- Youth

Other vulnerable populations mentioned were:

- Young adults
- People of Low Socioeconomic Status (SES)
- Blue collar workers (both males and females)
- Language and cultural groups (e.g., Francophones across Canada)
- Lesbian, Gay, Bisexual and Transgender (LGBT) people (and other sexual minorities)
- Immigrants and refugees
- Hospitalized patients with chronic diseases

Specific issues with these groups are discussed below.

Aboriginal – First Nations

All of the key informants identified Aboriginal people as a vulnerable population needing attention. Tobacco use is a complex issue among Aboriginal people. Some provinces, such as Ontario and British Columbia, have therefore developed a separate Aboriginal tobacco strategy in addition to their provincial tobacco strategy.

There is political will to work with First Nations on tobacco issues, but there are jurisdictional and policy issues related to self-determination. First Nations have the right to freely determine and pursue their economic, social and cultural development under the International Treaty Law. A few bands in Ontario and Quebec have chosen to produce and sell tobacco, which has negatively impacted the public health goal of

reducing tobacco use among Aboriginal people and the general population, especially in those two provinces, because of easily accessible cheap cigarettes on which no tax is paid. One suggestion to reduce this problem was to raise the price of cigarettes on reserve, but give any provincial or federal taxes collected back to the bands for their use.

Public health needs to find champions among First Nations leaders who care about reducing access to cheap cigarettes by minors. Otherwise, the cycle of minors accessing tobacco will continue to increase rates of smoking over the longer term as youth become addicted.

In order to work effectively with Aboriginal people there are longstanding inequities that must first be understood. Public health therefore needs to build understanding and trust by using a model of cooperation.

Champions such as Dr. Kim Barker, the Assembly of First Nations Public Health Advisor, who is also an advocate and working on the Lung Health Framework, can be helpful to public health in addressing tobacco use in this population.

Additional challenges in addressing this vulnerable population's needs include the following:

- There is a need for increased recognition of cultural connections to the traditional use of tobacco and what that means for cessation
- A community development approach is needed with respect to reducing tobacco use, as well as ongoing support at the community level
- Public health does not provide any tobacco related programs on reserve in some jurisdictions
- Tailored interventions for pregnant smokers are needed that have been adapted to meet the requirements of various Aboriginal communities
- Exploration of the appropriateness of social networking tools for smoking cessation (Facebook, Twitter, etc.) and engagement interventions (e.g., videos on YouTube)
- First Nations have limited cultural acceptance of demanding their home be smoke-free, as homes are respectfully open to everyone, including smokers

Overall, it was felt that we have to work in collaboration with this community and find leaders, identify success stories, take small steps, and work on new communications and new ways to reach First Nations. This might be accomplished in part with messages about asthma, smoke-free homes and children, or through the integration of tobacco with chronic disease prevention (CDP) strategies.

Aboriginal – Inuit Communities

Many of the same points about challenges and approaches to tobacco control mentioned above for First Nations also hold true for Inuit communities.

One of the major challenges facing this community has been the cancellation of federal funding for the First Nations and Inuit Tobacco Control Strategy (FNITC). Given this gap,

it was suggested that the CPHA could apply for funding to work with community groups in Inuit, First Nations and Métis communities.

The Inuit do not have a spiritual connection to the tobacco plant, as First Nations people do, but they do have some of the highest smoking rates in the world. Before significant progress can be made, the Inuit must first recognize smoking as a health issue and want to do something about the negative health impact of tobacco use. A community development approach is also necessary to ensure that the Inuit are part of the solution to the tobacco epidemic.

Tobacco free initiatives sponsored by Health Canada have taken place under the direction of National Aboriginal Health Organization (NAHO) and the community leaders in all Inuit communities. Two community programs have seen particular success. The Secondhand Smoke in the Home “Blue Light”² campaign, in which families are given a blue light bulb to install on their porch to signal that their home is smoke-free, has worked remarkably well. Born Smoke-Free³ is an information campaign aimed at pregnant women and women who may become pregnant that has been adapted for Inuit women.

Some additional current initiatives include:

- The Nunavut Government is working with community health committees, which have identified tobacco as a priority – CPHA could support the Government of Nunavut to do program evaluation
- NAHO has coordinated a tobacco training program and launched a website dedicated to Inuit communities
- NAHO is working in partnership with the University of Waterloo to identify smoking patterns, and rates and types of cancers among the Inuit

Women and their Families

It was felt that special attention is needed in meeting the needs of women smokers in child-bearing years or who are already pregnant and smoking. Women in low SES groups also require new approaches to better meet their needs.

People with Mental Health Issues and Comorbidities

A high percentage of people with mental health issues are smokers, many of whom suffer from comorbidities such as substance abuse. An overall wellness strategy is needed for mental health that reduces susceptibility to tobacco use and focuses on mental fitness. This population needs to be treated for tobacco addiction when they are younger, before they have been diagnosed with a psychiatric disorder. Interventions

² Inuit Tapiriit Kanatami (2010). Blue light outside Inuit homes sign of tobacco enlightenment. Media Release, June 1, 2010. Accessed June 16, 2010. URL: <http://www.itk.ca/media-centre/media-releases/blue-light-outside-inuit-homes-sign-tobacco-enlightenment>

³ The First Perspective. National Inuit Leader President's Speech: World No Tobacco Day. May 31, 2010. Accessed June 16, 2010. URL: <http://www.firstperspective.ca/index.php/component/content/article/25-releases/361-national-inuit-leader-presidents-speech-world-no-tobacco-day>

should be tailored for this population and learnings shared with public health and mental health practitioners. It is important to note that people with mental health issues need sustained support when trying to quit smoking as it may take longer for them to quit. Smoke-free treatment facilities may help encourage quit attempts and prevent relapse, as well as protect others from secondhand smoke.

