Eliminating Tobacco in Canada: Public Health Priorities, Capacity, and Comprehensive Action

A Report of the *Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks* Project

Final Report

April 2011

Canadian Public Health Association

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EXECUTIVE SUMMARY

The substantial decline in smoking among Canadians over the past half century represents a major public health achievement. Yet, this success is only partial. Tobacco retains its ranking as the leading cause of preventable death and disease among Canadians, and overall progress has stalled in recent years with continuing marked disparities in tobacco use among population sub-groups. Tobacco control is faced with a series of new challenges including: a tobacco industry that continues to adapt to and circumvent control efforts; the emergence of contraband tobacco, which undermines price and supply policies; and, the emergence of new tobacco products and delivery agents. In addition, with the successes achieved to-date, maintaining a focus on tobacco control has been challenging for public health organizations, particularly as competing priorities have emerged for health promotion efforts.

Funded by Health Canada, the Canadian Public Health Association (CPHA) embarked on a national project, entitled *The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks*, in order to engage Canada's public health community in documenting and sharing evidence-informed and practice-based strategies and interventions in tobacco control. In anticipation of a renewed Federal Tobacco Control Strategy (FTCS), the *Next Stage* project has sought a better understanding of the public health tobacco control context in Canada in order to inform future tobacco control policy and action.

While recognizing the many different governmental and non-governmental organizations, groups and volunteers operating at the local, regional, provincial/territorial (P/T), and federal levels that collectively contribute to comprehensive tobacco control in Canada, the particular focus of this report is on local/regional public health organizations. Whether integrated within regional health authorities or as public health units, the local/regional level of Canada's public health systems plays a critical role in tobacco control efforts.

Over the course of the *Next Stage* project, the public health community has actively participated through workshops, key informant interviews, organizational surveys, and the profiling of a series of tobacco control 'success stories'. A series of literature reviews was also conducted, focussing on local/regional best/better practices, interventions with priority populations, and knowledge exchange dissemination tools and technologies related to tobacco control. The final report describes facilitating factors for successful planning and implementation of tobacco control programs, professional development opportunities, areas for further knowledge development, and opportunities for greater networking among local/regional organizations on a pan-Canadian basis.

As a result of CPHA's *Next Stage* project, recommendations were developed calling for leadership at every system level, to mobilize and act to achieve the elimination of tobacco as a threat to the health of current and future generations of Canadians. Recommendations address the

establishment and funding of comprehensive tobacco control strategies across systems, including dedicated tobacco control capacity in local/regional public health organizations. These organizations are dependent on the P/T and federal governments to provide the critical contextual environment and resources for local practice. Recommendations are included to address tobacco use inequities among population sub-groups, including Aboriginal populations. Additional recommendations address the support functions of education, knowledge development, and exchange.

Recommendations

1. Tobacco Control: A Public Health Priority

Despite the burden of tobacco use on the public's health and the nation's healthcare systems, federal and P/T government investments in tobacco control are a fraction of recommended levels based on the best available evidence. The situation in Canada today risks a reversal of decades of progress in reducing tobacco-related disease and death. However, maintaining the status quo is not the goal. It has been often quoted that "the history of public health may well be written as a record of successive redefinings of the unacceptable." That population groups in this country have tobacco use rates that are two to three times greater than the Canadian average is unacceptable. That children are enticed to become addicted to a product that has been proven to be lethal is unacceptable. That only a haphazard approach is employed to provide cost-effective interventions to support smokers to stop smoking is unacceptable. The fundamental purpose of public health is to protect and promote the health of the public and tobacco use remains a deadly burden to be eliminated. Tobacco control is a 'winnable battle', but that battle is not being fully engaged.

Therefore, it is recommended that:

Public health leaders, their organizations, and their associations mobilize and act to achieve the elimination of tobacco as a threat to the health of current and future generations of Canadians.

2. Comprehensive Strategies and Capacity

The clear and overriding message from the *Next Stage* project is that program implementation, staff competencies, research, and knowledge exchange, while important, are not the stumbling blocks to more effective tobacco control action. Rather, the recurring theme throughout this project has been the limited, and in some settings, *diminishing* capacity available for tobacco control activities within local/regional public health organizations. We have seen limited activity in pursuing new policies, preventing smoking initiation, and systematically providing supports

for cessation. Fundamentally, this is an issue of 'preventive dose'[i], the attainment of which depends on capacity and political will. Local/regional public health organizations require dedicated resources to ensure a sufficient tobacco control preventive dose.

Therefore, it is recommended that:

Federal and provincial/territorial governments provide sufficient and sustainable tobacco control funding to achieve the 'preventive dose' necessary to achieve reduction targets in tobacco use.

Provincial/territorial public health systems identify comprehensive tobacco control as a core requirement of local/regional public health organizations.

Dedicated tobacco control capacity be established in every local/regional public health organization. While its organizational structuring may vary, dedicated tobacco control capacity needs to be preserved in order to achieve the necessary 'preventive dose.'

A considerable body of evidence and substantial experience exists in supporting the application of comprehensive tobacco control strategies. To be successful, planning and implementation of initiatives must be tailored to address community needs and contexts. Comprehensive tobacco control strategies are required at each system level since local/regional public health tobacco control efforts do not exist in isolation, but are highly reliant on federal and P/T system levels for providing the context for their work. The need for more comprehensive approaches to cessation was one of the most commonly heard themes during the *Next Stage* project and is specifically addressed in the following recommendations.

It is recommended that:

Comprehensive tobacco elimination/control strategies be established at federal, provincial/territorial, and local/regional levels. This includes the establishment of a renewed and comprehensive Federal Tobacco Control Strategy with the explicit goal of eliminating tobacco use in Canada.

> **Within all levels of comprehensive tobacco control strategies, effective cessation interventions be included to support systematizing cessation efforts, with a 'no wrong door' approach that will ensure smokers' access to information, counselling, medication, and other supports where and when they need them. Key components include:**

[i] The extent of policy and program activity necessary to achieve specific health outcomes. Source: Ad Hoc Working Group of the Conference of Principal Investigators of Heart Health. Marketing the heart health vision: Delivering the "preventive dose". WHO Collaborating Centre for Policy Development in the Prevention of Noncommunicable Disease, Health Canada, 2000.

- **Creating a supportive social and physical environment to encourage cessation;**
- **Providing cessation media campaigns;**
- **Establishing quit lines and other counselling mechanisms; and**
- **Ensuring the provision of cessation interventions including cessation medication and Nicotine Replacement Therapy (NRT), behavioural support, resources for self-help and support through providers and groups, and subsidized cessation medication and NRT, particularly for lower income groups.**

A population health approach is concerned with not only achieving more favourable health outcomes in the population overall, but also with reducing disparities in health outcomes among population sub-groups. This perspective is reflected in the goals of comprehensive tobacco control strategies. The continued existence of disparities in tobacco use among sub-populations and, the potential that populations may be missed by universal approaches, or experience adverse effects from them, indicate that a mix of universal and targeted approaches is required.

Therefore, it is recommended that:

Comprehensive tobacco control strategies address the disparities in tobacco use among population sub-groups including:

- **Tobacco control interventions, policies, and programs be implemented with a population health/health equity lens;**
- **Targeted approaches be utilized in addition to universal approaches to focus on those populations that may be missed by universal approaches or experience adverse effects from them; and**
- **Tobacco control be linked to a health equity agenda that addresses the underlying determinants of tobacco use and explores the impact of a range of policy options.**

Despite the continuing high rates of tobacco use among Aboriginal populations, there is no federal tobacco strategy for Aboriginal peoples as the First Nations and Inuit Tobacco Control Strategy (FNITCS) was discontinued in 2006 by the federal government. While evidence regarding effective interventions remains limited, particularly in the Canadian context, the literature does point to the need for capacity building of Aboriginal health workers or community health representatives, in their own language, and strong involvement of Aboriginal community members to address tobacco control in their own communities.

Therefore, it is recommended that:

A comprehensive, federal Aboriginal tobacco control strategy be re-established that provides dedicated tobacco control capacity for Aboriginal populations. Such a strategy should consider:

- **High involvement of Aboriginal peoples in research and development of tobacco control strategies;**
- **Positive messages that reflect the strengths and values of culture and communities while maintaining social relevance, using Elders' wisdom, tradition, and knowledge;**
- **Responsiveness to the emotional, physical, social, and spiritual needs of Aboriginal people who use tobacco, adopting a holistic approach that is consistent with Aboriginal teachings;**
- **Provision of client supports to eliminate barriers to participation and mitigate some of the social and economic pressures;**
- **Interventions that approach tobacco with a community focus (e.g., opportunity to develop, implement, and enforce policies and by-laws in Aboriginal communities);**
- **Materials and approaches that have a high degree of relevance to the community; and,**
- **Continuity of projects with sustained funding and delivery to build capacity and long-term change.**

3. Education, Knowledge Development and Exchange

Tobacco-related education of the public health workforce is an important foundational element for implementing comprehensive tobacco control strategies. Staff learning and development is a key organizational strategy to support individual and organizational performance and needs to be tailored to staff needs and roles. While this may vary depending on local context, three broad categories of staff can be identified with respect to tobacco-related education: all staff; staff providing 1:1 services; and, dedicated tobacco control staff. In addition, managers within public health organizations can influence tobacco control efforts in a myriad of ways including priority setting, resource allocation, establishing work structures, and supporting innovation.

Therefore, it is recommended that:

Continuing learning needs and the education of the public health workforce be pursued by:

- **Embedding tobacco control concepts and examples within the orientation and continuing education of all public health staff;**
- **Assessing opportunities for systematically incorporating brief-contact cessation interventions into existing 1:1 programs and services;**
- **Supporting and requiring new tobacco control staff to take the free, online, bilingual course: *Tobacco and Public Health: From Theory to Practice*;**

- **Assessing and addressing tobacco control continuing education needs over time on a provincial/territorial and national basis; and**
- **Seeking the engagement of Canadian Public Health Schools and Programs in a coordinated approach to comprehensively integrate tobacco control concepts and examples throughout institutions' public health graduate curriculum.**

While there is a considerable body of tobacco control-related evidence and experience, gaps remain regarding the most effective ways to support the development and implementation of tobacco control policies and their enforcement. Among different population groups, numerous gaps and challenges continue with respect to the availability of evidence-based research to inform effective practice. An opportunity exists to foster innovation and knowledge development through the support of local/regional projects and knowledge exchange since the experience accumulated at the local/regional level across the country represents important practical knowledge likely of benefit for other local/regional organizations.

Therefore, it is recommended that:

Key federal organizations, including Health Canada, the Public Health Agency of Canada, and the Canadian Institutes of Health Research (CIHR), actively support the development and synthesis of the evidence base and knowledge exchange for local tobacco control initiatives including those targeting priority populations.

Health Canada support a comprehensive range of tobacco control projects to foster innovation and the building of capacity, knowledge development, and exchange among local/regional public health organizations.

The federal government provide support for the ongoing operation and coordination of a pan-Canadian knowledge exchange network of local/regional public health organizations working in tobacco control and their associated networks.

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Public Health Priorities, Capacity and Comprehensive Action

> We shall have no better conditions in the future if we are satisfied with all those which we have at present.
>
> - Thomas Edison (1847-1931)

CHAPTER 1: INTRODUCTION

The Canadian Public Health Association (CPHA) recently celebrated its centenary and used this milestone to highlight the public health achievements of the past century (see text box, right). Among these, "recognition of tobacco use as a health hazard" reflects the dramatic decline in tobacco consumption and a pervasive shift in societal attitudes. Yet, this success is only partial. Tobacco retains its ranking as the leading cause of preventable death and disease among Canadians, and overall progress has stalled in recent years with continuing marked disparities in tobacco use among population sub-groups. Canada is not alone in this regard. As recently noted by the U.S. Secretary of Health and Human Services, "The lesson that we should take from the successes of the past 50 years is not that progress is inevitable. It's that saving lives and reducing health costs is possible, but only if we pursue an aggressive policy agenda."[1]

12 Great Public Health Achievements

- Safer and healthier foods
- Control of infectious diseases
- Healthier environments
- Vaccination
- Recognition of tobacco use as a health hazard
- Motor-vehicle safety
- Decline in deaths from coronary heart disease and stroke
- Healthier mothers and babies
- Acting on the social determinants of health
- Universal policies
- Safer workplaces
- Family planning

Source: Canadian Public Health Association, Celebrating CPHA's Centenary. www.cpha.ca/en/about/100.aspx#12

The CPHA project, entitled *The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks*, was funded by Health Canada in order to engage Canada's public health community in documenting and sharing evidence-informed and practice-based strategies and interventions, and to inform future tobacco control policy and action in Canada. Appendix 1 provides the project's objectives.

Many existing reports describe comprehensive tobacco control strategies from international, national, and sub-national perspectives. The achievement of pan-Canadian comprehensive tobacco control involves many different players including governmental and non-governmental organizations (NGOs), researchers, community groups, and volunteers working at local, regional, provincial/territorial (P/T), and federal levels. The focus of this project however, has been on tobacco control from the perspective of local/regional public health organizations.

Whether integrated within regional health authorities or as public health units, the local/regional level of Canada's public health systems plays a critical role in tobacco control efforts and is often the backbone of such efforts.

With the anticipated renewal of the Federal Tobacco Control Strategy (FTCS), the *Next Stage* project sought a better understanding of the tobacco control context of local/regional public health. This includes best practices and recent success stories, the potential for greater networking among local/regional public health staff across the country, and opportunities for other system-level involvement and support for local/regional public health action.

Since the project's inception in December 2009, a wide range of sub-projects has been pursued including consultations and workshops, literature reviews, key informant interviews, an online survey, and the profiling of tobacco control 'success stories.' The intent of this report is to summarize the key themes that have emerged over the course of the project and identify needed actions going forward. In addition to this final report, detailed reports have been produced for each of the sub-projects and are available on CPHA's website for those seeking further information on specific topics.

Over the course of this project, it became clear that the issues of greatest concern to those working in local/regional public health tobacco control were much broader than 'what works.' Limited dedicated capacity, limited current and planned local tobacco control activity, and limited support of decision makers were recurrently encountered themes. While progress has stalled and new challenges are emerging, there is an increasingly obvious gap between the current state of tobacco control efforts and, what is necessary to address this public health priority.

The report is structured in the following manner:

Chapter II: provides a brief overview of the various *Next Stage* sub-projects.

Chapter III: provides a brief overview of tobacco trends, impacts and emerging challenges. It highlights the population burden still experienced due to tobacco use; the slowing progress in the decline in overall smoking rates; and, the continuing marked disparities in tobacco use among population sub-groups. It also describes new and continuing tobacco control challenges.

Chapter IV: provides a brief overview of public health systems and the local/regional context for tobacco control including public health functions, core programs, principles, funding and the local/regional workforce.

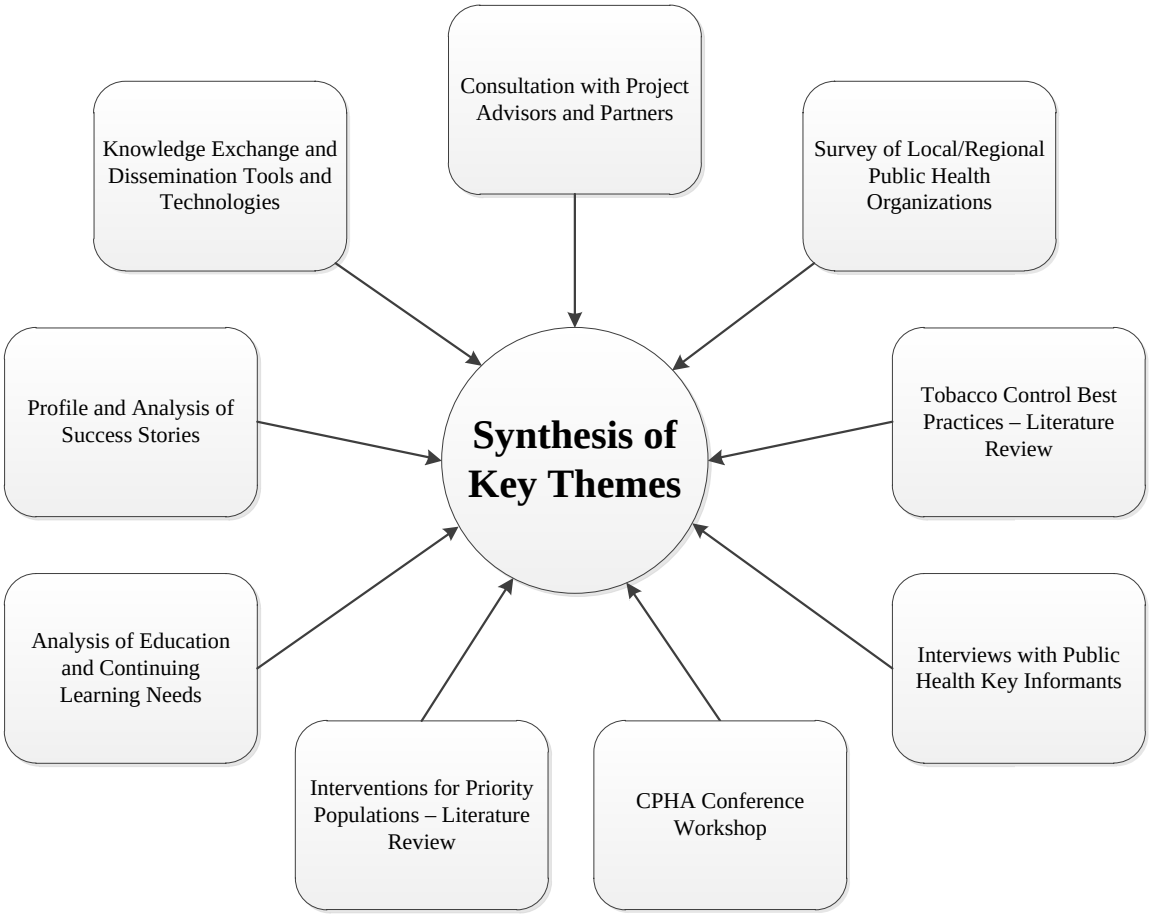
Chapter V: provides a synthesis of the key findings from the *Next Stage* sub-projects with associated analysis and recommendations. This includes the relative priority of tobacco control; extent of existing local/regional capacity and action; the evidence and experience in applying comprehensive tobacco control to community needs and contexts; tobacco control and health inequities; continuing learning needs and education; and, research and knowledge exchange.

Chapter VI: provides the report's conclusion.

Appendices: provide additional detail and supplementary information to the main body of the report.

CHAPTER 2: OVERVIEW OF *NEXT STAGE* SUB-PROJECTS

The *Next Stage* project was comprised of multiple components addressing key themes that are summarized in this report.



Briefly, the project components included:

- Consultation with project advisors and partners

  In a March 2010 facilitated workshop, project advisors and partners learned about the goal and objectives of the project and provided feedback on planned activities. Participants also discussed priorities for public health and its approach to tobacco control.

- Survey of local/regional public health organizations

  An online survey was conducted of public health professionals representing public health units, health authorities or health regions across the provinces and territories of Canada. This report explores successful tobacco control practices, programs, and policies relating to prevention, cessation, protection, and enforcement, many of which were raised during the

survey. The survey also inquired about current gaps and challenges. With the exception of Québec, representatives from all P/T units/regions participated, with responses from 83 of 97 organizations (85.6%). Additional information gathering was conducted through key informant interviews with representatives of key organizations in Québec.

- Literature review of best/better practices

  This report provides a review of the literature and best/better practices with respect to the effectiveness of prevention, protection, and cessation activities with potential relevance to the local/regional public health community.

- Key informant interviews with public health representatives

  Key informant interviews were conducted with representatives of local/regional, P/T and NGOs. The interviews focused on: successes and challenges in tobacco control; priority populations; key priorities; knowledge development and exchange (including best practices); and, the potential role for CPHA in tobacco control.

- 2010 CPHA conference workshop

  Workshop participants discussed successes and challenges in tobacco control in the context of the preliminary findings from the project's literature review, public health organization survey, and key informant interviews.

- Focused literature review of tobacco interventions for priority populations

  This review of the grey literature identifies promising and evidence-based tobacco control interventions for priority populations to inform the work of local/regional public health practitioners.

- Education and continuing learning needs of the public health workforce

  This report addresses the continuing learning needs and education of public health staff in tobacco control.

- Local/regional public health tobacco control success stories

  This report examines 'what works' in tobacco control through the profiling of 22 tobacco control initiatives identified by public health leaders and practitioners. The analysis reveals nine facilitating factors of success among these initiatives.