Youth

We need a better understanding of why youth are starting to smoke as there has been a shift in initiation patterns in recent years. Is it because of resiliency factors, access to tobacco or a new generation in which tobacco use has a new purpose?

Respondents felt strongly that youth must be an integral part of any tobacco control strategy. Youth engagement strategies seem to be working and are being used in several provinces. New Brunswick is working on prevention of tobacco use with the Joint Consortium of School Health, including the Ministry of Health and the Ministry of Education.

With Web 2.0, there is room for innovation in smoking prevention by using social media and promoting a smoke-free social movement among youth.

Young Adults

New ways of reaching young adults, such as the use of social media, need to be developed since this group has the highest smoking rate in Canada. Although the number of cigarettes smoked per day may not be high at this stage in their lives, social and light smokers who believe that they can quit any time in the future present a challenge because they often continue smoking until they are addicted and find out too late how difficult it really is to quit.

People of Low Socioeconomic Status (SES)

People on lower incomes have higher smoking rates. Given the vulnerabilities of people in low SES groups, we need to be careful about smoke-free housing policies, as well as other public policies, so as not to increase social disparities.

An informant mentioned that one way to reach smokers in lower SES is by offering smoking cessation programs in community health centres. Another draw would be to offer free NRT to those who cannot afford it. It was mentioned that we should advocate for drug benefit plans to cover NRT and other stop smoking medications, as this population cannot afford these cessation aids.

In addition, partnerships with food banks have been shown to be an effective outreach mechanism, as food security is an issue with smokers from lower SES communities.

Women of low SES have higher rates of smoking and if they become pregnant, have more difficulty quitting, thereby putting their baby's and their own health at greater risk.

It was suggested that a strategy using recreation may work with marginalized youth. The Northwest Territories and British Columbia have been working on Tobacco Free Sports initiatives in an effort to reach this population.

Blue Collar Workers

Both male and female blue collar workers have high rates of tobacco use. Innovative programs are needed to reach this group. It was suggested that workplace programs should cover and offer free medications to employees. One informant mentioned that an Atlantic trucking company is currently working with health authorities to figure out the best way to reach the trucking industry with quit smoking messages.

Lesbian, Gay, Bisexual and Transgender (LGBT) People

LGBT and other sexual minorities were mentioned by one key informant. This population has very high rates of smoking, although few Canadian smoking prevalence statistics exist. Public health needs to target tobacco control efforts at the LGBT population and conduct further research on the determinants of tobacco use among LGBT communities.⁴

Language and Cultural Groups

There is a need to look at how cultural factors, such as being francophone, influences the uptake and continuation of smoking. In particular, we need to look at cultural factors when designing interventions.

Immigrants and Refugees

Immigrant and refugee populations currently have lower smoking rates than the general population. However, there are pockets of immigrants who come to Canada with high smoking rates, especially among men. Some adults may start smoking due to the stress of being a newcomer to Canada.

Immigrants' children may become the next generation of smokers if they model their parents' smoking behaviour. In addition, as the children of immigrants become acculturated, they often take on the smoking behaviour and other characteristics of the general youth population.

Hospitalized Patients with Chronic Diseases

A firstline intervention for hospitalized smokers suffering from a chronic disease is to give them free quit smoking aids, especially NRT that can reduce cravings during their hospital stay. The Ottawa Model for Smoking Cessation⁵ provides an effective integrated approach to treating hospitalized smokers. Hospital property should be smoke-free for all patients and staff.

⁴ Clarke M, Coughlin R. The Toronto Rainbow Tobacco Survey: A Report on Tobacco Use in Toronto's LGBTTQ Communities. The Rainbow Tobacco Intervention Project, Toronto, Ontario, January 2007. Accessed June 15, 2010. URL: <http://www.sherbourne.on.ca/PDFs/TRTS-Report.pdf>

⁵ University of Ottawa Heart Institute. The Ottawa Model for Smoking Cessation. Accessed June 18, 2010. URL: http://www.ottawamodel.ca/en_main.php

What Needs to Be Done

Key informants felt that it should be a priority to first understand why people start smoking today, including the behavioural determinants of smoking and the interaction with the environment in which people live.

Some of the respondents felt that tobacco control interventions should largely continue to use a general population approach. Data do not support shifting "all" emphasis on "special (vulnerable) populations." We need to take a broad-based approach, while focusing our efforts on vulnerable populations at the same time, but not at the expense of a general population approach.