- Knowledge exchange and dissemination tools and technologies

  This environmental scan was undertaken to identify Web 2.0 knowledge exchange dissemination tools and technologies related to tobacco control.

Appendix 2 provides additional information about each of the sub-projects and provides links to the more detailed, stand-alone reports that were prepared for each sub-project.

CHAPTER 3: TOBACCO AS A PUBLIC HEALTH PRIORITY – TRENDS, IMPACTS, AND EMERGING CHALLENGES

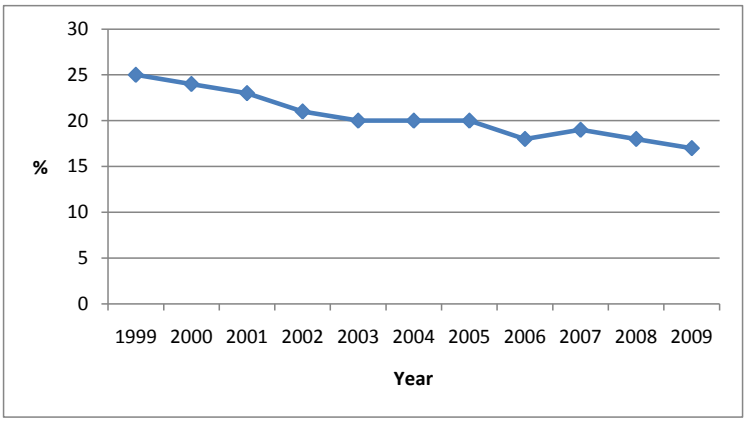
This chapter provides a brief overview of the population burden of tobacco use in Canada, tobacco use trends, and continuing disparities among populations. Further details are readily available from recent comprehensive reports at national and provincial levels.[2,3] This chapter concludes with a brief discussion of current tobacco control challenges.

A. Population Burden and Trends

An estimated 37,000 Canadian deaths per year are caused by tobacco use with deaths from malignancies (17,427), cardiovascular diseases (10,275) and respiratory diseases (8,282) being the most frequent.[4] The economic costs of tobacco use in 2002 included $4.4B in direct health care costs and an additional $12.5B in indirect costs.[5]

Compared to the 1960s when almost 50% of Canadian adults smoked, the 2009 smoking rate of 17% among Canadians 15 years of age and older represents substantial progress. However, as shown in Figure 1, most of the reduction in tobacco use over the past decade occurred in the first few years when there was an average 1% drop in the smoking rate per year. From 2006 through 2009, the current smoking rate has fallen only 1%.

Figure 1: Percentage of Current Smokers, Age 15+, Canada, 1999 to 2009



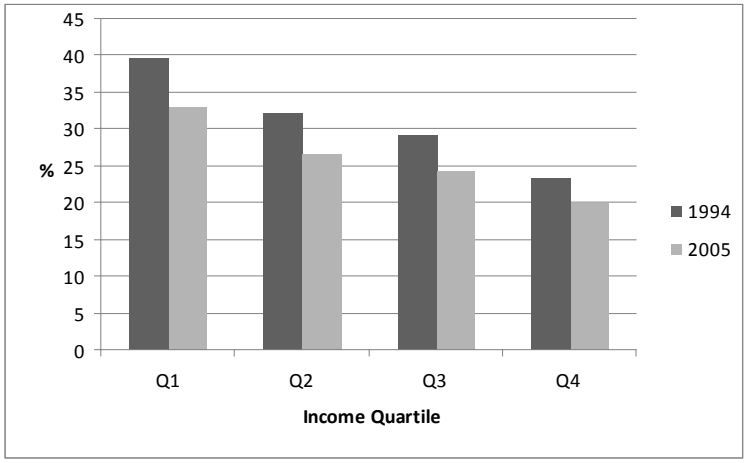
Source: Canadian Tobacco Use Monitoring Survey (CTUMS), 2009

B. Disparities in Tobacco Use Among Populations

Despite the progress made regarding overall smoking rates, there continue to be marked differences in smoking rates among population sub-groups. Figure 2 compares smoking rates by income quartile for the years 1994 and 2005. While overall (i.e., *average*) population smoking rates decreased substantially over this time period—and there were significant decreases in smoking rates in each income quartile—there has been much less progress regarding the marked difference in smoking rates across income quartiles. In 1994, there was a 16.2 percentage point

difference between highest and lowest quartiles compared to a 13 percentage point difference in 2005.[6]

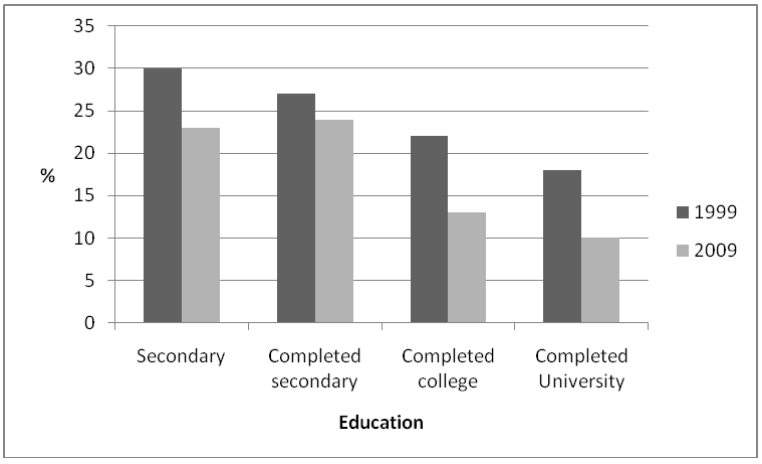
Figure 2: Current Smokers by Income Quartile, Canada, 1994 and 2005



Source: Lee *et al*., 2009.[6]

Similarly, while overall smoking rates decreased by eight percentage points between 1999 and 2009, Figure 3 shows that there has been no change in the spread of smoking rates by education level. There was a 12 percentage point difference between those with some secondary school and those that had completed university education in 1999, and this difference was 13 percentage points in 2009.[7] Table 1 provides population estimates of current smokers by education level.

Figure 3: Current Smokers by Education, Age 15+, Canada, 1999 and 2009



Source: CTUMS, 2009

Table 1: Estimated Number of Smokers in Canada, Age 15+ Years, by Education Level, 2009

Education Level	Population Estimate ('000)	Current Smokers (%)	Number of Current Smokers ('000)
< Secondary	4,639	23.3	1,081
Completed Secondary	9,517	22.3	2,122
Completed College	5,702	15.7	895
Completed University	7,390	9.3	687

Source: CTUMS, 2009

Differences in smoking rates by education and income levels are also reflected in existing differences in smoking rates by occupational group. In 2008, the Canadian Tobacco Use Monitoring Survey (CTUMS) assessed smoking rates by occupational group finding that smoking rates in the blue-collar occupational group were considerably higher than white-collar or sales/service groups (see Table 2).

Table 2: Smoking Rates by Occupational Group, Canada, 2008[ii]

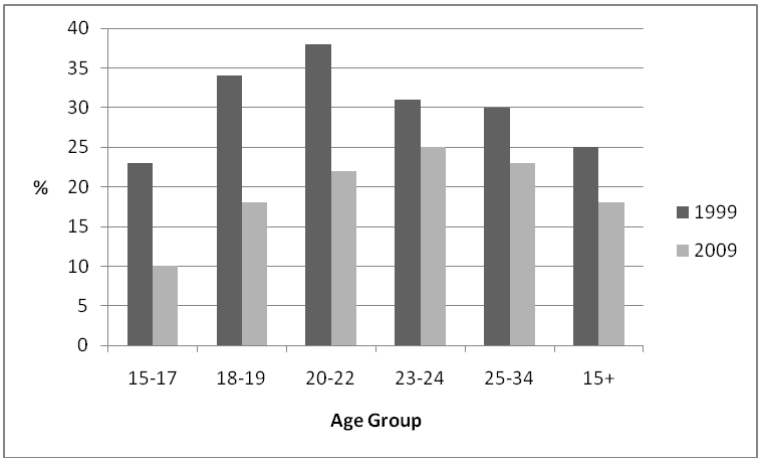
Occupational Group	Current Smokers (%)	95% Confidence Interval	Number of Current Smokers ('000)
White-collar	14.9	13.4, 16.4	1,496
Sales-service	21.0	18.2, 23.8	909
Blue-collar	27.0	24.0, 30.0	1,124

Source: CTUMS, 2008

Progress in smoking reductions among age groups has also been uneven. Figure 4 provides a comparison of current smoking rates in 1999 and 2009 by age group with a focus on youth and young adults. Marked improvements have been observed in the younger age groups. However, less improvement has been observed in young adults. Cohort effects may be contributing to the observed rates. Table 3 provides estimates of the numbers of current smokers by age group.

[ii] While the blue-collar occupational group had a much higher prevalence of current smokers than the white-collar group, the absolute number of current smokers is larger in the white-collar group. This is because the overall size (i.e., denominator) of the white-collar group is more than twice that of the blue-collar group based on the occupational groupings in CTUMS.

Figure 4: Current Smoking Rates in Youth and Young Adults, Canada, 1999 and 2009



Source: CTUMS, 2009

Table 3: Estimated Number of Smokers in Canada, Age 15+ Years, by Age Group, 2009

Age Group	Population Estimate ('000)	Current Smokers (%)	Number of Current Smokers ('000)
15-17	1,340	9.7	130
18-19	866	18.0	156
20-22	1,457	21.9	319
23-24	819	25.0	205
25-34	4,628	22.5	1,041
15+	27,679	17.5	4,844

Source: CTUMS, 2009

There are limited national data for tobacco use[iii] among Aboriginal populations overall, as well as specifically for First Nations, Inuit and Métis populations. Available information indicates that Aboriginal smoking rates are approximately two to three times higher than general population rates. For example, the 2005 Canadian Community Health Survey observed current daily or occasional smoking rates of 40.3% in Aboriginal populations living off-reserve compared with an overall Canadian rate of 21.7%.[8] The First Nations and Inuit Health Branch of Health Canada reports that in 2004:

- 60% of First Nations people aged 18-34 living on-reserve currently smoke;
- 52% of First Nations people living on-reserve who smoke started smoking between the ages of 13-16;
- 70% of Inuit in the North aged 18-45 currently smoke; and
- 46% of Inuit who smoke started smoking at age 14 or younger.[9]

Among Canadian P/Ts, Nunavut, where the vast majority (83%) of Nunavummiut are Inuit, has the highest rate of smoking in the country with over 50% of those aged 12 and above being

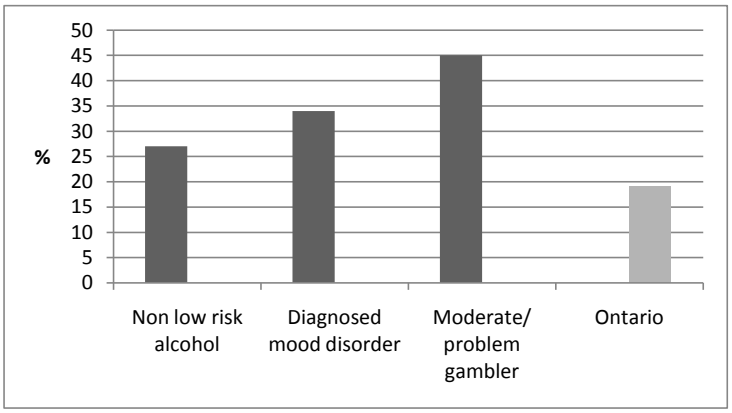
[iii] In this report, 'tobacco use' refers to non-traditional/ceremonial use of tobacco.

current smokers.[10] Earlier initiation of smoking and smokeless tobacco use are of particular concern in Aboriginal populations.[11]

Disparities in smoking rates occur in other populations as well. Pregnancy-related smoking prevalence rates are not homogeneous for all population sub-groups. For example, nationally, younger mothers (15-19 years) reported the highest proportion of pre-pregnancy smoking with 55% having smoked daily or occasionally. Pre-pregnancy smoking also varied by educational level with 47% of women with less than a high school education reporting smoking either daily or occasionally, compared with 8% of women with a university degree.[3]

Higher prevalence of tobacco use is observed among those who have mental health conditions or misuse other substances. While national level data are not available in Canada, information from specific settings illustrates this situation. For example, a Calgary-based study indicated that over half (52%) of adults attending outpatient mental health clinics were current smokers.[12] Data from Ontario indicate that smoking rates in those who misuse alcohol or have mental health issues are substantially higher compared to the overall population (see Figure 5).

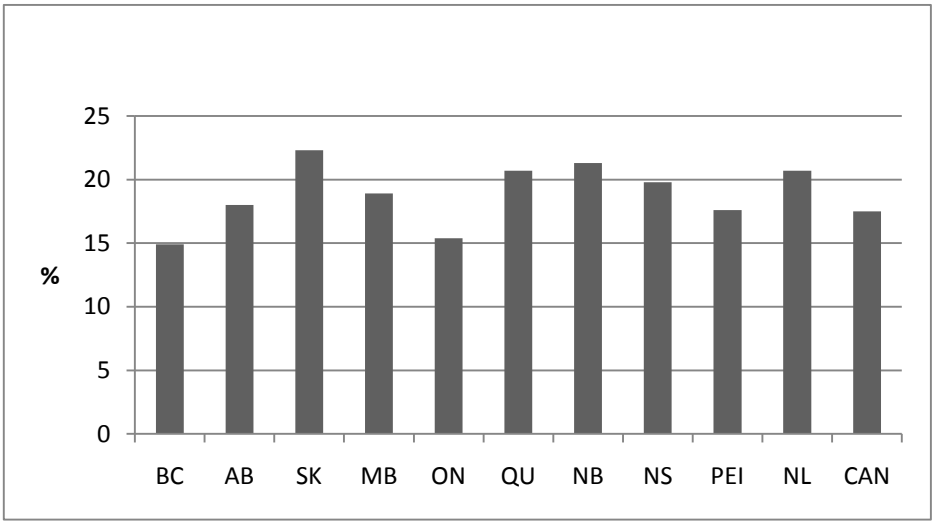
Figure 5: Current Smoking Prevalence, by Selected Risk Factors, Ages 12+, Ontario, 2007-08



Source: Smoke-Free Ontario - Scientific Advisory Committee. Evidence to guide action: comprehensive tobacco control in Ontario. OAHPP, 2010.[3]

Disparities also exist among and within provinces. Figure 6 illustrates the variation in smoking among provinces. While territorial smoking rates are not included, the 2005 Canadian Community Health Survey indicates a prevalence of current smokers aged 12 and older of 53% in Nunavut, 36% in the Northwest Territories and 30% in the Yukon.[10]

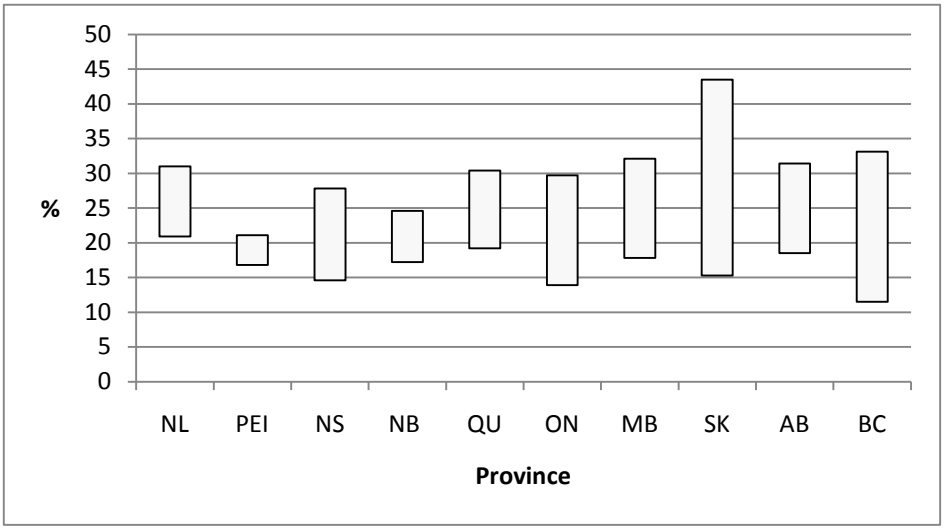
Figure 6: Prevalence of Current Smokers, Provinces and Canada, 2009



Source: CTUMS, 2009

Figure 7 demonstrates the range of variation in the proportion of current smokers by health region within each province. The implication is that 'one size does not fit all,' and individual local/regional public health organizations need to tailor their strategies to local circumstances including the distribution of priority populations.

Figure 7: Inter-Regional Variation in Prevalence of Current Smokers by Province, 12+ Years, Canada, 2009



Source: Statistics Canada, Canada Community Health Survey, 2009.
Note: 2007 Health Region Boundaries

The foregoing brief overview of disparities is not intended to be exhaustive of all existing disparities, but to illustrate that tobacco control success to-date has been partial with considerable differences in smoking rates remaining among population sub-groups. Furthermore, while presented separately, there are significant inter-relationships among the observed disparities (e.g., income, education, and occupation).

C. New and Continuing Tobacco Control Challenges

The most commonly identified challenges to tobacco control efforts include:

- The tobacco industry;
- Contraband tobacco products;
- New tobacco products and delivery agents; and
- Tobacco control 'fatigue'.

Unlike many other health issues, tobacco control is faced with an industry whose sole purpose is to produce and market a product that eventually kills half of its users. Vector control is a longstanding concept in public health although typically vectors are biologic in nature (e.g., mosquitoes and West Nile Virus control). However, for tobacco, it is the tobacco industry that is the vector. It is adaptive and self-interested to maximize profits and thereby needs to recruit new smokers, increase or maintain consumption, and fight regulations that impede its ability to make money.[3] This includes the development of new products such as flavoured cigarettes, as well as supports to retailers. As such, comprehensive tobacco control strategies increasingly address this disease vector.

The increased availability and lower price of contraband tobacco products have the potential to negatively affect the public health goal of reducing tobacco use among Canadians. Contraband tobacco circumvents existing tobacco taxes and sales-to-minors legislation. The RCMP reports that provinces in Central Canada (Ontario and Québec) are the largest consumers of contraband cigarettes, although the effects are not limited to these jurisdictions.[13]

There is more readily available information on the amount of illicit tobacco seized than the extent to which Canadians are using illicit tobacco products. Although CTUMS does not explicitly monitor self-reported levels of contraband use, nearly half of Canadian smokers purchased cigarettes from "cheaper sources"[iv] in 2009.[2] A study released by the tobacco industry estimates that 30% of tobacco purchased in Canada is bought illegally with even higher rates in Québec (40%) and Ontario (50%).[14] A series of recent reports have recognized the complex nature of the issue and the many stakeholders that need to be involved, including the federal and P/T governments, tobacco manufacturers and retailers, NGOs, First Nations communities and leadership, researchers and American counterparts.[3]

[iv] Cheaper sources included, in order of prevalence of smokers' self-reported purchase in the past six months: discount brand; First Nations reserve; outside province; smuggled; and, other (including Internet and mail order). Many of these source categories may include contraband.[2]

There are a number of new products and delivery agents being produced. These include the electronic cigarette, which is promoted as a non-tobacco, alternative nicotine delivery agent. The use of hookahs, or water pipes, is another emerging tobacco issue, which makes enforcement of smoke-free places challenging due to the difficulty of differentiating tobacco and herbal products.

Despite the flattening of tobacco use trends and the emergence of new tobacco control challenges, tobacco control efforts are faced with widespread fatigue among decision makers, the public and within the public health community itself. The success of increased smoke-free places and point-of-sale legislation has made tobacco products and smoking much less visible, and therefore not an immediate priority for many in the general public. In addition, public health organizations are faced with competing priorities for health promotion efforts such as obesity.

CHAPTER 4: PUBLIC HEALTH SYSTEMS AND THE LOCAL/REGIONAL CONTEXT

A. Mission, Functions, and System Levels

The core mission of public health is to promote and protect the health of the public. Public health seeks to understand health-related issues within populations through its core functions of population health assessment and health surveillance, and then takes comprehensive action typically through a combination of public education, policy change, partnership and collaboration, enforcement of regulations, and the provision of clinical services.