Other key informants stated that the reason vulnerable populations smoke comes down to a health equity issue. They believe that a greater focus on the social determinants of health could further reduce smoking rates in Canada. Several informants expressed the need for public health to look at the issue of vulnerable populations with a social equity lens and address the differential effects from tobacco control interventions on vulnerable populations. From the perspective of these key informants, we must understand the psychosocial and economic underpinnings of smoking or we will see marginalized groups continuing to smoke despite our efforts. CPHA could promote a national vision for dealing with inequalities.

A majority of informants felt that our current population approach needs to be reviewed. We need to target our outreach to those with the highest prevalence rates and who therefore cause the greatest burden to society. We could start by examining trends in tobacco use through CTUMS and other monitoring surveys to further develop the profile of the Canadian smoker.

It was recommended that the smoking behaviour and prevalence rates of vulnerable populations be monitored and their specific needs identified before addressing these needs through an engagement strategy. It is clear that vulnerable groups need to be involved in initiatives to help determine what works best for them. Gaining commitment from willing communities will no doubt lead to innovations in tobacco control.

Public health also needs to reach out to other sectors to identify best practices that work with these populations. One approach suggested to improve our work with vulnerable populations is to look at what specifically makes them vulnerable, e.g., gender differences. Given that knowledge, there will be implications for how we address tobacco use based on what we know works, how we adapt successful approaches, and design effective interventions that take into account the context of the individual within a special population.

Concern was also expressed about the need to study the unintended consequences of public policies, such as the results of having addiction services prohibit smoking on the premises. It was noted that mental health patients who are institutionalized frequently must be treated using tailored interventions, which means there is a need for targeted training for the health care providers who care for these patients.

A few key informants mentioned that the tobacco industry continues to target vulnerable populations, so public health needs to actively monitor how the industry is reaching youth and young adults, with a view to thwarting these efforts.

The following suggestions were made in the area of cessation:

- We need to examine current interventions to determine how they will need to be adapted to reach vulnerable populations and how communications need to be targeted to increase the use of these interventions
- Stop smoking medications should be free to vulnerable populations
- Hospitalized patients need first line interventions and should also be offered free stop smoking medication
- Workplaces should cover stop smoking medications and treatment
- We need to take a population health approach as well as provide outreach education and cessation services by a variety of health care providers in the community, residential facilities and institutional settings
- Partnerships with food banks could help with food security as this is an issue with smokers in low SES
- Education on secondhand smoke may motivate some smokers to quit as vulnerable populations are not always aware of the effects of SHS on those around them, including family members

A few success stories in the area of cessation among vulnerable groups were also shared:

- The Atlantic provinces are piloting a program to reach truckers with quit smoking messages
- New Brunswick is working with Wellness Networks to offer cessation in the workplace
- A harm reduction approach for low income women is working in the Yukon using the Start Thinking About Reducing Secondhand Smoke (STARSS)⁶ program produced by Action on Women's Addictions - Research & Education (AWARE) in conjunction with the Canada Prenatal Nutrition Program (CPNP)

Priority Issues

The issues are listed below in priority sequence as identified by the key informants.

Smoking Cessation

Smoking cessation was mentioned by the majority of informants and is a high priority for action.

⁶ AWARE – action on women's addictions – research & education (2009). Start Thinking About Reducing Secondhand Smoke (STARSS). Accessed June 18, 2010. URL: <http://aware.on.ca/>

The informants felt that cessation efforts must be comprehensive and integrated. The silo approach does not work and is a waste of resources. Smokers need access to assistance whenever they are ready to try to quit. There needs to be a “no wrong door” approach for smokers so that they can access information, counselling, medication or other forms of support whenever and wherever they enter the health care system. For example, communities need services like the Smokers’ Helpline that links patients through the health care system or mass media messages to a personalized service to help them quit. However, the Smokers’ Helpline needs to be better resourced to fully meet the needs of the smokers and health practitioners it serves.

Some respondents felt that public health should provide outreach education to smokers and that cessation services should be available from all care providers in the community, residential facilities and institutional settings to encourage all smokers to quit.

However, others stated that the track record of smoking cessation has been “marginal” and thought that people should be given a variety of options. A few informants suggested people should be given the option of a harm reduction approach if they are unwilling or unable to quit entirely. It has been shown that cutting down on the number of cigarettes smoked may also be a step towards stopping smoking completely. Using less damaging tobacco products may also reduce the physical harm caused by smoking and secondhand smoke.

“A harm reduction approach needs to be seriously considered as an option for some individuals in society who do not want to quit smoking.”

Public health needs to learn from other fields, shift its perspective and look at harm reduction as a viable option, but this can only be done if we stop thinking of tobacco in moralistic terms, i.e., complete cessation is the only way to go. With HIV/AIDS public health was moralistic at the start but found that it didn’t work. We were able to facilitate change for people living with HIV/AIDS by using a harm reduction approach for gay men with respect to their sexual activities. The same holds true for alcoholism and the harm reduction approach. For some alcoholics, once they understand their addiction they can manage it.

It is the same for smoking. Two informants felt we need to facilitate change by taking into account what the smoker is willing and able to do. The consumer therefore needs to be fully informed about alternative nicotine delivery systems and the fact that it is not the nicotine that is particularly harmful but the delivery device and associated smoke.

The regulatory process needs to be changed to make it easier to make nicotine alternatives more readily available but still have a health warning on the package. Consumers need to be informed of the health risks, as realistically compared to the risks of smoking, given a variety of options and allowed to make their own decisions based on what suits them best at a particular time in life.

Family physicians have a unique role to play in smoking cessation. There must therefore be more communication and collaboration between public health and clinical medicine. Primary care physicians see individuals and families and should ask about tobacco use and chart the response during every visit. This would give them an opportunity to

intervene, i.e., a “teachable moment.” Public health authorities can help physicians and other health care workers with smoking cessation interventions by providing information, support, training, etc.

Additional ideas on smoking cessation that came out of the interviews include:

- We need to understand why the current system is not reaching those who continue to smoke, by looking at smoking in a broader context
- There has been extensive research into pharmaceutical aids for smoking cessation, but we also need research into alternatives to medication, such as what types of counselling work best to prevent relapse
- Funds invested in cessation must be for comprehensive services that are integrated into the community
- All provinces and territories should be accountable for providing tobacco treatment for all populations served

The Tobacco Industry and its Products

Regulating the tobacco industry and its products was the priority that was mentioned the second most often by respondents. Ideas were suggested in the areas of tobacco advertising and promotion, tobacco products regulation and tobacco industry denormalization.

Tobacco Advertising and Promotion

The provinces and territories must legislate to prohibit all tobacco advertising and promotion by enacting legislation that is more restrictive than the Federal *Tobacco Act*. Picture-based health warnings that cover at least 50% of the ad should be required on any advertising allowed under Federal legislation until such time as there is a complete ad ban.

With respect to packaging, plain packaging is another priority, especially given that some provinces already have regulatory authority for it. A toll-free Smokers' Helpline telephone number should be required on the front and back of every package.

All signage at retail should be banned, with tobacco product information confined to a price list or a catalogue/information binder accessible to consumers.

Great concern was expressed about the latest youth trends of smoking hookah pipes, cigarillos and other tobacco substitutes, and how they are being marketed.

Governments need to take advantage of supply and demand strategies to make the tobacco industry non-viable over the longer term.

Tobacco Products Regulation

We need to examine what tobacco related public policy will cover in the future, e.g., product regulation, implementation of safeguards and means of informing the consumer

of the risks of tobacco use. For example, it is important to begin to examine options for completely removing tobacco products from the market.

Research evidence will continue to play a large role in developing social policy on tobacco products and will influence how society views the use of tobacco products. One informant felt that if we accept that tobacco products are to remain on the market then we need to work to make them safer for the consumer.

The number of retail outlets (retail density) needs to be reduced significantly. In addition, store employees serving tobacco should have to be at least 19 years of age (or the age of majority in a particular province/territory). A minimum age requirement typically exists for staff serving alcohol, in both bars and in stores selling alcohol for take-away, so a similar precedent exists. Retailers should also be required to ask anyone who appears to be under age 25 for identification.

The cost of tobacco outlet licensing fees should be increased substantially (New York State has increased its licensing fees by 40%), which would allow municipalities to recoup some funds from fees that they spend on public education and community media campaigns to reduce tobacco use, youth tobacco use prevention programs, enforcement of sales to minors legislation, disposal of litter from tobacco products, and other public health activities related to tobacco.

The theory behind increased licensing fees is that higher costs would decrease the number of outlets, so less enforcement would be needed, there would be more control over sales, and less access to tobacco products by minors and adults trying to quit. Each province and territory would have to check the legal issues with respect to how much they could charge for licensing fees and how much they are eligible to recover.

Enforcement techniques for all types of legislation should be examined to ensure that they are as cost-effective as possible.

Tobacco Industry Denormalization

A National Tobacco Industry Denormalization strategy needs to be developed and supported so that the public is better informed about the deceptive practices of the tobacco industry. This knowledge could influence the public's decisions about smoking and support of public policy measures that restrict the tobacco industry's practices. One informant felt that all governments should work collaboratively with NGOs and sue the tobacco industry to recover Medicare costs related to tobacco use, using the British Columbia model that has already been tested in court.

Public health needs to start treating tobacco products and the litter they create as an environmental problem, given that they increase pollution and forest fires, and are poisonous to birds and fish. If such an approach were taken, public health may be able to collaborate with the environmental movement to send new messages to the public about tobacco, thereby further denormalizing its use.

New Approaches for Public Health Action on Tobacco

The third priority indicated by key informants was the need to reframe tobacco control strategies. This reframing exercise should be built on consensus and address how to move forward by looking at current policies and setting priorities for the future.

Before we can reframe tobacco control, there is a pressing need to better understand what governments are spending per tobacco user, per disease, and per death in order to justify new tobacco control policy measures.

Any new approaches to tobacco will require the public health community to develop new partnerships outside the current tobacco control community.

New planning tools for healthy public policy and a health impact approach are needed. These tools have been used in the environmental sector where there are many lessons to be learned and a possible partnership to be developed.

Social Marketing and Mass Media Campaigns

Social marketing could be considered as a broad-based approach to knowledge exchange. Some of the key informants felt that a new social marketing campaign that includes mass media is fundamentally important to reinvigorate tobacco control, engage smokers and encourage them to embrace tobacco control policies. Since smokers are feeling marginalized, such a campaign could shift attitudes by integrating tobacco messages into healthy lifestyle messaging. Messages should emphasize that it is never too late to quit smoking.