Levels of the Formal Public Health System

- Local/Regional
- Provincial/Territorial
- Federal
- International (WHO)

Within Canada, there are primarily three levels of the formal public health system: local/regional, P/T and federal. At the international level, the World Health Organization (WHO) serves as a mechanism for coordination and agreement on health issues among countries. For example, the *WHO Framework Convention on Tobacco Control (FCTC)* is an international treaty established in 2003 to provide "a framework for tobacco control measures to be implemented at national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke."[15]

B. Structures

The formal (governmental) public health system is uniquely defined within each province and territory. At the local/regional level, most provinces have regional health authorities (RHAs) that have a broad range of health responsibilities, including public health. In these jurisdictions, the number and boundaries of local/regional public health organizations are determined by the structure of the health system overall. In recent years, the trend in most, but not all, jurisdictions has been a reduction in the number of RHAs.

Considerable structural variation exists among and within P/Ts. Among regionalized health systems, Québec is unique in not only integrating health and social services, but also in having separate regional and local system levels. Ontario has a series of local public health units that are distinct from the rest of the healthcare system and are jointly funded by provincial and municipal governments. At the time of the online survey (March 2010), 115 local/regional public health organizations[v] were identified across Canada (see Appendix 2 for more details).

At the federal level, the Public Health Agency of Canada (PHAC) was established in 2004 following the SARS outbreak. PHAC has a range of public health responsibilities including

[v] This figure is the sum of the number of RHAs and public health units (Ontario) across the country. With both local and regional levels in Québec, the number of Québec regions (18) was used.

surveillance, health promotion, and chronic disease prevention. Health Canada retains lead responsibility for tobacco control overall. In addition, through its First Nations and Inuit Health Branch, Health Canada has the lead role for First Nations and Inuit health issues within the provinces and for northern populations, in partnership with the territories. Within the territories, Health Canada provides some funding, but the delivery of public health programs and services is the responsibility of territorial governments. In First Nations communities, Health Canada funds the delivery of public health services, and these programs and services have tended to operate separately from provincial public health systems, although this varies among jurisdictions. In recent years, there has been increasing attention to the design, structure, and capacity of public health in Aboriginal communities.[16,17]

C. Core Programs

Each P/T has a public health act, although these are of varying comprehensiveness and explicitness. A small minority of provinces have defined expectations for public health core programs and these vary to the extent they are explicitly linked to legislation.[18-21] There are typically four main categories of public health programs to which the core system functions[vi] are applied. Tobacco control is explicitly included within the descriptions of core programs for these provinces.

Main Categories of Public Health Core Programs

- Prevention and control of communicable diseases
- Environmental health
- Prevention of chronic diseases and injuries
- Maternal/child health - healthy development

Health Canada has a *First Nations and Inuit Health Program Compendium* that describes a range of public health-related programs and services provided or funded by Health Canada.[23] The compendium is less comprehensive and less detailed than existing provincial core program descriptions. Of note, tobacco/smoking is not mentioned anywhere in the compendium. Health Canada previously funded a tobacco control strategy for First Nations and Inuit populations, but this was discontinued by the federal government in 2006 and has not yet been replaced.

A key underlying principle of public health practice is applying a 'population health' approach to the analysis of, and response to, health issues. Some confusion exists in equating a population health approach with universal interventions. These approaches are not the same, since a population health approach involves seeking both an improvement in the health of the entire population, as well as reducing inequalities in

Population Health Approach

- Focuses on improving the health status of the population.
- Action is directed at the health of an entire population, or sub-population, rather than individuals.
- Necessitates the reduction in inequalities in health status between population groups.
- Reductions in health inequities require reductions in material and social inequities.

Source: Public Health Agency of Canada

[vi] Population health assessment; health surveillance; health promotion; disease and injury prevention; and, health protection.[22]

health status.[24] With the release of key international[25] and national reports[26,27] on the importance of the social determinants of health (SDOH), there is increasing recognition that public health approaches to health issues need to balance universal strategies with targeted approaches in order to disproportionately improve the health of disadvantaged groups while at the same time improving the health of the entire population (i.e., 'levelling up').[28]

While legislative frameworks and core programs, where they exist, strive to encourage consistency among local/regional public health organizations, a key challenge for, and strength of, these organizations is the tailoring of approaches to the unique characteristics of their communities. For example, in the Québec Public Health Program 2003-2012, "the support to vulnerable groups" is one of its five key strategies to maintain and enhance population health status.[21] In B.C., their core public health functions describe that "core programs should be specifically tailored" for populations of concern.[18] Likewise, Ontario's Public Health Standards describe that public health units "shall continuously tailor their programs and services to address needs that are influenced by differences in the context of their local communities."[20]

D. Funding

In most provinces, RHAs receive funding as a global budget, which may not explicitly identify the public health component. Some provinces do not allow public health funds to be transferred to other budget areas. In Ontario, there are standalone budgets for public health units. Local/regional organizations determine how they will allocate their public health budget to the programmatic areas. The need to fulfil health protection regulatory requirements and the historical delivery of maternal/child programs often result in a small proportion of resources being available for the prevention of chronic diseases and injuries, and other health promotion and community development initiatives. Several provinces use targeted funding for particular priority areas, including tobacco control, to ensure dedicated resources. The overall level of funding for formal public health systems in Canada remains uncertain. *The Report of the National Advisory Committee on SARS and Public Health, October 2003* (referred to as *The Naylor Report*) estimated that core public health expenditures at federal and P/T levels combined accounted for about 2.6% of public health care expenditures in 2002.[29]

E. Workforce

There continues to be limited information regarding basic characteristics of the public health workforce in Canada including its size and distribution, although this is the subject of a current pilot project in some jurisdictions.[vii] Among provinces that have enumerated their local/regional workforces, public health nurses account for more than half of the staff complement.[30,31] In those P/Ts in which public health organizations employ public health inspectors, this discipline group appears to be the second largest staff group.[31] While in smaller numbers, a range of other

[vii] The Public Health Human Resources Task Group of the F/P/T Public Health Network is conducting a pilot project to enumerate the core public health workforce at provincial/regional/local levels in a limited number of jurisdictions.

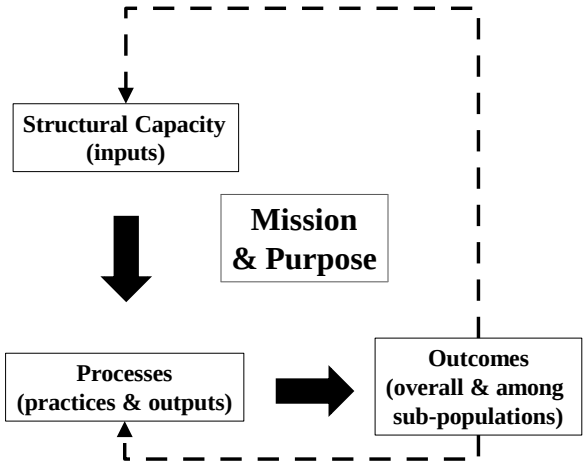
disciplines are typically encountered in these organizations including Medical Officers of Health, epidemiologists, health promoters, nutritionists/dieticians, and others.

CHAPTER 5: LOCAL/REGIONAL PUBLIC HEALTH TOBACCO CONTROL – FINDINGS, ANALYSIS, AND RECOMMENDATIONS

A. Overview

The purpose of this chapter is to provide a high-level overview of the key findings from the *Next Stage* sub-projects with associated analysis and recommendations. While a central tenet of this project has been the identification of opportunities to facilitate greater tobacco control-related interaction, knowledge exchange and coordination among local/regional public health organizations, a prerequisite for these activities is the presence of receptor capacity within these organizations. Therefore, a broader consideration of the dimensions of public health performance[32] is required and was guided by the following framework (see Figure 8).

Figure 8: Public Health Performance Framework



In analyzing these dimensions[viii] of performance, the following key themes emerge:

- Tobacco control: a public health priority;
- Public health tobacco control capacity and extent of activity;
- Evidence and experience in applying comprehensive tobacco control to community needs and contexts;
- Tobacco control and health inequities;
- Continuing learning needs and education; and
- Research and knowledge exchange.

[viii] See Appendix 4 for more details.

Following a discussion of each of the above themes, this chapter concludes with a summary of the recommendations that appear within each section and a further breakdown by public health system level (i.e., federal, P/T, and local/regional). This breakdown is important since federal and P/T system levels provide the critical contextual environment for local practice. The contributing role of the public health practice community (i.e., CPHA) is also outlined.

B. Tobacco Control: A Public Health Priority

> Tobacco control needs to be a high priority at all public health system levels.

As described in Chapter III, from a multi-decade perspective, tobacco control in Canada has achieved tremendous success. However, the job is not done. Tobacco use remains the leading cause of preventable death and disease; trends in declining use have stalled; large inequities in use continue to exist among populations; and, there remain millions of users, many of whom express a desire to quit.

In the successes achieved to-date, a considerable amount of tobacco control experience and evidence have been accumulated.[3,33] However, despite the magnitude of the health and cost impacts of tobacco, and the knowledge of what to do about tobacco use, a repeated concern expressed by public health practitioners during this project has been the lack of leadership, visibility, and support for tobacco control. Key informants indicated that while tobacco remains 'a priority', often little or no resources are allocated to address it. Some key informants also indicated that tobacco control in their P/T jurisdictions is not a core requirement. Tobacco issues are addressed only after mandated public health responsibilities such as health protection and maternal/child services are fulfilled.

The extent of investment in tobacco control provides a further indication of the priority given to tobacco control in this country. Based on their review of the scientific evidence, the U.S. Institute of Medicine recommended in 2007 that each state should fund tobacco control in the range of $15-20 per capita depending on the state's population, demography, and prevalence of tobacco use.[34] In contrast, the average P/T funding for tobacco control is approximately $3.50 per capita with an additional $1.94 per capita from the federal government.[35] Considering the budgetary impact of healthcare costs on P/T and federal budgets in Canada, there is an even greater incentive for aggressive action on tobacco.[36] The level of existing tobacco control funding has direct implications as to the capacity available for tobacco control at all system levels. The limited extent of tobacco control capacity and activity in local/regional public health organizations is described in more detail in the next section.

While used throughout this report, the term 'control' is potentially misleading since it implies the intent to restrain or limit and not let something worsen. Such a perspective invites complacency and inertia particularly as past successes have made tobacco use much less visible and there are

many competing priorities for health promotion initiatives. Considering the flattening of tobacco use trends, the emergence of new challenges, and the current fatigue after decades of tobacco control efforts, the existing situation risks a reversal of decades of progress in reducing tobacco-related disease and death.[34]

It has been observed that "the history of public health may well be written as a record of successive redefinings of the unacceptable."[37] That population groups in this country have tobacco use rates that are two to three times greater than the Canadian average is unacceptable. That children are enticed to become addicted to a product that is potentially lethal is unacceptable. That only a haphazard approach is employed to provide cost-effective interventions to support smokers to stop smoking is unacceptable. The fundamental purpose of public health is to protect and promote the health of the public, and tobacco remains a deadly burden to be eliminated.

> If we do not act decisively today, a hundred years from now our grand-children and their children will look back and seriously question how people claiming to be committed to public health and social justice allowed the tobacco epidemic to unfold unchecked.
>
> - Dr. Gro Harlem Brundtland, former Director-General of WHO, 1999.

Over the decades, public health has taken action to eliminate other key risks to human health including smallpox, polio, and measles. Preventing tobacco-related deaths and disease has been identified by the U.S. Centers for Disease Control and Prevention (CDC) as one of six winnable[ix] public health battles.[39] Tobacco needs to be eliminated as a threat to the health of current and future Canadians. Other countries, including the U.S. and England, have reached a similar conclusion[1,34,40,41] (see text box, right).

> Our vision is of a smokefree future: a future where our communities are free from the harms of tobacco use and where people lead healthier and longer lives. Smoking kills half of all long-term users and is the biggest single cause of inequalities in death rates between rich and poor in the UK. A future free of tobacco use will mean our children will not die early and unnecessarily from smoking-related illnesses.
>
> - A Smokefree Future: A Comprehensive Tobacco Control Strategy for England, 2010.

Public health leaders, including Medical Officers of Health, need to individually and collectively speak to the need for concerted action to eliminate this risk to the public. This includes developing a long-term strategy that would change the fundamental model of the production and sale of tobacco products to support the eventual elimination of this risk.

"A goal without a plan is just a wish."[x] Comprehensive tobacco control/elimination strategies need to exist at each system level; address the objectives of prevention, protection, cessation, and

[ix] "CDC's Winnable Battles are public health priorities with large-scale impact on health and with known, effective strategies to address them. The current Winnable Battles have been chosen based on the magnitude of the health problems and our ability to make significant progress in improving outcomes."[38]

[x] Source: Larry Elder, lawyer and radio talk-show host (1952-).

denormalization; and apply a range of mutually reinforcing components including, but not limited to:

- Product and packaging (ban flavoured products; restrict new products; and implement plain and standardized packaging, large graphic warnings and visible quit line numbers);
- Price (increase tobacco taxes);
- Contraband tobacco (act with relevant partners; address in a comprehensive manner);
- Retailers (license and restrict numbers and locations of retailers);
- Promotion (close existing exemptions on advertising/promotion; require adult ratings and warnings for movies and video games with tobacco imagery);
- Increase control over tobacco growing, manufacturing, and importing;
- Media campaigns (denormalize tobacco use and tobacco industry; encourage cessation);
- Systematize cessation support; and
- Increase protection from environmental tobacco smoke exposure.[3,15,34]

Isolated efforts addressing one or two components are insufficient. Many of the components listed above fall predominantly within the sphere of influence of federal and P/T governments, which need to create the necessary supportive environments for local/regional action.

It is recommended that:

> **Public health leaders, their organizations, and their associations mobilize and act to achieve the elimination of tobacco as a threat to the health of current and future generations of Canadians.**

C. Public Health Tobacco Control Capacity and Extent of Activity

There is limited and unequal distribution of local/regional tobacco control capacity. Furthermore, existing capacity is decreasing in some settings. Consequently, there is limited activity pursuing new policies, preventing smoking initiation, and systematically providing supports for cessation.

1. Local/Regional Tobacco Control Capacity

At the front-lines of public health action, local/regional public health plays a critical role in tobacco control efforts whether in advocating and supporting public policy change, raising public awareness and support, enforcing limits on tobacco exposure and supply, or working to address the needs of priority populations. Throughout the course of this project, two capacity-related themes were repeatedly raised. One was the importance of dedicated tobacco control capacity within organizations. The other was the risk in some settings of a loss of tobacco control capacity following its integration within chronic disease prevention (CDP) initiatives. Fundamentally, this is an issue of 'preventive dose', which has been defined as "the extent of policy and program activity necessary to achieve specific health outcomes.[42] Its attainment "depends completely on the existence of capacity—which is characterized as adequate infrastructure (scientific, financial, programmatic, etc.) and the application of political will."[42] The experience in the U.S. is that the more states have spent on comprehensive tobacco control, the greater the decline in smoking.[33]

Information on local/regional public health tobacco control capacity in Canada is available from two sources. A 2004/05 survey of local/regional CDP capacity found that on average, 6% of organizations' capacity was allocated to CDP.[43] Since the CDP programs targeted three main risk factors, and the intensity of involvement at that time was higher with tobacco than other risk factors, this would mean that just over 2% of capacity was likely targeting tobacco control.

This result is consistent with the findings of this project's online survey of local/regional public health organizations that reported an <u>average</u> of 2.3% of the local/regional workforce is dedicated tobacco control staff.[44] Considerable variation in capacity exists among organizations. For example, almost a quarter (22.9%) of organizations have <u>no</u> dedicated tobacco control staff. A potential limitation of the existing data's use of percentages is the unknown disposition of the denominator. Some jurisdictions have experienced a decrease in their overall public health staff complement so that even a stable proportion of staff allocated to tobacco control efforts in such settings reflects a net decrease in actual capacity.

In those organizations with dedicated staff, most (72.3%) are structured within a health promotion/disease prevention unit. A minority of organizations surveyed have dedicated tobacco control units (15.7%). Several project participants reported that in recent years, shifts to more

integrated CDP/Healthy Living programs had resulted in substantial net reductions in resources available for tobacco control activities.

The primary motivator for considering an integrated multi-risk factor CDP program is that the triad of tobacco use, unhealthy eating, and physical inactivity collectively cause a substantial proportion of the major chronic diseases: cardiovascular, cancer, diabetes, and chronic lung diseases. It is preferable to have a collective primary prevention program than a series of disease-specific preventive initiatives.[45] Additional motivations for an integrated approach include: i) the existence of some overlap among those with risk factors; and, ii) opportunities for integration when implementing in some settings (e.g., smoke-free recreational programs, school-based campaigns/programs). As such, high-level core public health program descriptions, such as those in Québec and Ontario, have presented relatively integrated CDP programs.[20,21]

The challenge is that individual public health interventions tend to be risk-factor specific. Whether it is policies, key media messages, or targeted behavioural change mechanisms, as shown in the following table, what needs to be done to reduce tobacco use is quite different from what needs to be done to encourage physical activity or healthy eating.

Characteristic	Tobacco	Physical Activity	Healthy Eating
Main health goal:	Zero use	At least minimum levels	Balance of healthy foods
Supportive policy environment (examples):	Smoke-free places	Pedestrian-friendly communities	Healthy choices, affordable prices
Personal skills/services (examples):	Accessing cessation counselling, pharmacotherapy	Building activity into daily life	Understanding nutrition labels, meal planning, cooking skills

Reflecting the importance of risk-factor specific strategies and interventions, both Saskatchewan's and B.C.'s core program descriptions have acknowledged the clustering of CDP/Healthy Living, but present explicit risk-factor specific models.[18,19] In addition to Ontario's public health standards, a comprehensive tobacco control-specific guidance development has been developed.[46] From a preventive dose perspective, the issue is less about whether or not tobacco control is embedded within a broader CDP initiative, but whether there is dedicated tobacco control capacity to perform targeted tobacco-related interventions. While an integrated program can foster a multi-risk factor perspective, the preventive dose for tobacco control needs to be assured.

2. Local/Regional Tobacco Control Activity

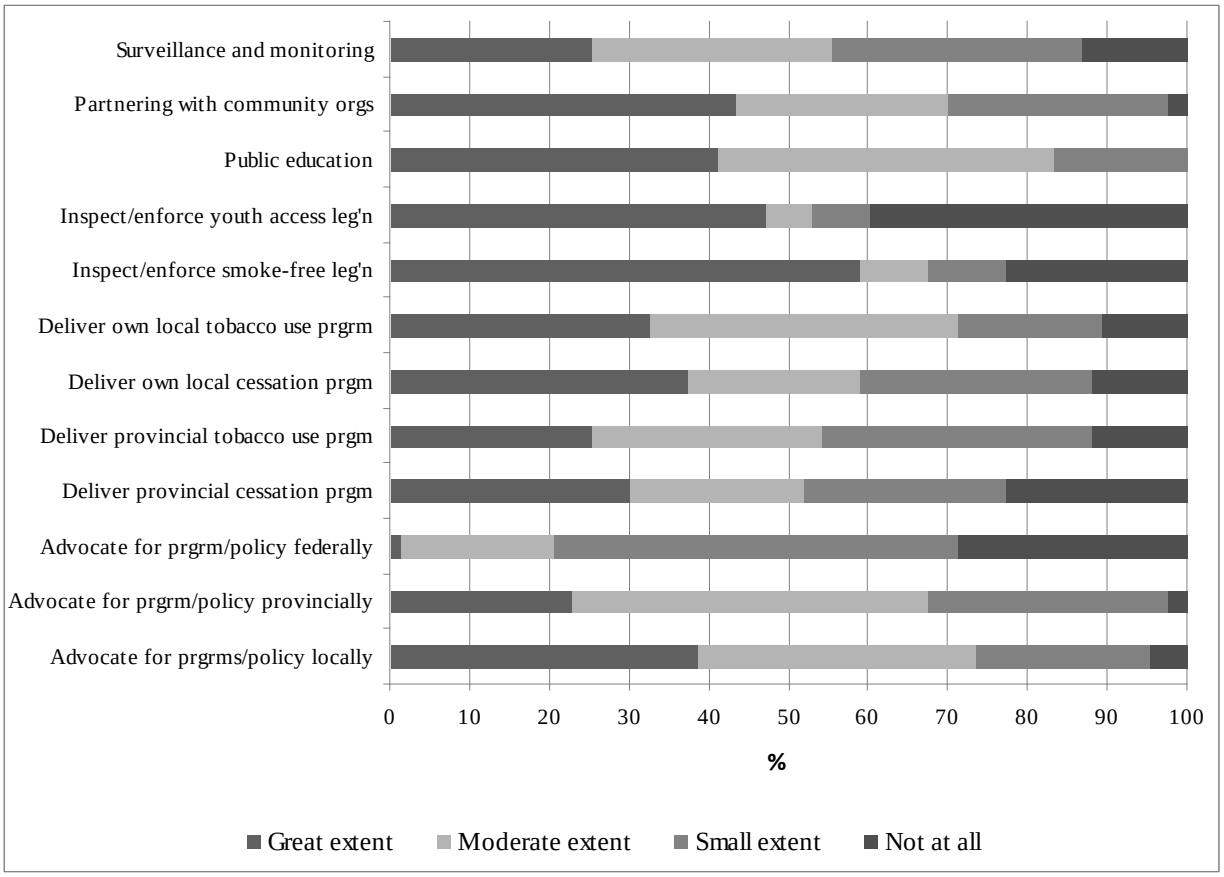
Likely reflecting differences in capacity as well as P/T strategy contexts, local/regional public health organizations' involvement in different aspects of tobacco control varies considerably (see Figure 9). Between one-half to two-thirds of organizations are involved to a great or moderate extent in:

- Promoting/advocating new tobacco control policies/programs at the public health unit level (74%);

- Promoting/advocating new tobacco control policies/programs at the provincial level (68%);
- Delivery of their own local tobacco use prevention programs (71%);
- Inspection and enforcement of smoke-free legislation (68%);
- Public education (83%); and
- Partnering with community organizations in planning or implementing tobacco control programs/initiatives (70%).[44]

In contrast to promoting/advocating new policies and programs at local and provincial levels (74% and 68% respectively), doing so at the federal level was relatively uncommon (21%).[44]

Figure 9: Level of Health Unit/Region Engagement in Tobacco Control Pursuits (n=83)



Source: Babayan et al. Survey on tobacco control in Canada's public health units and health regions. OTRU, 2010.[44]

The following sub-sections provide more detailed findings regarding specific tobacco control activities.

Policies for Smoke-Free Spaces and Restrictions on Supply of Tobacco Products

Over the course of the *Next Stage* project, many examples of areas for smoke-free policies were identified (see text box, right). Local/regional public health organizations have a leadership role in advocating for such laws and, in many instances, in their enforcement. Leading edge tobacco control initiatives have frequently started in local settings before they are incorporated into P/T legislation. Therefore, the benefit of being innovative is not only obtained by the local population, but also paves the way for later broader success.

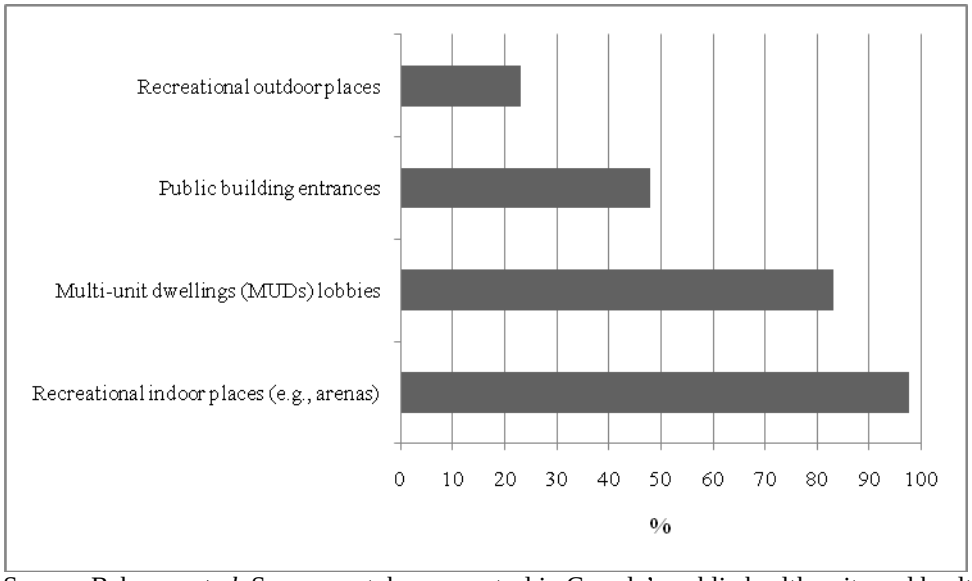
Examples of Potential Smoke-Free Policies

- Public building entrances
- Recreational outdoor places (e.g., playgrounds; athletic/recreation facility grounds, outdoor swimming pools, skating rinks)
- Parks and/or beaches
- Multi-unit dwellings
- Motor vehicles
- School grounds (i.e., enforcement of existing prohibition)
- Hotels and hotel properties
- Restaurant/bar patios including buffer zone around them
- Hospital/health facility grounds
- College/university campuses
- Outdoor seating areas (e.g., stadium, theatre)
- Festivals, fairs, parades, & other outdoor gatherings
- Line-ups (e.g., ATMs, movies)
- Bus shelters/bus stops including buffer zone around them
- Use of hookahs/herbal cigarettes

Local/regional public health organizations were asked about the state of current and future policies for smoke-free air and restrictions on the supply of tobacco products, as well as plans to adopt such policies within two years. Overall, policies existed to a variable extent and only a minority of organizations described policies that were being adopted or considered for adoption within two years.

Smoke-free areas are primarily defined through a blend of P/T legislation and local by-laws. According to the survey of local/regional public health organizations, the extent of smoke-free policies in their catchment areas is more widespread in indoor settings than outdoor settings (see Figure 10).

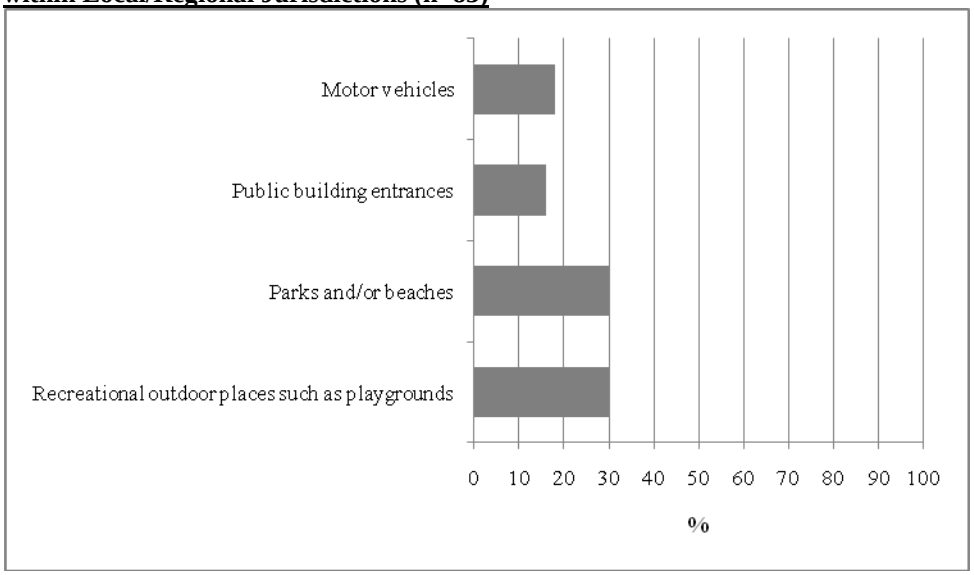
Figure 10: Extent of Current Smoke-Free Policies in Local/Regional Catchment Area, (n=83)



Source: Babayan *et al.* Survey on tobacco control in Canada's public health units and health regions. OTRU, 2010.[44]

A minority of survey respondents indicated that smoke-free policies were being pursued in the near future. The most common smoke-free policies in the process of being adopted or considered for adoption within the next two years include recreational outdoor places and parks/beaches (see Figure 11).

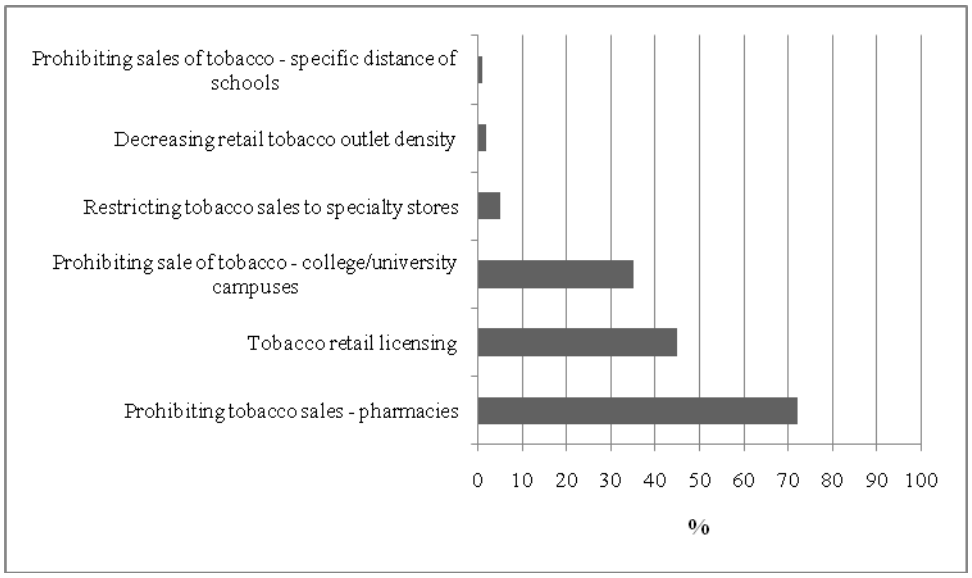
Figure 11: Most Common Smoke-Free Policies Being Adopted or Considered for Adoption within Two Years within Local/Regional Jurisdictions (n=83)



Source: Babayan *et al.* Survey on tobacco control in Canada's public health units and health regions. OTRU, 2010.[44]

Existing policies reflect a mix of federal and P/T legislation, and local by-laws. Figure 12 provides the results from the survey of public health organizations regarding the current existence of policies to control the supply of tobacco products within their catchment area.

Figure 12: Extent of Restrictions on Supply of Tobacco within Local/Regional Jurisdictions (n=83)



Source: Babayan *et al.* Survey on tobacco control in Canada's public health units and health regions. OTRU, 2010.[44]

Regarding planned policy changes to address the supply of tobacco products, less than 11% of local/regional organizations described policies that were in the process of adoption or under consideration within the next two years. For example, about 90% of organizations reported they are not considering adopting policies to remove tobacco within a certain distance from schools or restricting tobacco sales to specialty stores. Close to 60% are not considering adopting policies to restrict the sale of tobacco products on college and university campuses. An exception was tobacco sales in pharmacies, a policy that 18% of health units were in the process of adopting or considering adopting.

Enforcement

Almost half of local/regional public health organizations (47%) indicated that there had been an increase in the level of enforcement in the past three years. This increase was mainly related to the passage of or amendments to provincial legislation, as well as the availability of funding. A smaller proportion (12%) reported a decrease in enforcement level linked in the majority of cases to having achieved full compliance.

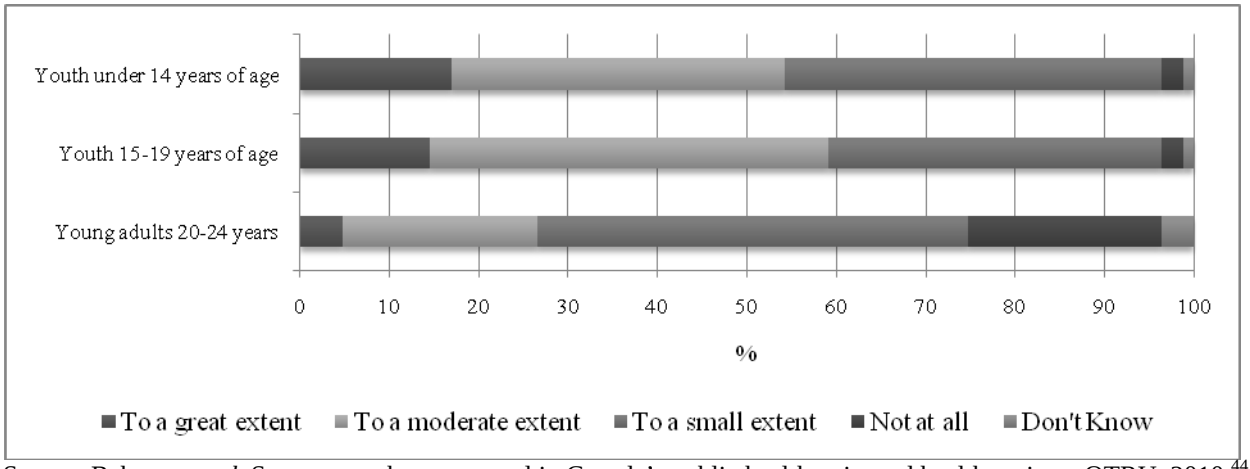
Prevention in Youth and Young Adults

The historical focus of prevention has predominantly been on youth. However, one fifth of current young adult smokers in Canada tried their first cigarette after the age of 18 years, and the

majority of young adults who smoke became regular smokers after the age of 18. Therefore, 'young adults' need to be considered for future prevention initiatives.

Considerable proportions of local/regional public health organizations reported that existing prevention programs only address prevention needs to a 'small extent' or 'not at all' (see Figure 13). This proportion increased with the increasing age of the target populations. An overall theme across different project components was that existing programs are not meeting the needs of youth and young adults.

Figure 13: Extent that Prevention Programs Are Perceived to Meet Needs of Youth and Young Adults (n=83)



Source: Babayan *et al.* Survey on tobacco control in Canada's public health units and health regions. OTRU, 2010.[44]

While almost half (47%) of organizations had experienced an increase in prevention-related capacity due to dedicated funding and partnership with local community organizations/coalitions, over a quarter (26.5%) had experienced a decrease in capacity due to funding cuts, diversion to other activities, or lack of staff.

Cessation

The perception from local/regional public health organizations is that cessation needs are being addressed to a small (48.2%) and moderate extent (38.6%). The majority of surveyed local/regional public health organizations reported increases in the level of cessation activities with increased priority and funding directed to cessation. This has been manifested in the hiring of dedicated staff, staff education, and expansion of services. In particular, public health organizations are increasingly becoming involved in supporting systematic policy changes to support cessation in health care settings. Nevertheless, the information gathered over the course of this project indicates that the cessation needs of the general population, and particularly population sub-groups (youth, young adults and Aboriginal populations being identified most commonly), are not being met.

3. Summary

There is limited and unequal distribution of local/regional tobacco control capacity, and existing capacity is decreasing in some organizations. Consequently, there is limited activity at this time in pursuing new policies for smoke-free areas and restricting availability, preventing smoking initiation, and systematically providing supports for cessation. Local/regional public health organizations require dedicated resources to ensure a sufficient tobacco control preventive dose.

It is recommended that:

> **Federal and provincial/territorial governments provide sufficient and sustainable tobacco control funding to achieve the 'preventive dose' necessary to achieve reduction targets in tobacco use.**
>
> **Provincial/territorial public health systems identify comprehensive tobacco control as a core requirement of local/regional public health organizations.**
>
> **Dedicated tobacco control capacity be established in every local/regional public health organization. While its organizational structuring may vary, dedicated tobacco control capacity needs to be preserved in order to achieve the necessary 'preventive dose.'**

D. Evidence and Experience in Applying Comprehensive Tobacco Control to Community Needs and Contexts

A considerable body of evidence and substantial experience exists in supporting the application of comprehensive tobacco control strategies. The successful planning and implementation of initiatives needs to be tailored to address community needs and contexts.

1. Section Outline

The main purpose of this section is to provide a synthesis of several *Next Stage* sub-projects related to the evidence and experience in applying comprehensive tobacco control to community needs and contexts. The section begins with an overview of comprehensive tobacco control, followed by a brief description of the 22 tobacco control 'success stories' that were profiled to gain greater insight into the facilitating factors for successful tobacco control in the local/regional public health context. The sub-sections that follow present a synthesis of the findings from relevant sub-projects for the following tobacco control topics: smoke-free areas; youth and young adults; and cessation (education and development is included in a later section dedicated to this issue). The section concludes with a brief summary and recommendations.

2. Overview of Comprehensive Tobacco Control

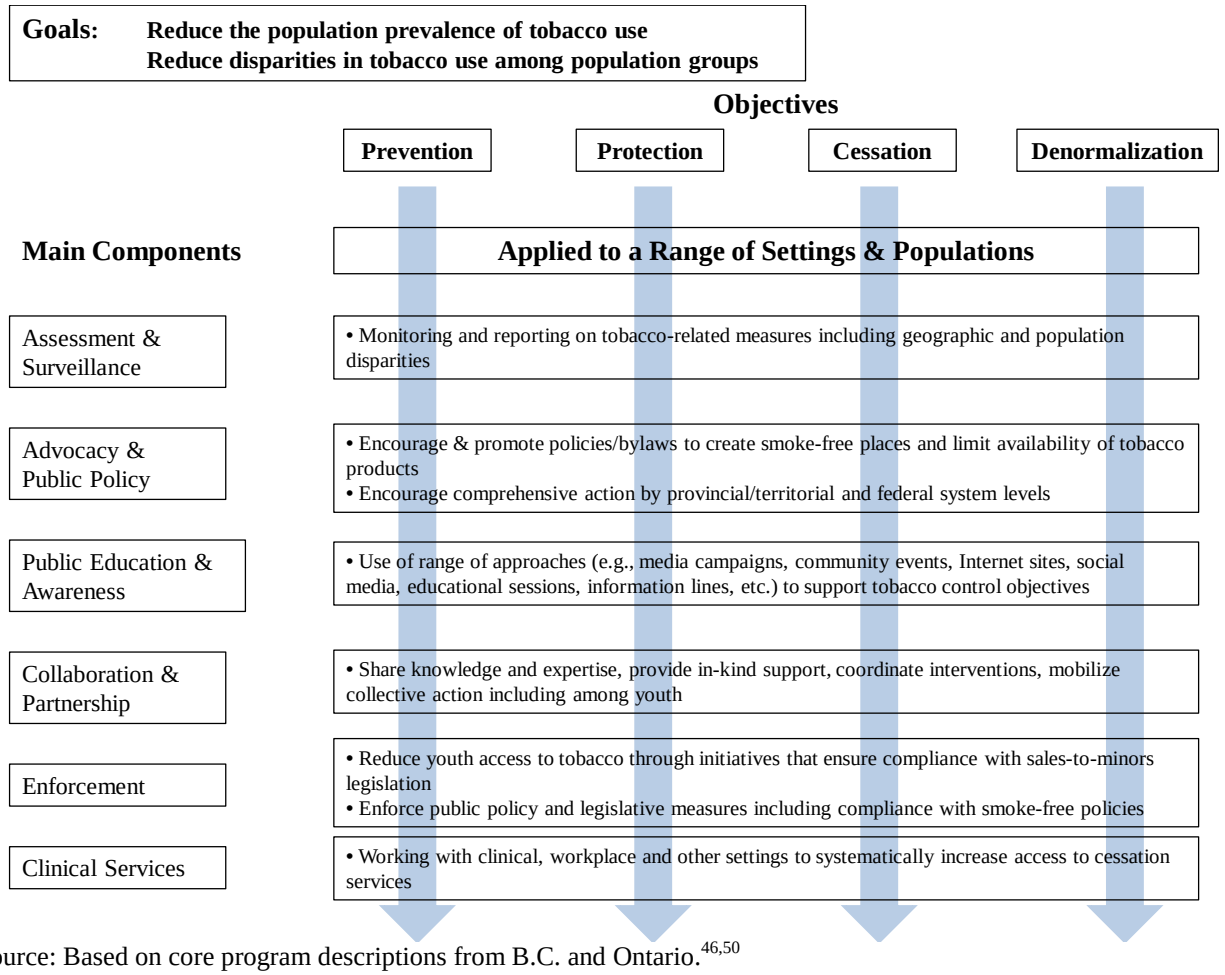
Multiple detailed evidence summaries and recommendations can be found for tobacco control. Key sources include the U.S. Surgeon General, the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Institute of Medicine and the World Health Organization's (WHO) Tobacco-Free Initiative.[33,34,47,48] The recent *Evidence to Guide Action* report from Ontario provides a comprehensive description of the evidence and key components of a provincial comprehensive tobacco control strategy[3] (see Appendix 3).