Smoke-free By-laws to Reduce Exposure to Secondhand Smoke

Exposure to secondhand smoke is a public health issue and health units need to address it more effectively because of the respiratory effects on persons with disabilities, the elderly, and children who are exposed. When secondhand smoke is eliminated the reduction in costs to the health care system and general public health gains are significant.

It is important to continue to reduce the places in which one can smoke. Some respondents felt that we need to require that an increasing proportion of social housing multi-unit dwellings (MUDs) be 100% smoke-free. However, caution was expressed by others, given the consequences smokers who live in social housing may suffer. Now that most indoor public spaces and workplaces are smoke-free, we need to regulate outdoor public spaces and workplaces, as well as the remaining indoor workplaces that are not regulated. This calls for public health units to work with community coalitions to change public policy to prohibit smoking, as follows:

- In all vehicles carrying passengers under age 18/19
- On school grounds (although smoking is prohibited on school grounds in many jurisdictions, it is not effectively enforced)
- In hotels and on hotel property
- A specific distance from entrances and exits

- On restaurant/bar patios, including a buffer zone around them
- On children's playgrounds, in municipal parks, on public beaches and on the grounds of athletic/recreational facilities, including public outdoor swimming pools and skating rinks
- On hospital/health facility grounds and university campuses
- In outdoor seating areas (e.g., baseball stadium, outdoor theatre)
- During festivals, fairs, parades and other outdoor public gatherings
- In line-ups, including those for ATM machines, movies, etc.
- At bus shelters and bus stops, including a buffer zone around them
- And at any other location prescribed by regulation

Contraband

Several key informants mentioned the issue of contraband. Three informants suggested a number of steps to help reduce the availability of contraband tobacco in Canada:

- Work with the federal interdepartmental task force on contraband
- Work with the U.S. federal government to eliminate illegal production on the U.S. side of the Akwesasne/St. Regis reserve
- Initiate a bilateral treaty with the U.S. to help deal with cross-border contraband issues
- Maintain the border post near Cornwall at its current location, and ensure that the border post is not moved back to Cornwall island
- Eliminate illegal tobacco production on some Canadian reserves
- Enforce the Ontario reserve allocation system (GST collection affected)
- Ensure effective implementation of better package markings (due to be implemented in 2010)
- Implement a full tracking and tracing system
- Implement other federal contraband measures
- Undertake criminal and civil proceedings against the tobacco industry, especially JTI-Macdonald
- Undertake creditor protection proceedings against JTI-Macdonald

Integration of the Tobacco Strategy with Chronic Disease Prevention Strategies

Some participants in the study felt that the future successes of tobacco control will depend on how well public health collaborates with other partners and integrates tobacco with strategies for other risk factors. They pointed out that the focus has been tobacco for many years and now the focus has to shift as there are only finite dollars for disease prevention.

On the other hand, some key informants agreed that public health needs to address disease vectors where there are linkages (we do need cross-fertilization of risk factors) but that tobacco control's integration into Chronic Disease Prevention (CDP) is misunderstood. One respondent noted that the first principle of American CDP is not to harm existing programs but recognize all alliances and linkages that have risk factors. Tobacco control has a set of specific and unique strategies and challenges, e.g., tobacco is a universal risk factor to virtually all diseases and there is a tobacco industry whose mission it is to thwart public health efforts to reduce tobacco use. There is no evidence base for an integrated approach or for cutting the tobacco program to fund other programs. To illustrate, after having cut tobacco control funding significantly last year, Ontario is revitalizing its efforts and revising its tobacco control strategy based on a stakeholder review and expert round tables.

Knowledge Development and Exchange at CPHA

The majority of participants agree that CPHA should become involved in the area of knowledge development and exchange (KDE) for tobacco control. Some key informants cautioned that KDE is much more extensive than top down communication of information, i.e., "putting up a website."

"Websites are good but people must be behind the site to establish connections."

It was felt that CPHA has a credible voice and experience in tobacco control because of its international work with the CIDA funded Strengthening of Public Health Associations (SOPHA) project, the WHO Framework Convention on Tobacco Control (FCTC) and the youth surveys that CPHA has undertaken internationally.

It was suggested that CPHA do a gap analysis and consider taking on some of the following new roles in tobacco control.

CPHA could seek funding to support local campaigns through training, media relations, etc. It could build relationships, networks and commitment to tobacco control.

There is a need for an organization to disseminate information and assist with collaborative problem-solving, thereby helping to build effective change in the area of tobacco. This can be undertaken by facilitating information exchange, modelling, and showcasing of tobacco control initiatives.

CPHA could build on community interventions by using qualitative and case study approaches to guide interventions. Public health units across Canada need easy-to-use information and resources for public health or community based tobacco control interventions. They also need assistance in evaluation methods, including how to do it, determining what works and what doesn't, how to measure the results, and how to take the results and move in another direction. CPHA could also assist in making the results available to stakeholders in all provinces and territories.

CPHA could become a knowledge system enabler with schools of public health and undergraduate programs in nursing, health inspection, etc. It needs to work with professional associations and other NGOs with respect to KDE.