Implementation of comprehensive state tobacco control programs in California, Massachusetts, and New York have demonstrated marked reductions in tobacco use. Key components of the California program included a state-wide media campaign; tobacco cessation helpline; coordinated tobacco control efforts by their 61 local public health departments; state-wide technical support services; community-based organizations and thousands of volunteers; and, partnerships with NGOs.[3] Similarly, this project's literature review highlighted the importance of healthy public policy as a key strategy, including taxation and real price increases on tobacco products, smoke-free air laws, advertising bans and other legislative controls on the tobacco industry, evidence-based cessation services, and funding for mass-media campaigns.[49] Copious research points to the need for such comprehensive and integrated approaches. "Interventions

that focus only on one or a few population groups, such as women or youth, or on one or a few approaches, such as restrictions on sales to minors, have little impact."[3]

Local/regional tobacco control efforts are conducted in the context of broader strategies. Figure 14 provides a high-level conceptual model for a local/regional tobacco control program. Reflecting a population health approach, the goals of tobacco control are to achieve a reduction in overall tobacco use *and* to reduce disparities in tobacco use among population groups. Reflecting the need for comprehensiveness, a range of approaches is applied to a variety of settings and populations contributing to the four over-arching objectives of tobacco control: prevention, protection, cessation, and denormalization. Brief descriptions of example activities are included that would be applied to a range of settings and populations. More detailed descriptions of local/regional tobacco control programs are available elsewhere.[46,50]

Figure 14: Example of a High-level Local/Regional Comprehensive Tobacco Control Program



Source: Based on core program descriptions from B.C. and Ontario.[46,50]

Depending on the jurisdiction, not all local/regional public health organizations have the lead responsibility currently for all of the programmatic components shown in Figure 14. Some responsibilities may be allocated to the P/T public health level or other departments. Some

responsibilities may also be split among different organizational units within RHAs. Nevertheless, from planning and implementation perspectives, integration and mutual reinforcement among program components still need to be sought.

3. An Overview of the Tobacco Control Success Story Initiatives

As part of the *Next Stage* project, a series of 22 tobacco control 'success stories' from across the country were profiled and analyzed to gain greater insight into the factors, conditions, and mechanisms that contribute to local successes in tobacco control.[51] A better understanding of the 'how' of successful initiatives represents practical knowledge of potential value to other practitioners.

This sub-section describes the initiatives that were profiled and the key findings from their analysis. Later sub-sections discuss specific tobacco control topics, synthesizing findings from all of the *Next Stage* sub-projects including the success story initiatives.

Table 4 lists the success story initiatives grouped into the following categories: smoke-free areas, youth and young adults, cessation, and education and development. Appendix 2 provides a description of the approach taken to identify and profile the success story initiatives. Appendix 5 provides a synopsis of each initiative. The sub-project report provides additional details.

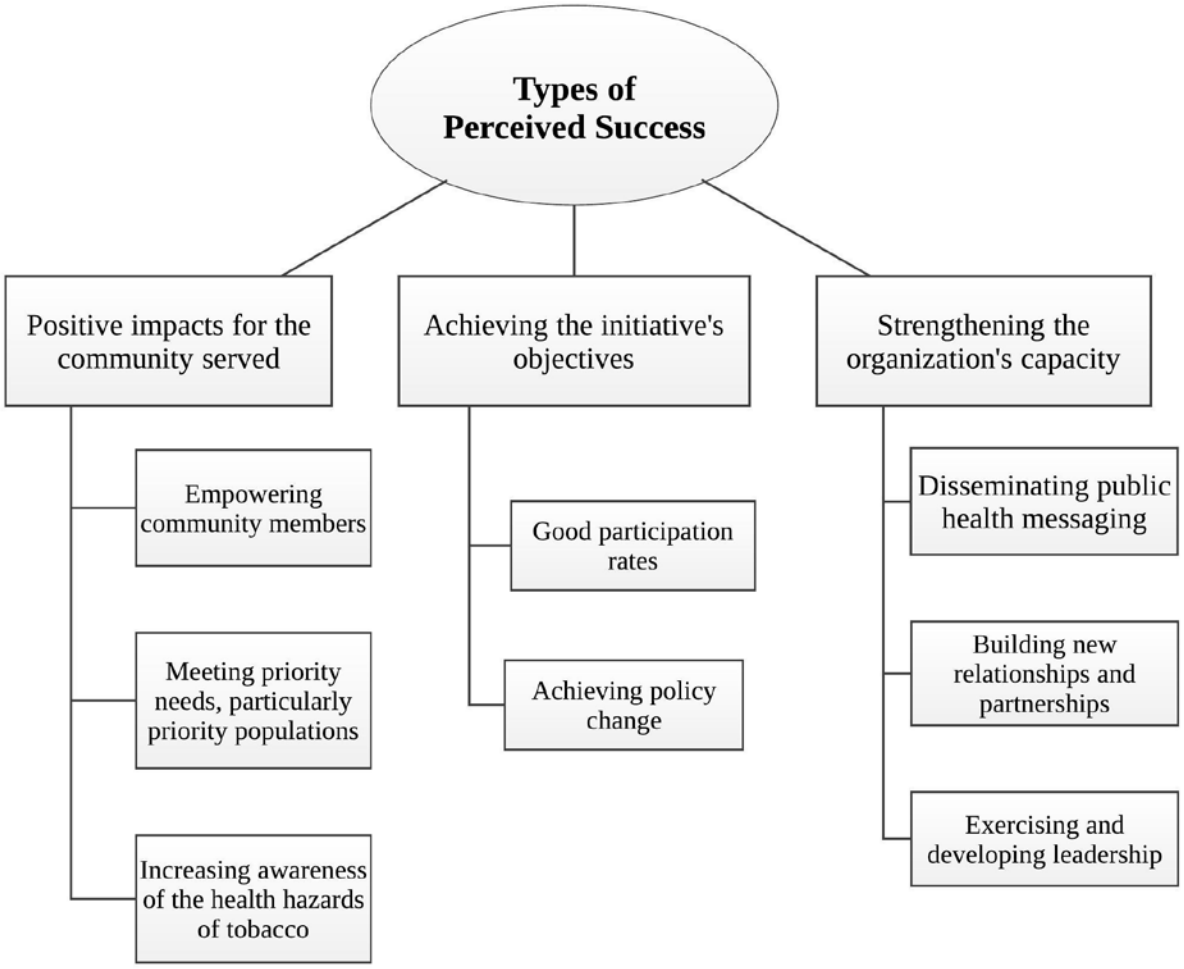
Table 4: List of Profiled Tobacco Control Success Story Initiatives

Category	Initiatives
Smoke-Free Areas /Places	Smoke-Free Places Legislation, *New Brunswick* Smoke-Free Vehicles By-law/Provincial Legislation, *Nova Scotia* Amendments to Smoke-Free Places Act, *Prince Edward Island* Smoke-Free Environment Policy, *Newfoundland* Blue Light Program, *Manitoba*
Youth/Young Adult - School-based initiatives - Youth Engagement Strategies	Quitters Unite*, *British Columbia* Flavour Gone, *Ontario* High School Grants, *Ontario*** Community Grants, *Ontario*** Don't be a Butthead, *Northwest Territories* DeFacto, *Québec*
Cessation - Counselling - Incentive Programs - NRT	Quitters Unite*, *British Columbia* Driven to Quit, *Ontario* TAR, *Saskatchewan* NICC Program in Mental Health & Addiction*, *British Columbia* Subsidized Nicotine Replacement Therapies, *Ontario* Quitpath, *Yukon* PACT*, *Saskatchewan*
Education and Development***	NICC Program in Mental Health & Addiction *, *British Columbia* Inuit Tobacco Free Network, *Nunavut* PACT*, *Saskatchewan* TRaC, *Alberta* RNAO, *Yukon*

*Some initiatives address more than one category.
**Profiles of two health units for each of the high school and community grant initiatives were conducted, thereby raising the total number of initiatives to 22.
***The findings from these initiatives are addressed in a subsequent section focused on staff education and development.
Appendix 5 provides a brief synopsis of each initiative.

Key informants described three broad categories of perceived success for the success story initiatives: positive impacts for the community being served; achieving the initiative's objectives; and, strengthening the organization's capacity (see Figure 15). The types of objectives described were predominantly process (e.g., participation rates) and intermediate-type outcomes (e.g., increase awareness, policy change).

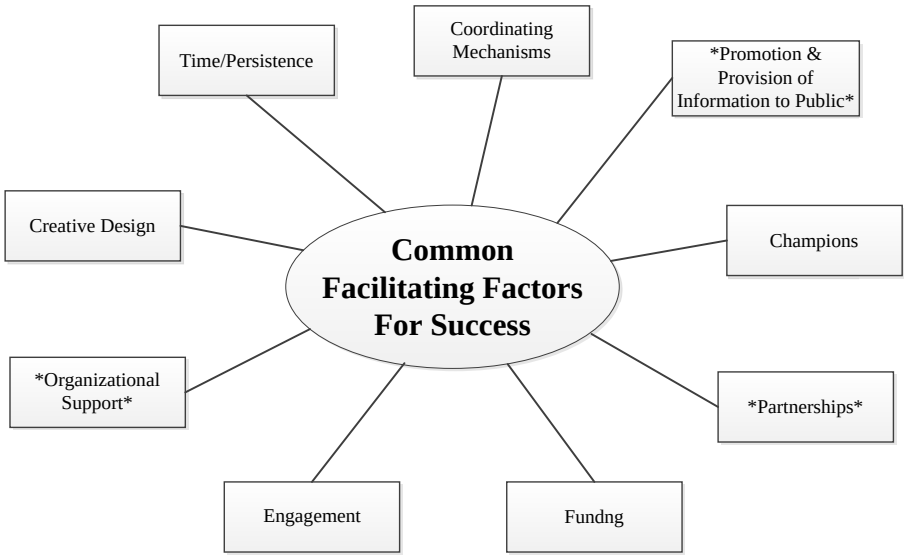
Figure 15: Types of Perceived Success Among Profiled Success Stories (n=22)



To better understand the 'ingredients' for success, the facilitating factors for success in these initiatives were explored with the key informants. Figure 16 illustrates the nine facilitating factors for success that were described. Among these, the three facilitators most consistently described among the initiatives included:

- Partnerships,
- Organizational support, and
- Promotion and provision of information to the public.

Figure 16: Summary of Facilitating Factors for Success, Success Story Profiles, (n=22)



The most commonly identified facilitating factors are marked with '*'.
Appendix 5 provides an overview of each factor.

How specific factors influenced success varied among the different categories of initiatives. For example, while the importance of 'partnerships' was commonly identified, variations existed in the 'who' and 'what' of these relationships for different types of initiatives. For example, partnerships in smoke-free area initiatives involved coordinating mechanisms among community participants, and in one initiative, enforcement through the leverage of existing resources among multiple organizations. In contrast, youth and young adult initiatives stressed the importance of strategic partnerships with schools and school boards, where relevant, to facilitate rapid uptake of initiatives. Linkages with NGOs and other public health organizations to enable effective youth advocacy were also highlighted. Appendix 5 and the success story sub-project report[51] provide further details.

While certain themes emerged among the facilitating factors and categories of initiatives, which facilitating factors predominated and how they influenced success varied among individual initiatives. The implication of this considerable variation by the nature and context of initiatives illustrates the importance of local/region-based action in order to engage relative stakeholders and tailor interventions to local circumstances. While the facilitating factors were identified from only 22 initiatives, the factors that emerged are consistent with the evidence reviews and information provided by public health key informants and workshop participants during other *Next Stage* sub-projects.

The next sub-sections integrate the findings from the specific categories of success story initiatives with other sub-project findings for the following areas of tobacco control practice: smoke-free areas, youth and young adults, and cessation. As previously noted, findings from the education and development-related initiatives are included later in this report.

4. Smoke-Free Areas

Exposure to environmental tobacco smoke is a health hazard known to cause a wide range of adverse health outcomes. Smoke-free area policies are a key strategy to prevent exposure of non-smokers to this hazard. In addition, in the context of comprehensive tobacco control, such policies also prevent initiation of smoking, support decisions to stop smoking, support recent quitters, and contribute to the denormalization of tobacco use.

In terms of how best to support the development and implementation of smoke-free policies, there is a paucity of research on the most effective ways to do so. Better practice recommendations from this project's literature review are listed in the text box.

Better Practice Recommendations for Policy Development & Implementation

1. Consideration of the policy context
2. Policy as part of a comprehensive program or strategy
3. Preparation, planning and logistics as central to policy success at both the development and implementation stages
4. Collaboration, leadership and support
5. Communication and media
6. Issue framing and information provision
7. Construction of the policy
8. Countering opposition
9. Enforcement
10. Policy reinforcement - monitoring, evaluating, and celebrating successes.

Borland T, Schwartz R. A literature review prepared by the Ontario Tobacco Research Unit for the Canadian Public Health Association. Toronto: OTRU, 2010.

Among the five smoke-free area success stories, the most frequently identified facilitating factors for success were: partnerships; senior management support; coordinating mechanisms; and, promotion and provision of information to the public. These highlighted facilitating factors are similar to the input provided by workshop participants and key informants (i.e., community support; promotional campaigns; use of evidence-based practices; and lessons learned from other jurisdictions), and illustrate many of the literature's better practice recommendations. For example, collaborative committees or councils were instrumental in the planning and implementation of policies, and leadership was critical from a variety of sources including from within communities, health authorities, provincial governments, and elected officials depending upon the specific initiative.

Provision of information to the public and decision makers was identified as important to gain credibility, win support, raise public demand for the policy, and raise awareness once the policy was implemented. Success stories also addressed enforcement, where relevant, highlighting partnerships, coordination of efforts between multiple enforcing organizations, as well as informing the public of complaint mechanisms. The sub-project report provides additional details.[51]

Enforcement

Guidelines from the international NGO community, as well as findings from the best/better practice initiatives, indicate the following to be effective components of an enforcement strategy:

- Early and visible enforcement following policy implementation;
- Placing onus on owners and individuals;
- Pursuing legal action if businesses repeatedly violate laws;
- Educational efforts aimed at the public to raise awareness and support for the law;
- Guidance materials for workplaces; and
- A combination of proactive and reactive enforcement and compliance lines.[49]

Facilitators for successful implementation identified by public health key informants included legislation that is enforceable by law and active compliance checks. Concern exists regarding the current compliance-check protocol for tobacco sales to minors, which does not accurately capture vendor non-compliance. Evaluation data reported that "the protocol was not realistic enough to capture vendor non-compliance since test shoppers are unable to lie about their age, they are strangers to store clerks, and sometimes the test shopper does not fit in with the area's ethnic culture."[3]

5. Youth and Young Adults

In the context of comprehensive tobacco control, prevention is most effective when implemented as part of a comprehensive strategy. High tobacco prices and smoke-free legislation aimed at protecting youth and young adults from exposure will also contribute to preventing initiation of tobacco use."[3] School and community environments play an important role in influencing the behaviour of young people, but school policies alone are not sufficient to prevent initiation or tobacco use.[3] For example, a recent study of randomly sampled secondary schools in five Canadian provinces indicated that the ideal school setting that supports low student smoking levels is located in a neighbourhood where the cost of cigarettes is high, provides tobacco prevention education, and has a policy prohibiting smoking.[52]

The literature has been historically undecided about the effectiveness of school-based prevention programs, although there is evidence that school-based programs can work and are most effective when implemented in high-risk contexts.[3] Best practice recommendations from the project's literature review suggest to:

- Include active learning, awareness of influences of smoking, skill building, deconstructing media messages that promote tobacco use, and youth involvement in developing and implementing interventions;
- Implement programs in conjunction with other community tobacco control initiatives;
- Adapt to the needs and cultures of minority groups;
- Adapt to fit with different education curricula;
- Take advantage of electronic media and communications; and

- Comprise at least 15 sessions and include booster sessions.[49]

There is also some limited evidence that supports the effectiveness of community interventions compared to single interventions. Best practice recommendations suggest to:

- Build upon elements of existing programs that have been shown to be effective rather than repeating methods that have achieved limited success;
- Be flexible to the variability between communities so that the different components of a given program can be modified to achieve acceptability;
- Undertake developmental work with representative samples of the target audience to ensure appropriate messages and activities are implemented;
- Use theoretical constructs about how behaviours are acquired and maintained to develop program messages and activities (i.e., Social Learning Theory); and
- Ensure community activities reach the intended audience in order to be successful in influencing their behaviour. [49]

Generally, a lack of research on the effectiveness of youth engagement in tobacco control activities exists, however, examples of activities found among programs that reflect youth development principles include peer education; planning of school and community-based activities such as cessation services; forming youth advisory and action committees; and, developing campaigns and action materials. Also, the employment of youth advisors from underserved neighbourhoods and the formation of partnerships within the target communities may help facilitate the recruitment of underserved youth into youth-oriented tobacco initiatives.[49] There is also little research regarding effective prevention and cessation programs for young adults.

Principles for increasing participation of youth in smoking cessation interventions include:

- Establishment of non-smoking as a social norm;
- Availability of effective youth-specific smoking cessation interventions;
- Evidence-oriented recruitment;
- Positive branding of cessation interventions;
- Choosing the right language;
- Dissemination of information about cessation aids;
- Being proactive and using a personal touch;
- Using incentives; and
- Creating partnership with stakeholders in youth (health) matters.[53]

Public health key informants identified that youth buy-in and involvement, as well as youth-specific approaches (e.g., peer-to-peer mentoring, mascots) were key facilitators of successful implementation. The most commonly identified facilitating factors in several youth-focused success stories were partnerships, engagement, and funding. The identified themes among these initiatives illustrate many of the features from the literature, including the formation of youth

advisory and action committees, the employment of youth advisors, and the development of campaigns and action materials. For example, many of the youth initiatives utilized user-generated material, social media and other non-conventional methods. Success story key informants indicated the importance of organizations' actions being aligned with the needs and principles of youth engagement approaches. This included supporting youth to proceed with their vision for the projects, facilitating staff interaction with programs by providing flexibility, and the provision of training to staff and youth.

6. Cessation

Tobacco use cessation was one of the most frequently identified tobacco control issues among public health key informants over the course of this project. While smoking rates have reduced over time, 4.5 million smokers remain in this country. According to survey work conducted by the Lung Association, 79% of current smokers want to quit and have tried quitting.[54] In addition, immediate health benefits and a reduction in health care costs are predominantly associated with smoking cessation. Considering the healthcare cost savings of cessation, and the limited extent of existing public health tobacco control resources, costs related to establishing the clinical aspects of cessation—such as the provision of subsidized/free NRT and individual counselling—should not be borne by public health budgets.

Socioeconomic disparities exist at each step of the quitting process (from quit intentions to making quit attempts to achieving smoking abstinence), suggesting these disparities need to be considered when developing and implementing cessation interventions.[55] In addition to cessation-specific initiatives, many of the components of a comprehensive tobacco strategy create a supportive environment that motivates individuals to quit and is conducive to remaining smoke-free.

The project's literature review indicated that smoking cessation interventions are effective when delivered by a variety of health professionals (e.g., physicians, dentists, and nurses) across a broad range of settings and situations. Individual (brief and intensive) therapy, group therapy, and proactive telephone counselling that incorporate support and encouragement appear to be most effective for reducing tobacco use. Four or more counselling sessions are also recommended to increase success. Tailored self-help materials may aid in cessation, and motivational interviewing lasting at least 20 minutes is encouraged for individuals not interested in quitting. Research examining the success of cell-phone and web-based smoking interventions is promising, however this is a relatively new area of cessation and more research is needed to deliver information on best/better practices.[49] Nicotine replacement therapy (NRT) as well as Bupropion and Varenicline are effective cessation aids. The use of pharmacotherapy as an adjunct to behavioural therapy is more effective than when either is used on its own.[49]

Health professional associations have jointly agreed on their contributing role to smoking cessation.[56] To support clinical practice, CAN-ADAPTT provides practice-informed and evidence-based smoking cessation guidelines.[57] However, a key challenge is their systemic application in a range of clinical settings from primary care, to acute care, to the care of specific priority populations such as pregnant women and those suffering from mental health and addictions conditions. Education of health professionals in providing cessation interventions is highly underdeveloped. Financial barriers to pharmacological cessation aids are also a major challenge. Within Canada, Québec offers the most comprehensive coverage of smoking cessation medications. From 2000 to 2005, approximately $66M was invested in smoking cessation therapies, while economic analysis for this time period "found that each percentage-point decrease in smoking prevalence would save $114.3 million. This translates into savings of $686 million to Québec society, including $246 million for the Québec health care system alone, between 2000 and 2005. The program was also effective at reaching financially disadvantaged tobacco users."[3]

There is increasing interest in systematizing cessation in healthcare settings. The Ottawa Heart Institute has developed the '*Ottawa Model for Smoking Cessation Best Practices'*. Implementation of the Ottawa Model "has led to an absolute 15% increase in long-term quit rates at the Ottawa Hospital (from 29% to 44% at 6 months)."[58] An evaluation of the first nine secondary care hospitals to implement the program revealed an 11.1% increase in long-term cessation rates (from 18.3% to 29.4%).[58]

Ottawa Model for Smoking Cessation Best Practices

1. Tobacco-use queried and documented for all admissions and visits.
2. Training (i.e., workshops, in-services, new staff orientation) for tobacco dependence treatment offered regularly to staff.
3. Program responsibilities are designated to staff (i.e., program coordination, counselling, education, consultation).
4. Tobacco dependence treatment included on clinic forms, treatment pathways, care maps, Kardexes, etc.
5. Self-help materials readily available to patients, family members, and staff.
6. Referral to community resources readily available.
7. Pharmacotherapy (Nicotine Replacement Therapy, Bupropion, Varenicline) available with prescription or through hospital formulary.
8. Processes to follow-up tobacco users for at least one month after initial consultation.
9. Processes to evaluate the degree to which healthcare providers are identifying, documenting, and treating patients who use tobacco.
10. Processes to provide feedback to healthcare providers about performance and program effectiveness.

Similarly, the creation of Alberta Health Services has facilitated greater coordination of addiction and public health resources with the institution of system performance measures (e.g., percentage of patients who smoke discharged with a smoking cessation plan), establishment and promotion of a range of cessation support services, and healthcare provider education.

According to project key informants, facilitators of successful implementation include increased accessibility to programs and services including NRT, as well as one-on-one discussion with cessation counsellors and availability of personal support. Employer and management support facilitate implementation in workplace settings.

Among the cessation success stories, the most commonly identified facilitating factors were partnerships, funding, and promotion/provision of information to the public. As per previous descriptions, how each applied to particular initiatives varied depending on the specific context. Two of the cessation initiatives targeted specific sub-populations. A key informant for the initiative targeting those with mental health issues and addictions indicated that quit attempts in this population are different from those of the general population and therefore the intervention was tailored accordingly. The second initiative worked with an Aboriginal population and employed an Aboriginal advisor who met with Elders and offered one of their stories as the basis for the cessation approach to better reach the target audience.

7. Summary

This section provided a brief, high-level overview of comprehensive tobacco control, followed by a more detailed synthesis of the evidence and experience of several *Next Stage* sub-projects in applying specific tobacco control initiatives to address community needs and contexts. The findings from 22 tobacco control 'success stories' were profiled to gain greater insight into the facilitating factors for successful tobacco control in the local/regional public health context. While common facilitating factors were identified among these initiatives, the relative importance and the means by which these factors influence implementation are highly context specific. The implication is that initiatives need to be carefully planned and consider a range of inter-related factors, which is consistent with health promotion planning models.[59] Furthermore, individual initiatives need to be considered in the context of the overall comprehensive tobacco control strategy and how they reinforce other initiatives in the strategy. Comprehensive tobacco control strategies are required at each system level since local/regional public health tobacco control efforts do not exist in isolation, but are highly reliant on federal and P/T system levels for providing the context for their work. The need for more comprehensive approaches to cessation was one of the most commonly heard themes during the *Next Stage* project and is specifically addressed in the following recommendations.

It is recommended that:

> **Comprehensive tobacco elimination/control strategies be established at federal, provincial/territorial, and local/regional levels. This includes the establishment of a renewed and comprehensive Federal Tobacco Control Strategy with the explicit goal of eliminating tobacco use in Canada.**
>
> > **Within all levels of comprehensive tobacco control strategies, effective cessation interventions be included to support systematizing cessation efforts, with a 'no wrong door' approach that will ensure smokers' access to information, counselling, medication, and other supports where and when they need them. Key components include:**
> >
> > - **Creating a supportive social and physical environment to encourage cessation;**
> > - **Providing cessation media campaigns;**

- **Establishing quit lines and other counselling mechanisms; and**
- **Ensuring the provision of cessation interventions including cessation medication and Nicotine Replacement Therapy (NRT), behavioural support, resources for self-help and support through providers and groups, and subsidized cessation medication and NRT, particularly for lower income groups.**

E. Tobacco Control and Health Inequities

> The continued existence of disparities in tobacco use among sub-populations and, the potential that populations may be missed by universal approaches, or experience adverse effects from them, indicate that a mix of universal and targeted approaches is required.

A population health approach is concerned with not only achieving more favourable health outcomes in the population overall, but also with reducing disparities in health outcomes among population sub-groups. This perspective is reflected in the goals of comprehensive tobacco control strategies. A full treatment of tobacco-related equity concerns is beyond the scope of this report, however key considerations include the following:

- As outlined in Chapter 3, many examples of disparities in smoking status among population sub-groups continue to exist despite improvements in average smoking rates.
- A significant proportion (as much as 50%) of the difference in overall mortality between the highest and lowest social strata of developed societies can be attributed to tobacco use and exposure (i.e., tobacco use itself is significantly responsible for observed health inequities).
- Tobacco use by certain groups involves a variety of factors, including social, economic, political, and historical realities.
- Universal interventions to reduce smoking, particularly taxes on tobacco products, have a greater effect on low-income groups than high-income groups and therefore can reduce tobacco-related disparities. However, not all lower income smokers will quit, and unintended consequences of price increases must be considered and addressed.[3,41]

The recently published WHO report, *Equity, Social Determinants, and Public Health Programmes*, points out that targeted approaches will be necessary in addition to population approaches in order for parties to fulfill the articles of the *WHO Framework Convention on Tobacco Control (FCTC)*.[60] As noted by Cohen, "while universal tobacco control policies and programs are still important, creating additional tailored supports to ensure that vulnerable populations are not placed at an even greater disadvantage by such policies will likely reduce tobacco use prevalence."[61] A recent summary of the evidence suggests that targeted approaches can focus on populations that may be missed by universal approaches or may experience adverse effects from them (e.g., coupling tobacco tax increases with publicly financed smoking cessation initiatives that are structured specifically to target low-income tobacco users).[3]

In addition, several authors have recommended that tobacco control interventions, policies, and programs be implemented with gender, social justice, and equity lenses.[62] Without consideration of the unique needs and contextual factors of population sub-groups, the impact could be lower participation, less access to interventions, failed change attempts, and disengagement from future

change attempts, especially among under-served populations who already have lower cessation rates.[63] In addition, public health organizations can "link comprehensive tobacco control with a [broader] health equity agenda which addresses the underlying determinants of tobacco use and explores the impact of a range of policy options."[3]

One of the reasons for the range of perspectives regarding the appropriate balance between universal and targeted approaches is the lack of existing evidence to inform effective interventions in priority populations. The *Next Stage* literature review found "an extreme paucity of research and availability of evaluated public health interventions on best or promising practices for prevention, protection and cessation for priority populations at a local/regional level. While there is emerging research on strategies for youth, pregnant women and mental health and addiction populations, evidence is especially lacking for Aboriginal, lesbian, gay, bisexual, transgender (LGBT) and socio-economically deprived populations, blue collar workers and young adults."[49] In seeking a balance between universal and targeted approaches, considerations of reach and cost also need to be considered.

As part of the *Next Stage* project, an additional focused review of the grey literature was conducted, but observed that "very little published or unpublished literature [was] found on best or promising practices for prevention, protection and cessation for vulnerable populations at a local/regional level."[62] What did exist was "often not detailed in what the components of the intervention or tailoring entail, or may not provide outcome evaluations. Furthermore, program information was not always available online."[62]

The U.S. CDC recommends that in order to identify and eliminate tobacco-related disparities, the following actions need to be taken:

- Undertake population assessments;
- Consult with the populations of interest and the organizations working with them;
- Ensure that disparity issues are an integral part of local/regional tobacco control strategic plans;
- Provide adequate funding to organizations that can effectively reach, involve, and mobilize identified specific populations;
- Provide culturally competent technical assistance and training to funded projects;
- Provide health communications to address tobacco-related disparities in appropriate languages that support community-level interventions; and
- Ensure that Quit Line services are culturally competent and have adequate reach and intensity to meet the required needs of population subgroups.[33]

The following sub-section provides better/best practice recommendations for selected priority populations examined for this project. Additional details may be found in the individual literature reviews.[49,62]

1. Aboriginal Populations

Despite the continuing high rates of tobacco use among Aboriginal populations, evidence regarding effective interventions remains limited. In addition, and as noted earlier in this report, there is no federal tobacco strategy for Aboriginal peoples as the First Nations and Inuit Tobacco Control Strategy (FNITCS) was discontinued in 2006 by the federal government.[64] While limitations of this strategy have been described,[64] it has yet to be replaced.

Though little Canadian information exists, the literature does point to the need for capacity building (i.e., cessation training) of Aboriginal health workers (AHWs) or community health representatives (CHRs), in their own language, and strong involvement of Aboriginal community members to address tobacco control in their own communities (e.g., smoke-free policies and programs).[62] Many Aboriginal communities do not have smoke-free policies, which may be a reason for less demand for prevention and cessation services. Within provinces, public health programs and services in Aboriginal communities tend to operate separately from provincial systems, although such communities have the option to establish their own by-laws.

As outlined in a sub-project review, a number of programs are underway involving Aboriginal populations. For example, while there are some interventions identified that promote smoke-free homes (e.g., Blue Light Campaign in Inuit communities), evaluation results are not yet available. The challenge of the current lack of best practice evidence is that even if communities are ready to act, they have little guidance to help increase the chance of implementing successful programs.[62]

Australia offers a greater body of research regarding cessation in Aboriginal populations, although findings may not be applicable to the Canadian context. Reviews of such programs demonstrate the potential for initiatives that combine NRT with face-to-face counselling or support, and train Aboriginal health workers in brief cessation counselling. Further, suggestions from the Canadian grey literature note that while knowledge is lacking about intentions to quit among Aboriginal populations, motivational enhancement may be a more successful strategy for increasing quit rates than simply providing programs tailored to individuals who already have high intentions of quitting.[62]

Existing cessation programs for Aboriginal populations identified through best/better practice sources were developed in consultation with Aboriginal community members and incorporated cultural themes into teachings and counselling. Informal group sessions and holistic programming were also characteristic of these programs. Further, significant support was provided to reduce the barriers preventing adults from attending sessions. Providers included trained facilitators, former Aboriginal smokers and health promotion personnel, and interventions took place in schools, in communities, or in community health centres.[62]

This project's literature review pointed to several characteristics of promising interventions/practices for Aboriginal populations, which include:

- Offering positive messages that reflect the strengths and values of culture and communities while maintaining social relevance;
- Being responsive to the emotional, physical, social, and spiritual needs of Aboriginal people who smoke and using a holistic approach that is consistent with Aboriginal teachings;
- Providing client supports to eliminate barriers to participation and mitigate some of the social and economic pressures;
- Orienting interventions towards a community rather than an individual approach;
- Ensuring materials and approaches have a high degree of relevance to the community;
- Ensuring continuity of projects and sustained funding and delivery to build capacity and long-term change; and
- Involving Aboriginal people throughout all phases of work from research, through the development of tobacco control strategies and solutions.[62]

Suggestions from public health key informants provided more detailed suggestions included:

- Needing to work in collaboration with communities, support internal champions, identify success stories, take small steps, and work on new communications and new ways to provide messages;
- Increasing the recognition of First Nations' cultural connections to the traditional use of tobacco and what it means for cessation. Also, greater appreciation of the different cultural contexts is needed; for example, understanding the complexity of demanding one's home be smoke-free, when homes are traditionally meant to be respectfully open to everyone, including smokers;
- Utilizing a community development approach to reducing tobacco use, as well as ongoing support at the community level. Community members must be part of identifying/framing the issue and finding a solution;
- Tailoring interventions for pregnant smokers, which have been adapted to meet the requirements of various Aboriginal communities;
- Exploring the appropriateness of social networking tools (e.g., Facebook, Twitter) for smoking cessation and engagement interventions (e.g., videos on YouTube); and
- Providing training and support to communities.[65]

2. Women (Pregnant and Post-Partum)

For those women who smoke at the time of pregnancy, promoting cessation throughout the pregnancy is encouraged, with a view to maintaining smoke-free status post-partum. The importance of incorporating tobacco interventions into standard antenatal care is emphasized in the literature. However, many practitioners do not actively engage in repeated screening, counselling, and treatment; guidelines and inquiries are generally limited to the first visit, with follow-up inquiries and advisement rarely occurring. [62]

Due to the relationship between smoking during pregnancy and socio-economic deprivation, wider community strategies to reduce social inequalities in health should be reflected in tobacco reduction strategies. Promising strategies identified in the grey literature include shifting the focus of interventions to include women's health as motivation for cessation; increased tailoring of interventions; and the incorporation of harm reduction, stigma reduction, and a woman-centred approach into clinical practice. The U.S. Department of Health and Human Services further recommends the provision of face-to-face psychosocial interventions and counselling that exceed minimal advice to quit, at the first visit and throughout pregnancy.[62]

3. Mental Health and Addictions

The integration of tobacco interventions into the mental health and addictions setting is another important component of smoking cessation interventions. However, Canada has not yet fully addressed tobacco use in its approach to care of this population. It is common for individuals to enter mental health settings as non-smokers and exit as smokers, and a recent survey of Canadian addictions-treatment programs indicated that most facilities stated their program placed "little emphasis" on smoking.[62]

Most reviews find that a combination of tailored psychological (cognitive behaviour therapy, motivational enhancement) and pharmacological interventions (NRT, Bupropion) is useful in reducing tobacco use, however they stress the need for more research in this area. One best/better practice initiative provided a cessation program for individuals with psychiatric disorders. Lessons learned from this experience include the importance of teaching slowly using repetitive messages, reviewing previous learning, and providing frequent rewards for short-term successes.[62]

4. Low Socio-Economic Status

While not always explicitly expressed, low socio-economic status (SES) is an underlying factor for many of the priority populations. As previously noted, existing evidence is especially lacking for socio-economically disadvantaged populations.[49] Tobacco use in low SES populations is often taken up as a stress reliever from the social and economic pressures they face. The sensitivity of low SES smokers to price increases has already been discussed earlier in this section. The Ontario *Evidence to Guide Action* report notes that well-crafted media campaigns can work with different population groups.[3] Access to cessation-related information, services, and pharmacological aids tends to be a challenge for low SES populations. Strategies that may support smoking cessation include bringing services to where the people are, such as dental health clinics, pharmacy-based services or community centres; ensuring that services are accessible (including time and format); providing client support (meals, transportation or childcare) to help address some of the socio-economic pressures; and, subsidized or free NRT and pharmacotherapy.[62]

It is recommended that:

Comprehensive tobacco control strategies address the disparities in tobacco use among population sub-groups including:

- **Tobacco control interventions, policies, and programs be implemented with a population health/health equity lens;**
- **Targeted approaches be utilized in addition to universal approaches to focus on those populations that may be missed by universal approaches or experience adverse effects from them; and**
- **Tobacco control be linked to a health equity agenda that addresses the underlying determinants of tobacco use and explores the impact of a range of policy options.**

A comprehensive, federal Aboriginal tobacco control strategy be re-established that provides dedicated tobacco control capacity for Aboriginal populations. Such a strategy should consider:

- **High involvement of Aboriginal peoples in research and development of tobacco control strategies;**
- **Positive messages that reflect the strengths and values of culture and communities while maintaining social relevance, using Elders' wisdom, tradition, and knowledge;**
- **Responsiveness to the emotional, physical, social, and spiritual needs of Aboriginal people who use tobacco, adopting a holistic approach that is consistent with Aboriginal teachings;**
- **Provision of client supports to eliminate barriers to participation and mitigate some of the social and economic pressures;**
- **Interventions that approach tobacco with a community focus (e.g., opportunity to develop, implement, and enforce policies and by-laws in Aboriginal communities);**
- **Materials and approaches that have a high degree of relevance to the community; and,**
- **Continuity of projects with sustained funding and delivery to build capacity and long-term change.**

F. Continuing Learning Needs and Education

> Tobacco-related education of the public health workforce is an important foundational element for implementing comprehensive tobacco control strategies.

One of the most important assets of public health systems is its workforce.[29] Staff learning and development is a key organizational strategy to support individual and organizational performance and needs to be tailored to staff needs and roles. While this may vary depending on local context, three broad categories of staff can be identified with respect to tobacco-related education: all staff; staff providing 1:1 services; and, dedicated tobacco control staff.

The majority of local/regional public health staff are typically prepared at the undergraduate level. While most new public health employees will have been previously exposed to tobacco-related issues in their training, key informants indicated that more opportunities exist to build tobacco control into orientation and continuing professional development (e.g., PHAC's *Skills Enhancement for Public Health* online modules).

Depending upon the jurisdiction, some public health staff provide direct services to individuals and families; childhood immunizations, family home visits, and sexual health clinic services are common examples. These interactions, some of which are targeted at higher risk populations, provide an opportunity to assess and advise on tobacco use and exposure. Public health organizations can systematize this intervention by institutionalizing it within relevant programs supported by appropriate policies, education, and performance measurement. Some key informants' organizations are currently pursuing this strategy (e.g., home-visiting nursing program).

More learning opportunities are underway for brief-contact cessation interventions. For example, the national, nursing best-practice, smoking cessation initiative of the Registered Nurses Association of Ontario (RNAO) includes an e-learning course, as well as a series of national smoking cessation workshops.[xi] Other learning opportunities also exist, although some are region- or province-specific.

The most frequently identified facilitators of success among five cessation-related educational initiatives were the existence of champions, funding, partnerships, and staff interest and willingness to participate in educational opportunities. The relative importance of the facilitating

[xi] "Helping People Quit Smoking": 1.5 hr e-learning course (http://www.rnao.org/smokingCessation/) ; National smoking cessation workshops (http://tobaccofreernao.ca/en/current-projects/smoking-cessation-champion-network)

factors and how they applied tended to vary among the initiatives. Further details are provided in Appendix 5 and the success stories sub-project report.[66]

Key informant interviews confirmed that in many local/regional organizations, the dedicated tobacco control workforce, where it exists, is reflective of the overall workforce in being predominantly prepared at the undergraduate level. New tobacco control staff typically enter their positions without previous tobacco control experience or training. This is not dissimilar to other specialized public health programmatic areas (e.g., communicable disease control) in which new staff require considerable orientation and preparation in order for them to fulfil their program-specific responsibilities.

To address the needs of new tobacco control staff, the Ontario Tobacco Research Unit (OTRU) has developed a basic online tobacco control course, Tobacco and Public Health: from Theory to Practice. The course is available in English and French, is self-paced, and free to anyone interested in taking it. The course consists of modules for protection, prevention, cessation and evaluation, and was developed by leading tobacco control experts. It covers a range of topics, from the biology and epidemiology of tobacco use, to programs, policies, treatment options, and strategies for countering tobacco industry opposition. On average, each module takes two to three hours to complete. Since its launch in 2006, over 5,400 people have taken the course with about one-third from local/regional public health organizations. Almost two-thirds of the participants are from Ontario (63%), followed by B.C. (17%) and Alberta (12%). On a proportional basis to population, Ontario is clearly over-represented, which may reflect OTRU's home province, as well as provincial tobacco control funding being contingent on all public health unit tobacco control staff in Ontario taking the course.[66]

Limited information is available regarding the ongoing learning needs of tobacco control staff. A comprehensive needs assessment conducted in Ontario categorized tobacco control staff into 11 distinct job categories and, after assessing 11 competency domains for each, determined that the areas with the highest percentages of fundamental learning needs were:

- Evaluation and monitoring;
- Socio-cultural domain; and
- Program development and implementation.[67]

Key informants interviewed for this project were asked about priorities for the professional development of existing tobacco control staff. The most commonly identified area was best approaches for public health staff to support policy changes to systematize tobacco policies, particularly with respect to cessation within healthcare organizations. In several organizations, public health staff were actively involved in influencing or leading such changes within their health authorities. Additional areas for continuing education that were identified included how best to target various populations including hard-to-reach populations, youth, and young adults. This point was also emphasized in the success story initiatives.

There are limited learning opportunities available for tobacco control staff on a national basis, although a number of Ontario-based courses and educational workshops can be found.[xii] Some key informants indicated that they had, in the past, arranged for instructors/experts to come to their province, which substantially reduced the number of staff that needed to travel long distances. The greater use of distance education such as webinars was also suggested.