Partnerships are needed with the research community to facilitate the uptake of evidence-informed practice. Developing a knowledge exchange network for tobacco control and healthy living, such as the Canadian Cancer Society's Knowledge Exchange Networks (KENs) and Ontario's Tobacco Control Area Networks (TCANs) would be one way of partnering.

CPHA could undertake distance education to reach public health practitioners by working collaboratively with the Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment (CAN-ADAPTT). It was noted that, to be effective, the public health sector needs to be responsible for training health practitioners, not governments.

"Much planning needs to take place in the area of KDE for tobacco control – building ability and skills, planning for change, developing and training change agents and champions."

In addition to KDE on tobacco, other programs can learn from the experiences of the tobacco control movement. CPHA could play a valuable role in KDE in this area. The lessons learned from tobacco are easily transferred to other programs, e.g., obesity and the food industry. CPHA could make linkages, adapt tobacco control strategies, and teach others how to apply interventions.

CPHA should look to Ontario for success with KDE through the Program Training and Consultation Centre (PTCC) partnership with the Ontario Tobacco Research Unit (OTRU) and the Learning through Evidence, Action and Reflection Networks (LEARN) and its Communities of Practice (CoP) research and evaluation project. Ontario's Training Enhancement in Applied Cessation Counselling and Health (TEACH) Project and the Ottawa Model for Smoking Cessation also offer KDE models that CPHA could consider.

Best Practices Approach

Most participants articulated the need for public health practitioners to use a best practices approach for comprehensive tobacco control intervention.

"CPHA could be the 'Mandala of Health'⁷ – and focus on enablers and mediators."

⁷ The "Mandala of Health" presents the determinants of health as a set of nested influences, ranging from the biological and personal to the ecological and planetary, including the social and political. Source: Hancock, T. Health (1993) Human Development and the Community Ecosystem: three ecological models. Health Promotion International, Vol. 8, No. 1, 41-47, 1993. Accessed July 16, 2010 at <http://heapro.oxfordjournals.org/cgi/content/short/8/1/41>.

Key informants suggested that CPHA identify and document best practices using existing resources, such as the Institute of Evaluative Services (ICES) investigative reports. It could work with the Canadian Best Practices Portal, where over 50 tobacco control interventions have already been evaluated, to include more evaluations. There is also a need for an organization to coordinate the development of a best practices evaluation framework for designing tobacco control interventions.

CPHA could use Ontario's Chronic Disease Prevention and Management (CDPM) Framework to inform planning. It could also make available and train people to use the Multiple Interventions Program (MIP) framework and other decision aids and tools for public health, such as health impact assessment tools.

CPHA should consider taking on a leadership role in the area of collaboration, as has been done with the National Collaborating Centres (NCCs) of the Public Health Agency of Canada (PHAC). CPHA could act as a conduit between the NCCs and public health.

CPHA could collaborate with the Canadian Council for Tobacco Control (CCTC) since it is not mandated to undertake KDE with health practitioners around public health interventions, setting up pilot projects, program evaluation, models for implementation, etc. The Ontario Public Health Association has funding to assist health units and other organizations with evaluation models to start up projects/programs called Towards Evidence Informed Practice (TEIP), so perhaps the CPHA could provide similar funding.

Information and training are needed, which CPHA could provide to the community through conferences and webinars.

It could also provide grey literature, Cochrane reviews, and other scholarly reviews to public health practitioners.

There is a need to document the "corporate memory" of tobacco control in Canada, i.e., historical changes and current interventions in tobacco control, such as has been done with the STATE system in the US.⁸

Comprehensive Tobacco Control and a Public Health Approach

It was suggested that CPHA help with setting priorities and building knowledge about a comprehensive approach to tobacco control. Indeed, CPHA could stimulate the next phase of tobacco control by using a facilitative process to develop a tobacco products regulation model, for the purposes of maximum public health and public safety that sequences initiatives in order of importance (rather than just putting out fires as was the case with the cigarillo issue). This approach would be based on best practice evidence, comparable parallel evidence from other jurisdictions, promising practice pilots and cost-effectiveness.

CPHA could articulate the goals and objectives of a strategy as they relate to Public Health Standards. This would include identifying themes for public health and brokering

⁸ Centers for Disease Control and Prevention. State Tobacco Activities Tracking and Evaluation (STATE) System. Accessed June 16, 2010. URL: <http://www.cdc.gov/tobacco/statesystem>

relationships, especially with non-traditional partners. CPHA could also identify system enablers, the facets of a system that work, such as KDE, and resourcing based on the CDC pillars (ASSIST Model) and on a supply and demand model.

There is also a need for an organization to take on a leadership role in shifting the indicators for success in tobacco control so that prevalence rates are not the only outcome measure.

Integration of Chronic Disease Risk Factors

Despite the difference of opinion in the tobacco control community about the integration of tobacco into a chronic disease prevention model, there are still roles that CPHA could play if so mandated. It could take on a leadership role on the correlation of risk factors and pilot strategies and interventions. Training is needed in the community on how to use the social determinants of health to focus on the public health impact of tobacco policy, which CPHA could undertake.

CPHA could broker cross-sector links and work with various settings and train practitioners how to integrate CDP and tobacco control messages.

National Symposia

Several symposia were suggested, which CPHA could coordinate. It was felt that there should be a national policy debate about transitioning from health to social policy that involves the federal government as well as the provinces and territories.