In addition to the three preceding tobacco-related staff roles, managers within public health organizations can influence tobacco control efforts in a myriad of ways (e.g., priority setting, resource allocation, establishing work structures, supporting innovation, etc.). In many public health organizations, there is a preference for management positions to be filled by Masters-level staff. Although Masters of Public Health (MPH)-type programs are still evolving across Canada, and are serving educational needs beyond the local/regional public health workforce, a key audience for these MPH programs is existing public health staff who are likely to fulfil leadership/manager roles in public health organizations. These programs, therefore, may provide an opportunity to orient future public health leaders to tobacco control concepts and issues. Very few universities currently have specific courses on tobacco issues, but universities indicated that tobacco issues are discussed or used as examples in most of their courses, although the extent to which this occurs is unknown. To foster consistency and avoid unnecessary duplication of efforts, Public Health Schools and Programs should be engaged to seek a coordinated approach to comprehensively integrating tobacco control concepts and examples throughout institutions' public health graduate curriculum.

It is recommended that:[xiii]

> **Continuing learning needs and the education of the public health workforce be pursued by:**
>
> - **Embedding tobacco control concepts and examples within the orientation and continuing education of all public health staff;**
> - **Assessing opportunities for systematically incorporating brief-contact cessation interventions into existing 1:1 programs and services;**
> - **Supporting and requiring new tobacco control staff to take the free, online, bilingual course: *Tobacco and Public Health: From Theory to Practice*;**
> - **Assessing and addressing tobacco control continuing education needs over time on a provincial/territorial and national basis; and**
> - **Seeking the engagement of Canadian Public Health Schools and Programs in a coordinated approach to comprehensively integrate tobacco control concepts and examples throughout institutions' public health graduate curriculum.**

[xii] PTCC: http://www.ptcc-cfc.on.ca/english/Site-Home/
[xiii] More detailed recommendations from the sub-project report are provided in Appendix 6.

G. Research and Knowledge Exchange

> While there is a considerable body of tobacco control-related evidence and experience, many new areas requiring increased understanding have emerged, including the most effective approaches for priority populations. The experience accumulated at the local/regional level across the country represents important practical knowledge likely of benefit for other local/regional organizations.

Considerable experience and evidence exists for comprehensive tobacco control and predominantly universal-type approaches—such as taxation, mass media, and smoke-free space policies. However, gaps remain regarding the most effective ways to support the development and implementation of such policies and their enforcement. Among different population segments, numerous gaps and challenges continue regarding the availability of evidence-based research to inform effective practice. Examples of these gaps and challenges include, but are not limited to:

- Youth: school-based prevention programs, youth engagement strategies, and strategies for youth outside the school system;
- Young adults: prevention and cessation strategies;
- Priority populations: prevention, protection, and cessation approaches for these populations at a local/regional level. As noted earlier, while there is emerging research on strategies for pregnant women and mental health and addiction populations, evidence is especially lacking for Aboriginal, LGBT, socio-economically deprived populations, and blue collar workers.[49,62]

In addition, this project's literature review found that many of the initiatives and interventions identified through the best/better practice sources were dated. It states that "the tobacco control climate in Canada has evolved over the past ten years and the documentation and evaluation of programs, policies and practices specific to the current Canadian context are required (i.e., smoking restrictions in multi-unit dwellings (MUDs), on restaurant patios and outside doorways, smoke-free parks and recreation, contraband, point-of-sale purchasing, plain packaging, retailer density and licensing schemes, comprehensive cessation services and web-assisted tobacco interventions (WATIs)."[49]

There is also an opportunity to foster innovation and knowledge development through the support of local/regional projects and knowledge exchange. Potential areas where federal support could increase knowledge and knowledge exchange in local/regional settings include:

- In partnership with Aboriginal populations, planning and evaluating tobacco control initiatives with these populations;

- Implementing and evaluating innovative local policy initiatives;
- Planning and evaluating comprehensive approaches to priority populations/settings (e.g., schools, workplaces, healthcare institutions); and
- Fostering interaction between research and practice communities to support knowledge exchange.

It is recommended that:

> **Key federal organizations, including Health Canada, the Public Health Agency of Canada, and the Canadian Institutes of Health Research (CIHR), actively support the development and synthesis of the evidence base and knowledge exchange for local tobacco control initiatives including those targeting priority populations.**
>
> **Health Canada support a comprehensive range of tobacco control projects to foster innovation and the building of capacity, knowledge development, and exchange among local/regional public health organizations.**

1. Inter-Organizational Linkages and Information Exchange

According to this project's organizational survey, the vast majority (88%) of local/regional public health organizations network with each other within the same P/T system, but only rarely do so with local/regional organizations in other P/T jurisdictions. Yet, there is considerable experience accumulated at the local/regional level across the country, representing a wealth of important and practical knowledge that could benefit all local/regional organizations working in tobacco control.[68] For example, local public health practice is context specific, and peer organizations may more likely exist outside a particular P/T jurisdiction than within one (e.g., large urban, rural, specific priority populations, etc.).

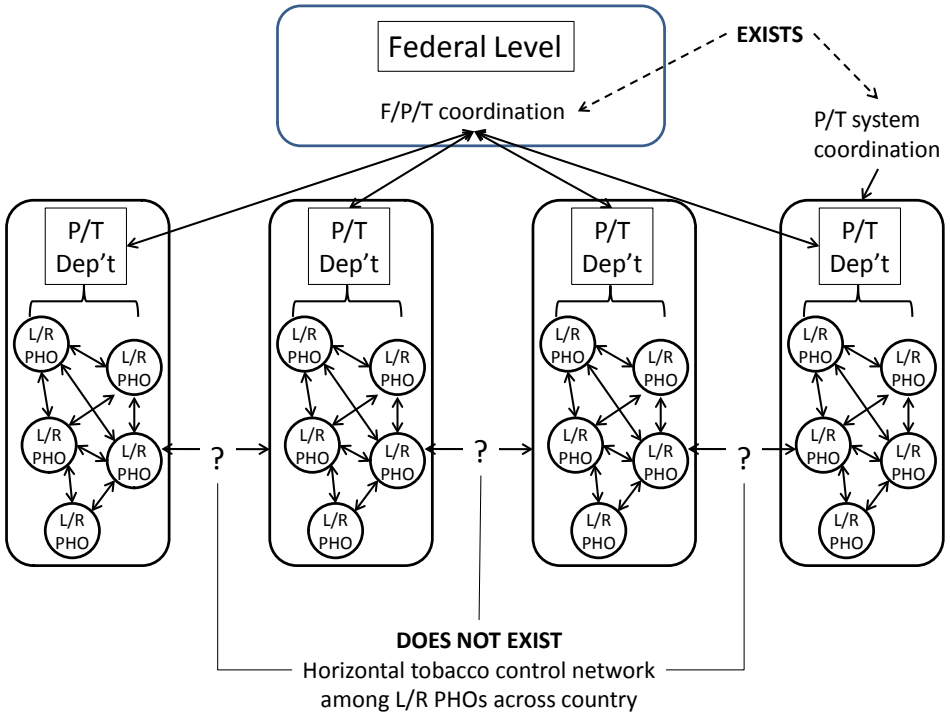
There is tremendous value in connecting, sharing, and learning among these front-line organizations on a pan-Canadian basis, particularly as innovative approaches are pursued (e.g., new smoke-free air policies; new policies to restrict the supply of tobacco; and addressing the needs of priority population groups). For example, the success stories profiled in this project provide information on the facilitating factors for the planning and implementation of a wide range of initiatives. This type of practical knowledge would be beneficial for public health staff in other organizations and could foster further knowledge sharing among local/regional staff.

The extent and interest for greater networking within and across P/T systems is not unique to tobacco control. Recognizing the need for greater horizontal knowledge exchange at the local/regional level, new initiatives such as the National Collaborating Centres (NCCs) for

Public Health[xiv] have been developed to promote and improve the use of evidence to strengthen public health practices and policies with a particular emphasis on local/regional public health organizations. Similarly, an Urban Public Health Network (UPHN)[xv] has been established among Canada's 18 largest cities to address public health issues common to urban populations and to develop strategies to address the issues. These initiatives indicate the interest and need to establish and support pan-Canadian networks involving local/regional public health organizations to foster information and knowledge exchange.

As shown in the following Figure, while there are Federal/Provincial/Territorial and intra-P/T coordination mechanisms for tobacco control, the lack of a mechanism to facilitate networking among local/regional organizations across the country is an important structural gap since a tobacco control network[xvi] would facilitate new connections, enable collaboration, collective action and knowledge exchange, and be a source of information on new and emerging programs and practices. The further dissemination of information would be facilitated by existing local and intra-P/T networks.

Figure 17: Conceptual Model of Networking among Public Health Organizations in Canada



P/T: provincial/territorial; L/R PHO: local/regional public health organization; Dep't: department

[xiv] Six NCCs include: Aboriginal Health, Environmental Health, Infectious Diseases, Methods and Tools, Health Public Policy, and Determinants of Health - http://www.nccph.ca/en/home.aspx
[xv] Urban Public Health Network - http://www.uphn.ca/
[xvi] Networks are relational organizational forms that involve interconnected individuals, groups, or organizations within a specific domain of knowledge and practice that interact socially and share knowledge with each other to achieve a common goal.[68]

In exploring the concept of a pan-Canadian network of local/regional public health organizations working in tobacco control, the vast majority of public health practitioners surveyed indicated that such a network:

- Should facilitate new connections to others working in tobacco control;
- Strengthen existing connections with tobacco control colleagues;
- Enable new collaborations with others;
- Enable sharing of knowledge and experience with others; and
- Provide knowledge of new and emerging programs and practices.

In addition, the most commonly identified knowledge and information needs that practitioners expect a pan-Canadian network to address include:

- Program/interventions for youth and young adults;
- Best practices in tobacco control including public education and counter-marketing, and best practices for specific sub-populations;
- Information on successful tobacco control initiatives/programs across Canada; and
- Emerging and promising practices.

An effective model will be more than a website of resources. In order to be relevant and have impact, a pan-Canadian tobacco control network needs capacity to engage the tobacco control community, identify and profile success stories and emerging practices, and facilitate connections among local tobacco control staff. Appendix 7 provides a list of key elements for network success identified in a review conducted by the NCC for Methods and Tools. The *Next Stage* project also conducted an environmental scan to identify knowledge exchange and dissemination tools and technologies, including networks, relating to tobacco control in Canada and internationally.[69]

Activities of the *Next Stage* project itself have created linkages between public health organizations. In 2010, P/T Public Health Associations (P/TPHAs) collaborated with CPHA to implement the online survey on tobacco control. P/TPHAs linked with primary contacts in their respective provinces and territories to engage local/regional practitioners working in tobacco control. The findings from the tobacco control success stories, identified through a series of consultations with P/T representatives, will be shared across jurisdictions.

It is recommended that:

> **The federal government provide support for the ongoing operation and coordination of a pan-Canadian knowledge exchange network of local/regional public health organizations working in tobacco control and their associated networks.**

H. Summary of Recommendations

1. Tobacco Control: A Public Health Priority

It is recommended that:

> **Public health leaders, their organizations, and their associations mobilize and act to achieve the elimination of tobacco as a threat to the health of current and future generations of Canadians.**

2. Comprehensive Strategies and Capacity

It is recommended that:

> **Federal and provincial/territorial governments provide sufficient and sustainable tobacco control funding to achieve the 'preventive dose' necessary to achieve reduction targets in tobacco use.**
>
> **Provincial/territorial public health systems identify comprehensive tobacco control as a core requirement of local/regional public health organizations.**
>
> **Dedicated tobacco control capacity be established in every local/regional public health organization. While its organizational structuring may vary, dedicated tobacco control capacity needs to be preserved in order to achieve the necessary 'preventive dose.'**
>
> **Comprehensive tobacco elimination/control strategies be established at federal, provincial/territorial, and local/regional levels. This includes the establishment of a renewed and comprehensive Federal Tobacco Control Strategy with the explicit goal of eliminating tobacco use in Canada.**
>
> **Within all levels of comprehensive tobacco control strategies, effective cessation interventions be included to support systematizing cessation efforts, with a 'no wrong door' approach that will ensure smokers' access to information, counselling, medication, and other supports where and when they need them. Key components include:**
>
> - **Creating a supportive social and physical environment to encourage cessation;**
> - **Providing cessation media campaigns;**
> - **Establishing quit lines and other counselling mechanisms; and**
> - **Ensuring the provision of cessation interventions including cessation medication and Nicotine Replacement Therapy (NRT), behavioural support, resources for self-help and support through providers and groups, and subsidized cessation medication and NRT, particularly for lower income groups.**

Comprehensive tobacco control strategies address the disparities in tobacco use among population sub-groups including:

- **Tobacco control interventions, policies, and programs be implemented with a population health/health equity lens;**
- **Targeted approaches be utilized in addition to universal approaches to focus on those populations that may be missed by universal approaches or experience adverse effects from them; and**
- **Tobacco control be linked to a health equity agenda that addresses the underlying determinants of tobacco use and explores the impact of a range of policy options.**

A comprehensive, federal Aboriginal tobacco control strategy be re-established that provides dedicated tobacco control capacity for Aboriginal populations. Such a strategy should consider:

- **High involvement of Aboriginal peoples in research and development of tobacco control strategies;**
- **Positive messages that reflect the strengths and values of culture and communities while maintaining social relevance, using Elders' wisdom, tradition, and knowledge;**
- **Responsiveness to the emotional, physical, social, and spiritual needs of Aboriginal people who use tobacco, adopting a holistic approach that is consistent with Aboriginal teachings;**
- **Provision of client supports to eliminate barriers to participation and mitigate some of the social and economic pressures;**
- **Interventions that approach tobacco with a community focus (e.g., opportunity to develop, implement, and enforce policies and by-laws in Aboriginal communities);**
- **Materials and approaches that have a high degree of relevance to the community; and,**
- **Continuity of projects with sustained funding and delivery to build capacity and long-term change.**

3. Education, Knowledge Development and Exchange

It is recommended that:

Continuing learning needs and the education of the public health workforce be pursued by:

- **Embedding tobacco control concepts and examples within the orientation and continuing education of all public health staff;**
- **Assessing opportunities for systematically incorporating brief-contact cessation interventions into existing 1:1 programs and services;**

- **Supporting and requiring new tobacco control staff to take the free, online, bilingual course: *Tobacco and Public Health: From Theory to Practice*;**
- **Assessing and addressing tobacco control continuing education needs over time on a provincial/territorial and national basis; and**
- **Seeking the engagement of Canadian Public Health Schools and Programs in a coordinated approach to comprehensively integrate tobacco control concepts and examples throughout institutions' public health graduate curriculum.**

Key federal organizations, including Health Canada, the Public Health Agency of Canada, and the Canadian Institutes of Health Research (CIHR), actively support the development and synthesis of the evidence base and knowledge exchange for local tobacco control initiatives including those targeting priority populations.

Health Canada support a comprehensive range of tobacco control projects to foster innovation and the building of capacity, knowledge development, and exchange among local/regional public health organizations.

The federal government provide support for the ongoing operation and coordination of a pan-Canadian knowledge exchange network of local/regional public health organizations working in tobacco control and their associated networks.

4. Further Breakdown of Recommendations by System Level

In order to assist the review of and action on this report's recommendations, this section provides a tailored list of recommendations for each system level. It also outlines CPHA's role in their fulfillment.

a) Federal Level

- Health Canada, the Chief Public Health Officer, and the Public Health Agency of Canada champion, mobilize, and act to achieve the elimination of tobacco as a threat to the health of current and future generations of Canadians.

- Complementing provincial/territorial government investments, provide sufficient and sustainable tobacco control funding to achieve the 'preventive dose' necessary to effectively achieve reduction targets in tobacco use.

- Establish a renewed, comprehensive, and adequately resourced Federal Tobacco Control Strategy with the explicit goal of eliminating tobacco use, including the reduction of existing inequities in tobacco use.

- Establish a comprehensive Aboriginal tobacco control strategy that provides dedicated tobacco control capacity for Aboriginal populations.

- Support comprehensive cessation strategies including the use of media campaigns, quit lines, and subsidization of cessation medication and NRT.

- Support the education of the public health workforce in tobacco control including orientation and continuing professional development of all staff (e.g., PHAC's *Skills Enhancement for Public Health)*; support periodic updating of OTRU's *From Theory to Practice* course; sponsor regional training opportunities; and support the integration of tobacco control concepts in the graduate-level public health curriculum.

- Actively support the further development of the evidence base, its synthesis and knowledge exchange for local tobacco control initiatives, particularly regarding interventions for priority populations

- Support a comprehensive range of tobacco control projects to foster innovation and support capacity building, knowledge development and exchange among local/regional public health organizations.

- Support the ongoing operation and coordination of a pan-Canadian network of local/regional public health organizations working in tobacco control and their associated networks.

- Support the provision of scientific and technical expertise and advice, particularly for those provinces without the critical mass to support these functions themselves.

- Provide national tobacco monitoring and surveillance (e.g., CTUMS).

b) Provincial/Territorial Level

- Chief Medical Officer of Health and relevant Ministry/Department champion, mobilize and act to achieve the elimination of tobacco as a threat to the health of current and future generations of Canadians.

- Complementing federal government investments, provide sufficient and sustainable tobacco control funding to achieve the 'preventive dose' necessary to effectively achieve reduction targets in tobacco use.

- Establish a renewed, comprehensive and adequately resourced provincial/territorial tobacco control strategy with the explicit goal of eliminating tobacco use, including the reduction of existing inequities in tobacco use.

- Identify comprehensive tobacco control as a core requirement of the local/regional level of the public health system.

- Ensure the establishment of dedicated tobacco control capacity in every local/regional public health organization.
- Establish a comprehensive approach to systematize promotion and supports for cessation including the use of media campaigns, quit lines, and the subsidization of cessation medication and NRT.
- Support the education of the public health workforce in tobacco control including:
    - orientation and continuing professional development of all staff;
    - requirement of all new tobacco control staff to take OTRU's *From Theory to Practice* course; and
    - periodic training needs assessments and ongoing professional development of tobacco control staff.
- Support a range of tobacco control projects to foster innovation and support capacity building and knowledge development and exchange among local/regional public health organizations.
- Ensure appropriate evaluation, monitoring and surveillance.

c) Local/Regional Level

- Medical Officer of Health and public health unit/health authority champion, mobilize, and act to achieve the elimination of tobacco as a threat to the health of current and future generations of Canadians.
- Establish a renewed, comprehensive and adequately resourced local/regional tobacco control strategy with the explicit goal to eliminate tobacco use, including the reduction of existing inequities in tobacco use.
- Establish and preserve dedicated tobacco control capacity whether or not it is integrated within a broader chronic disease prevention initiative.
- Support education of the public health workforce in tobacco control including:
    - orientation and continuing professional development of all staff;
    - brief-contact cessation training for selected staff as part of systematizing cessation into relevant 1:1 service delivery programming;
    - support all new tobacco control staff to take OTRU's *From Theory to Practice* course; and

- support periodic learning needs assessments and ongoing professional development of tobacco control staff.

- Support innovation and capacity building and knowledge development and exchange by participating in tobacco control projects.

- Participate in information exchange and collaboration via a pan-Canadian network of local/regional tobacco control organizations.

- Contribute to the establishment of a comprehensive approach to systematize promotion and supports for cessation.

- Participate in evaluation, monitoring, and surveillance and work with communities and population sub-groups to understand the qualitative meaning behind surveillance data.

d) The Role of CPHA

As the national professional association for public health in Canada, CPHA can play several key roles to strengthen tobacco control in Canada:

- Advocate for greater federal and provincial/territorial leadership:

  Through position statements and other mechanisms, seek comprehensive tobacco control leadership through federal and P/T strategies, legislation, and funding. This includes the establishment of an Aboriginal tobacco control strategy.

- Foster knowledge exchange and communication among local/regional public health organizations across Canada:

  Support stronger tobacco control practice across Canada through a knowledge exchange network to share tools, practices, and approaches. Identify and support sharing of success stories and approaches using qualitative and case study approaches – health units need easy-to-use, evidence-based information and resources for tobacco control interventions.

- Partner with other health professional organizations to encourage greater primary and continuing education to support cessation:

  Available information suggests that healthcare providers do not receive comprehensive education to support cessation in their practice. In addition, patients who smoke report that their healthcare providers do not commonly ask or advise them about their tobacco use. Health professional associations can play a key role in influencing the education of healthcare providers that is provided and available after graduation.