"We do not need a visioning exercise as we know clearly what we need to do."

CPHA could host a collaborative meeting of researchers to develop a research agenda and gain consensus and commitment to the plan. It could also work with partners such as the Non-Smokers' Rights Association (NSRA) to develop a policy forum or a national symposium that could plan the tobacco control agenda for the next ten years by setting priorities on policy and legislative issues, etc. Finally, CPHA could incorporate smoking cessation and other tobacco issues into its national conference program.

Coordination Role

Suggestions given for CPHA with respect to coordination were to redefine its role to provide coordination (if it doesn't already have such a mandate) and improve linkages, as well as seek the resources to carry out this role, ensuring to differentiate its role from that of the CCTC by serving public health practitioners directly.

CPHA could assist Health Canada by coordinating initiatives that must take place outside government. For example, it could support all of the national tobacco control organizations on the Canadian Coalition for Action on Tobacco (CCAT), of which it is an affiliate member.

The association could play a role in helping to coordinate and simplify tobacco control, in which there are many players. In a coordinating role, CPHA could champion working with new partners, such as the Lung Association via its Lung Health Framework, a smoking cessation project in which they are working with the hospitality industry.

CPHA could promote and coordinate surveillance, monitoring and research so that these are cross-cutting and undertaken in collaboration with others.

Cessation and the Role of CPHA

As mentioned in the Issues section of this report, smoking cessation was the issue most often identified as a priority by key informants. Respondents felt the CPHA could help establish a comprehensive cessation system across Canada. There would also be a role for the association to develop the capacity for cessation across every sector, i.e., primary and secondary intermediaries, including health practitioners and lay people working in the community.

CPHA could coordinate and integrate health promotion and cessation messages for a social marketing and mass media campaign on smoking cessation in which all levels of government participate. The campaign would include a communications plan, materials to support the campaign, a dissemination strategy, local follow-up, and public relations initiatives that benefit from earned media to extend the reach of the campaign.

Boards of Health should be encouraged to listen to family physicians and public health practitioners for ideas on how to reach smokers. H1N1 demonstrated the need for public health to work in closer collaboration with clinicians and other components of the healthcare system, including family physicians. CPHA could assist public health units to work with Boards of Health and family physicians.

CPHA could advocate for or train public health practitioners to advocate for cessation billing codes if they are not available in certain provinces or territories, promote the thoughtful use of such billing codes and set targets for practitioners (60% of smokers see their family physician), including behaviour modification counselling and recommendations for the use of stop smoking medications. The association could also train public health practitioners to advocate for access to stop smoking medications for their clients and develop related policies.

Advocacy and the Role of CPHA

It was suggested that CPHA could act as the voice behind the rationale for continuing to have a strong focus on tobacco. It could advocate for governments to continue to fund tobacco control at current levels.

It was felt by many key informants that CPHA should take on a greater role in public policy advocacy with respect to tobacco control, which may mean that it needs to redefine its position and role on CCAT. In this forum, it could work with NGOs to advocate for increased regulation of tobacco products, enforcement of regulations and more meaningful disclosure to the public, e.g., of the contents of tobacco products.

CPHA could build the capacity of provinces, territories and local public health departments with respect to tobacco taxation, smoke-free public and workplace policies, contraband, retail licensing, regulating alternative tobacco products and policy enforcement.

There is also a role to play in assisting public health units in rebuilding coalitions that support local tobacco control policy development. To this end, CPHA could develop a list of gold standard interventions for tobacco control, provide related briefing material to public health units and municipalities and rally them to increase their tobacco control interventions.

There is a need to identify core competencies related to advocacy around policy change and legislation, and provide related knowledge and skill development to public health practitioners. We also need to build public awareness of public policy advocacy and how to counter the tobacco industry's efforts to increase tobacco use.

CPHA could also play a role in making public health practitioners aware of the range of new tobacco products and suggesting what messages they could be imparting to clients about these products, including messages on health impact, harm reduction and cessation.

Conclusion

In general, the key informants were delighted to participate as key informants to *The Next Stage* project. There was an enormous amount of feedback and many suggestions were presented for moving forward. The majority of informants agreed that significant political commitment and funding are still required to carry out new and more effective tobacco control initiatives. Several respondents felt that governments at all levels need to treat tobacco control as an imperative public health measure. Others emphasized the need for continued collaboration at the provincial, territorial and federal level, given the enormous cost of tobacco to society.

When informants were asked to identify priority issues, they identified numerous without hesitation. Cessation was mentioned by the majority of informants. In fact, the responses for a number of questions included the topic of cessation and suggestions for intervention. The second most mentioned issue was the tobacco industry and the product itself, tobacco. The third most identified issue was the need for the public health field to take a new approach to public health action on tobacco. Many informants felt that "tobacco control was not done" and articulated a need for a renewed approach.

The opinions of key informants differed in some key areas, such as the approaches to be used in public policy (health policy vs. social policy), harm reduction vs. cessation, and whether tobacco control should be integrated into a chronic disease prevention strategy. However, the respondents were unanimous in identifying the need for CPHA to carve out a larger role in tobacco control in Canada.

Some of the suggestions went beyond the role of knowledge development and exchange (KDE), so a gap analysis should be undertaken, followed by collaborative processes to build community consensus on what exactly CPHA's role should be, given

the mandates of the current players in tobacco control. If there is consensus on the role it should play, CPHA can only serve to strengthen tobacco control across the country.

Appendix A – Key Informants

Name	Position title	Organisation
British Columbia		
Simon Barton	Manager, Tobacco Control Program	BC Ministry of Healthy Living and Sport
Dianne Stevenson	Regional Manager, Tobacco Control	Vancouver Island Health Authority
Alberta		
Dr. André Corriveau	Chief Medical Officer of Health	Government of Alberta
Andrew Douglas	Community Health Branch, Community and Population Health Division	Alberta Health and Wellness
Saskatchewan		
Lynn Greaves	Population and Public Health Services	Regina Qu'Appelle Health Region, Saskatchewan Health
Dr. Ross Findlater	Deputy Medical Health Officer	Saskatoon Health Region
Manitoba		
Margie Kvern	Program Specialist, Tobacco Specialist	Population and Public Health Program, Winnipeg Regional Health Authority
Andrew Loughead	Tobacco Control Coordinator	Manitoba Health and Healthy Living
Ontario		
Vito Chiefari	Executive Lead, Tobacco Strategy	Ministry of Health Promotion
Michèle Harding	A/Manager, Performance Management	Public Health Practice Branch/Public Health Division, Ministry of Health & Long-Term Care
Melody Roberts	Strategy and External Relations	Ontario Agency for Health Protection and Promotion
New Brunswick		
Marlien McKay	Manager, Department of Wellness	Culture and Sport, Government of New Brunswick
Prince Edward Island		
Kathleen Brennan	Chronic Disease Prevention Analyst, Primary Care	Chronic Disease Prevention Unit, PEI Department of Health
Nova Scotia		
Steve Machat	Manager, Tobacco Control Strategy	Nova Scotia Health Promotion and Protection
Dr. Robert Strang	Chief Public Health Officer	Nova Scotia Health Protection

Name	Position title	Organisation
Newfoundland		
Bernie Squires	Health Promotion Consultant	Department of Health and Community Services, Health Promotion and Wellness Division, Government of Newfoundland and Labrador
Nunavut		
Dr. Geraldine Osborne	Associate Chief Medical Officer of Health	Government of Nunavut
Alana Kronstal	Tobacco Reduction Specialist	Department of Health & Social Services, Government of Nunavut
Northwest Territories		
Miriam Wideman	Health Promotion Specialist, Tobacco	Department of Health and Social Services, NWT
Yukon		
Sandy Duncan	Health Promotion Coordinator, Health Promotion	Yukon Health and Social Services
Other		
Catherine Carry	Senior Program Officer, Inuit Tuttarvingat	National Aboriginal Health Organization
Rob Cunningham	Senior Policy Analyst	Canadian Cancer Society
Dr. John Garcia	Associate Professor, Department of Health Studies and Gerontology and Program Leader for the Master of Public Health Program	University of Waterloo
Dr. Lynn McIntyre	Professor and CIHR Chair in Gender and Health, Dept. of Community Health Sciences	Faculty of Medicine, University of Calgary
Michael Perley	Director	Ontario Campaign for Action on Tobacco
Dr. Maura Ricketts	Director, Office of Public Health	Canadian Medical Association
Erica Di Ruggiero	Associate Director/Lecturer	Canadian Institute of Population and Public Health, Canadian Institute of Health Research/ Public Health Sciences, University of Toronto
Dr. Peter Selby	Member	The College of Family Physicians of Canada
David Sweanor	Adjunct Professor of Law/ Researcher and Author	University of Ottawa

Appendix B – Interview Guide

The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks

Background

In December 2009, Health Canada funded the Canadian Public Health Association (CPHA) to undertake a project that will engage Canada's public health community in knowledge exchange activities, identify evidence-informed, practice-based strategies and inform the "next generation" of tobacco control policy in Canada. The Next Stage project is funded until March 31, 2011.

Objectives of Key Informant Interviews

To gain insight on:

successes in tobacco control
challenges and priorities for the next phase of tobacco control
mobilizing and strengthening public health networks for knowledge exchange on tobacco control

Interview Questions:

1. In your opinion, what is working well in tobacco control in terms of programs and policies 1) in your jurisdiction, and 2) nationally? What are the factors that contribute to these successes?
2. What is not working so well? Why? Where could improvements be made?
3. Are there vulnerable populations that require special attention? If so, what are these populations? What is the best approach for addressing the needs of these populations?
4. What are the 3 biggest challenges/issues for public health in the next phase of tobacco control?
5. How should these challenges/issues be addressed by the next generation of tobacco control policy? What are the priority areas that should drive public health practitioners and decision makers?
6. Of these priorities, which would benefit from a national coordinated approach? Is there a role for CPHA?
7. Knowledge exchange is key for designing and delivering effective tobacco control interventions. What are the most pressing knowledge needs of the public health community? What aspects of tobacco control would generate the most interest and lead to mobilizing and strengthening public health through knowledge exchange? To facilitate knowledge exchange on tobacco control, do you have any advice for CPHA?
8. Is there anything else you would like to add? Are there any other key people we should speak with?

Appendix C – Additional Resources

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