- Partner with networks/associations of public health academic institutions to ensure key tobacco concepts are included in the education of future public health leaders:

CPHA recently hosted an inaugural meeting of public health academic institutions from across the country and there is widespread interest in creating a pan-Canadian network/association of these institutions. Such a network/association may be an important mechanism to foster dialogue and collaboration to strengthen the coverage of relevant tobacco-related concepts in graduate degree-level public health staff.

- Partner with the Public Health Agency of Canada's Skills Online program to have key tobacco concepts embedded within relevant existing and future modules:

  The *Skills Online* series of modules are a key pan-Canadian continuing professional development mechanism for front-line public health staff. Many local/regional public health organizations use the modules as orientation for all new professional staff. As such, it would be advantageous to explore opportunities for embedding key tobacco control concepts within relevant existing and future modules.

CHAPTER 6: CONCLUSION

The purpose of the *Next Stage* project has been to engage Canada's public health community in documenting and sharing evidence-informed and practice-based strategies and interventions, and to inform future tobacco control policy in Canada. The project has used a range of information gathering and engagement approaches to gain a greater understanding of tobacco control issues with a particular emphasis on local/regional public health organizations. This report has provided a high level summary of key findings with associated analysis and recommendations. A series of detailed sub-project reports provide considerably more detail and are available on CPHA's website.

This report has described the widespread fatigue that currently exists regarding tobacco control efforts. In addition, the report notes that progress in reducing tobacco use has flattened, inequities in use among populations remain, and tobacco continues to be the leading cause of preventable death and disease among Canadians. While Aboriginal populations have considerably higher smoking rates than the Canadian average, the federal First Nations and Inuit Tobacco Control Strategy (FNITCS) was discontinued in 2006.

Tremendous progress has been achieved over a period of decades, however the existing situation risks a reversal of our progress in reducing tobacco-related mortality and morbidity. This is unacceptable. The fundamental purpose of public health is to protect and promote the health of the public, and tobacco remains a deadly burden to be eliminated. There is a considerable body of knowledge and experience regarding effective tobacco control practices, and this report provides additional insights into the facilitating factors for successful implementation.

Tobacco control is a 'winnable battle', but that battle has to be fully engaged. This report has outlined a series of recommendations calling on public health leaders, their organizations, and their associations at every system level to mobilize and act to achieve the elimination of tobacco as a threat to the health of current and future generations of Canadians. The recommendations address the establishment and funding of comprehensive tobacco control strategies at each system level, including dedicated tobacco control capacity in every local/regional public health organization. Recommendations are included to address inequities in tobacco use including those affecting Aboriginal populations. Additional recommendations address education, knowledge development and exchange.

APPENDIX 1: *NEXT STAGE* PROJECT OBJECTIVES

The *Next Stage* project's objectives include the following:

- Further mobilize and strengthen existing networks and facilitate online knowledge transfer among members of the inter-disciplinary public health community for knowledge exchange on tobacco control (prevention and cessation) initiatives, with specific populations, at local and regional levels;
- Generate information on "what works" with respect to prevention and cessation among youth and adults particularly for priority populations (i.e., evidence-based model policies and practices in tobacco control);
- Develop recommendations, case samples and intervention strategies for public health and its approach to tobacco control, based on extensive consultation with the Canadian public health community, Canada's schools and programs of public health, and allied organizations;
- Use of a social determinants of health lens to highlight policy and program opportunities;
- Support a coordinated approach to tobacco control education and capacity building for public health practitioners by providing recommendations to public health teaching institutions for future tobacco control curriculum within their public health education programs; and
- Provide an online knowledge centre for dissemination of information about evidence-based model policies and practices in tobacco control (prevention and cessation) among youth and adults, particularly for priority populations, to increase their use.

APPENDIX 2: FURTHER BACKGROUND ON *NEXT STAGE* SUB-PROJECTS

- Consultation with project advisors and partners

  This inaugural meeting was held in March 2010. It was the first of a series of consultations undertaken for the *Next Stage* project. During the meeting, participants learned about the goal and objectives of the project and provided feedback on planned activities. Discussions focused on challenges in tobacco control and knowledge needs of the public health community. Participants provided valuable input on a draft survey questionnaire (see below *Survey of local/regional public health organizations*).

  Priorities for the next phase of tobacco control in Canada were discussed, including key priorities that would benefit from a national, coordinated approach. A potential role for CPHA in relation to these priorities was also discussed.

  At the conclusion of the meeting, a participant expressed appreciation for the opportunity to hear about other jurisdictions' initiatives. There was general consensus that "there's still a lot of work that needs to be done."

- Survey of local/regional public health organizations

  An online survey was administered to inform the *Next Stage* project about effective tobacco control practices, programs and policies in prevention, cessation, protection and enforcement, including initiatives targeted to sub-populations. A key objective was to identify gaps and challenges in tobacco control.

  CPHA collaborated with provincial/territorial Public Health Associations who coordinated with their respective jurisdictions to identify survey response teams in health units/regions. As shown in the following table from the sub-project report, with the exception of Québec, representatives from all provinces and territories participated (key informant interviews were conducted with Québec representatives; see below *Key informant interviews - Québec*).

Table 5: Organizational Survey Completion by Provinces/Territories

Province/territory	Number of health authorities/units	Number of health authorities/units completed the survey
Alberta	6	8*
British Columbia	5	5
Manitoba	11	7
New Brunswick	2	2
Newfoundland and Labrador	4	4
Northwest Territories	8	2
Nova Scotia	9	9
Nunavut	1	1
Ontario	36	33
Prince Edward Island	1	1
Québec	18	-
Saskatchewan	13	10
Yukon	1	1
Total	115	83

*Due to the recent restructuring of health care in Alberta, the previous geographically based 9 health regions have been reorganized into 6 zones. Survey participants representing one of the newly organized health zones found it difficult to complete one survey because of the disparity in tobacco control activities and experiences among the three former health regions comprising a new zone. To provide a complete picture for that new zone three surveys eventually were completed. A thorough review of answers revealed more differences than similarities among the three completed surveys and therefore all of them were eventually included in the analysis.

Survey results provide valuable insight on public health tobacco control in Canada. Extensive findings indicate variations in levels of engagement in tobacco control across health units/regions, low levels of dedicated tobacco control units and staff and knowledge gaps. Results show a lack of connection and knowledge exchange between practitioners working in different provinces and territories.

- Key informant interviews - Québec

  Interviews were conducted with representatives of key organizations to gain knowledge and understanding of the structure and governance of tobacco control activities in Québec. This report identifies the sectors and organizations involved in tobacco control and respective roles. Effective programs and policies are discussed and initiatives that have been less effective are also noted.

  Key informants cited challenges in tobacco control including the diminished importance of tobacco as a public health priority, contraband tobacco and tobacco industry tactics. It was reported that knowledge exchange and development needs are generally being met in Québec however a major gap exists in terms of professional education in the medical and allied health fields.

- Literature review of best/better practices

  A review of the literature and best/better initiatives was conducted for the *Next Stage* project, with a focus on the effectiveness of tobacco control activities in protection, prevention and cessation. Initiatives with potential relevance to the local/regional public health community were identified including those targeted to priority and special populations.

  Findings revealed numerous gaps and challenges related to the availability of evidence-based research to inform effective practice. Many of the initiatives and interventions identified through best/better practice sources were dated. There is a lack of research and initiatives available to inform effective programs, policies and practices for protecting, preventing, and reducing tobacco use among priority and special populations.

  The literature review includes links to a range of best/better practice initiatives in prevention, cessation and protection targeted to the general population and sub-populations.

- Key informant interviews with public health representatives

  Key informant interviews were undertaken during April and June 2010 with representatives of local/regional public health, provincial/territorial governments (for Québec, see below *Key informant interviews - Québec*) and non-governmental organizations. These consultations focused on the following themes: successes and challenges in tobacco control, priority populations, key priorities, knowledge development and exchange (including best practices) and potential role for CPHA in tobacco control.

  Key informants expressed a need for political commitment and funding for new and more effective tobacco control initiatives. Top priorities include tobacco use cessation and the tobacco industry and its products. Key informants stressed that “tobacco control is not done”

and articulated a need for a renewed approach to tobacco control in Canada. There was consensus that CPHA needs to play a role in tobacco control.

- CPHA conference workshop

  A workshop was held at CPHA's annual conference in June 2010 to inform delegates about the *Next Stage* project objectives, activities and findings to date (literature review, survey and key informant interviews) and share perspectives and insights on challenges in tobacco control. Participants were asked to consider how public health tobacco control could be better coordinated to optimize results across the country.

  In small group discussions, participants considered two tobacco control issues — the availability of tobacco products and alternative, targeted interventions for special populations — and discussed the role of public health vis-à-vis these issues and related barriers and challenges. Coordination, knowledge exchange and CPHA's role in tobacco control were also discussed.

- Focused literature review of tobacco interventions for priority populations

  This review summarizes the grey literature and seeks to identify promising and evidence-based tobacco control interventions for priority populations. Results build on the findings of the literature review of best/better practices and may inform the work of local/regional public health practitioners.

  The review specifically focuses on the following priority populations: Aboriginal Peoples, youth/young adults, pregnant/post-partum women, those with mental health and addiction issues and those with low socio-economic status. Primarily grey literature sources from public health, tobacco control organizations, and organizations that work with these priority populations were examined. Results are presented for each of the priority populations in terms of prevention, protection, and cessation and include existing guidelines, best practices, gaps and challenges.

  The findings indicate numerous gaps and challenges in the availability of information in the grey literature on effective strategies for priority populations. Targeted interventions seem to help address the shortcomings of population strategies, which show modest effectiveness with priority populations.

- Education and continuing learning needs of the public health workforce

  This report addresses continuing learning needs and education of public health staff in tobacco control. The local/regional public health workforce is examined, including organizational structures, programmatic responsibilities, public health competencies, workforce enumeration and the tobacco control specific workforce. Tobacco-related education is discussed in relation to all public health staff, staff involved in 1:1 service delivery, tobacco control staff, and managers.

  Learning needs and opportunities are identified and recommendations are made regarding enhancing tobacco control content in public health program curricula, incorporating brief contact cessation interventions in existing 1:1programs and services and educating new tobacco control staff.

  Findings indicate that the extent to which tobacco control is a priority at provincial/territorial and federal levels, with provision of associated dedicated resources, is an enabler to increasing the need for and interest in seeking tobacco control-related education.

- Local/regional public health tobacco control success stories

  This report examines 'what works' in tobacco control in the local/regional public health context, including 'why' and 'how' initiatives succeed. Through a consultation process, public health leaders and practitioners identified twenty-two tobacco control initiatives spanning four categories (smoke-free areas/places, youth/young adults, cessation, and education) and a range of regions, settings, and populations.

  The analysis revealed nine facilitating factors for local/regional tobacco control success: champions, organizational support, partnerships, infrastructure, time, funding, promotion and provision of information, creative design/innovation, and engagement. The role and importance attributed to these facilitating factors differed across categories, and varied according to the initiatives' objectives, methods, settings, and target populations.

  The success stories constitute a rich resource of practice-based knowledge. Examining and documenting achievements in local/regional tobacco control represents an important step in facilitating the exchange of valuable tacit knowledge.

- Knowledge exchange and dissemination tools and technologies

  An environmental scan was undertaken to identify Web 2.0 knowledge exchange dissemination tools and technologies related to tobacco control. Results include a range of online knowledge exchange tools to inform and support the work of practitioners, researchers, and policy/decision-makers engaged in tobacco control.

  The scan was completed in 2010 and includes various Web 2.0 technologies based in Canada as well as notable internationally-based technologies, including networks, communities of practice, forums, wikis, blogs, web-assisted tobacco interventions (WATIs), portals and social networks, and more traditional platforms such as discussion boards and listservs.

APPENDIX 3: RECOMMENDED COMPONENTS OF A PROVINCIAL TOBACCO CONTROL STRATEGY

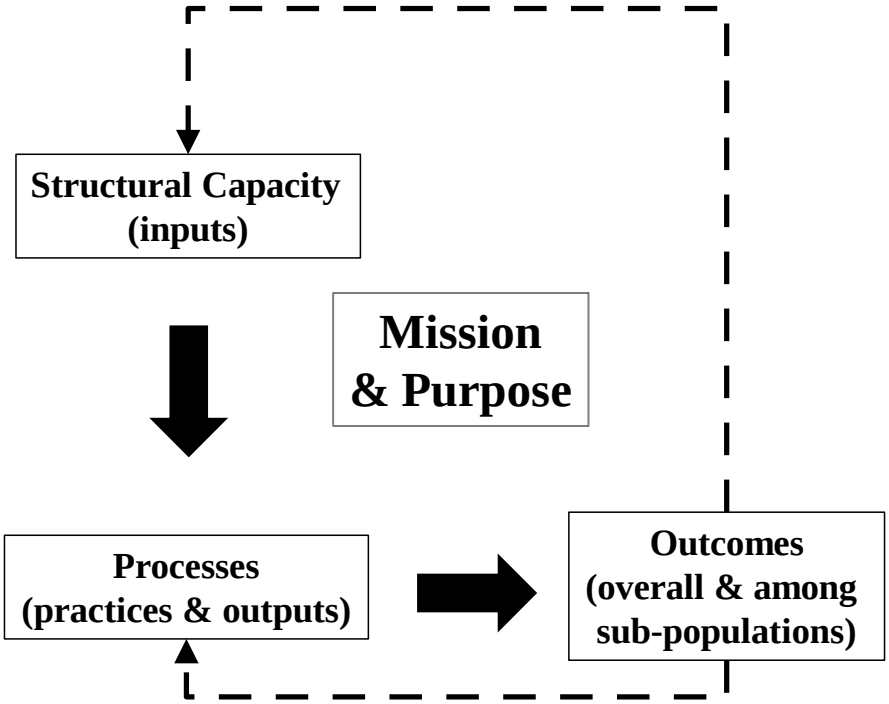
Table 6: Recommended Components of Ontario's Tobacco Control Strategy

Strategy Components	Interventions	
Confront the tobacco industry vector	• Price • Tobacco industry denormalization • Plan and standard packaging and health warnings • Tobacco product regulation	• Retail distribution and accessibility • Marketing and promotion (i.e., bans) • Tobacco industry accountability
Prevention	• Media and social marketing • Smoking in movies and video games • Effective and enforced policies • Aligned and co-ordinated interventions	• Targeted prevention interventions • Retail access and compliance • Cessation • Evaluation and learning
Protection	• Smoke-free legislation • Media interventions	• Health professionals • Evaluation and learning
Cessation	• Policies that support cessation • Cessation media campaign • Tobacco-user support system • Direct-to-tobacco-user cessation services	• Cessation interventions in primary care and across all other health care settings • Role of pharmaceutical companies • Socio-ecological approaches to cessation • Evaluation and learning
Disparities and equity	• Applying an equity lens • Universal and focused interventions	• Evaluation and learning

Source: Evidence to Guide Action: Comprehensive Tobacco Control in Ontario.[3]

APPENDIX 4: SUMMARY OF ANALYSIS BY PUBLIC HEALTH PERFORMANCE FRAMEWORK DIMENSIONS

As outlined in Chapter 5, analysis of the key findings that emerged over the course of the project was conducted utilizing the following framework.[32]



Key findings for each dimension are summarized in the following table. From this analysis emerged the themes represented by the sections in Chapter 5 of the report.

Mission & Purpose	Structure	Process	Outcome
• Explicit TC mandate for local/regional public health variable; TC not consistently identified as a core requirement. • TC not explicitly identified as a high public health priority. • Estimated TC funding by provincial and federal governments a fraction of recommended amounts based on effective U.S.-based state interventions. • No federal Aboriginal TC strategy since 2006.	• On average, 2.3% of public health workforce dedicated to tobacco control; however, this is variable (23.9% of organizations have no dedicated capacity). • Most TC staff are part of CDP units; concern for diversion of TC resources. • Dedicated funding for TC occurs in only some provinces. • While considerable knowledge exists on best practices, limited information exists on interventions for priority populations. • Linkages and information exchange are much more common between organizations within a P/T jurisdiction than across jurisdictions.	• Local/regional organizations report varying involvement in particular TC activities, their reach and intensity unclear. • Most (> 2/3) involved in advocating for local or provincial policies, enforcement of smoke-free legislation, public education, partnering with community organizations, and delivery of tobacco use prevention programs. • Lower proportion of organizations involved in surveillance and monitoring, enforcement of youth access restrictions, delivery of cessation services, advocating for federal policies. • New smoke-free policies being pursued in minority of organizations; fewer pursuing policies to address supply of tobacco products. • Widespread concern for gaps addressing youth/young adults and Aboriginal populations, as well as supporting cessation overall. • Common facilitating factors for public health initiatives; relative importance and how they contribute to success varies considerably by context.	• From a multi-decade perspective, considerable reductions in overall smoking rates among Canadians. • Overall progress in recent years has stalled. • Tobacco continues to be the leading cause of preventable death and disease among Canadians. • There are 4.5 million smokers in Canada. • Despite improvements in average rates, disparities in tobacco use among population groups continue, as do disparities among regions within jurisdictions.

Key: TC = tobacco control; P/T = provinces/territories; CDP = chronic disease prevention

APPENDIX 5: FURTHER DETAILS REGARDING PROFILED SUCCESS STORIES

Table 1: Brief Synopses of Success Story Profiles

A. Training Initiatives

Initiative	Administered By	Target Population	Description/Objectives
Inuit Tobacco-Free Network Distance Education Course	Inuit Tuttarvingat of the National Aboriginal Health Organization (NAHO)	Inuit community via community health representatives	- The Inuit Tobacco-Free Network and the training course are affiliated; the training course being one component of the network. The central component of the network is a website http://www.naho.ca/inuit/itn/whatsNew.php that links to materials relevant to tobacco control and reduction in Inuit communities, including: research, fact sheets, events, health promotion materials, stories, etc. The network site also includes an email listserv of people interested in working on Inuit tobacco reduction. - The training component is focused on promising practices, and is based on adult learning/education principles. It was designed to meet the specific needs of participants, according to what they wanted to learn and what they wanted to do with their learning. Overwhelmingly, participants of the training program are community health representatives (CHRs). An attempt has been made to reach a wider audience as well.
NICC Program for Mental Health & Addiction	Northern Health Authority, British Columbia	Mental health and addictions community via cessation and mental health workers	- The program partnered with the U.S.-based Mayo Clinic to adapt the cessation guidelines and program for the needs of the fairly large mental health & addictions base across the North. The program trains Northern health staff already working with mental health and addictions communities to implement the cessation guidelines and to support individuals through quit attempts. - Another component of the program is tailoring Nicotine Replacement Therapies (NRTs) to the needs of the mental health and addictions population. As such, the authority administers an eight-week supply of NRT as opposed to the one-week supply received by the general population.

Initiative	Administered By	Target Population	Description/Objectives
PACT (Partnership to Assist with the Cessation of Tobacco)	Pharmacists Association of Saskatchewan, Saskatchewan	General population via pharmacists and various health care providers (social workers, addiction counsellors, nurse practitioners and more)	- The program was developed by pharmacists for pharmacists, but has since evolved into a tobacco cessation program that any healthcare professional can deliver in virtually any setting. - There are over 500 pharmacists that are PACT-certified in Saskatchewan and all second-, third-, and fourth-year pharmacy students have been trained in addition to over 100 "other" healthcare professionals. - Training is ongoing with the goal of building capacity and encouraging cessation interventions as a standard of care, and to foster an environment of protection while enforcing a social norm of being tobacco-free.
TRaC (Tobacco Reduction and Cessation)	Alberta Health Services, Alberta	General population via various health care providers	- A two-day professional development program designed to strengthen capacity in front-line health care professionals to deliver cessation interventions to patients and clients. The TRaC course is accredited by a number of professional organizations. - To date, the program has trained approximately 450 health professionals. - Each of Alberta's five health regions presently has a part-time TRaC Coordinator who is responsible for program operations, course instruction, and program promotions in their area.
RNAO, Integrating Smoking Cessation Into Daily Practice	Department of Health and Social Services, Yukon	General population via community health nurses.	- The program is based on best practices and was developed by the Registered Nursing Association of Ontario (RNAO) to improve nurses' capacity by training them to implement smoking cessation strategies and techniques in their daily practice.

B. Cessation Initiatives

Initiative	Administered By	Target Population	Description/Objectives
Quitters Unite	Heart & Stroke Foundation of British Columbia and Yukon; Context Research; With support of Regional Health Authorities, British Columbia	Youth aged 18 to 24, with a secondary audience aged 25 to 29	- The program is a tobacco cessation and protection initiative promoting non-smoking and supporting youth who wish to quit smoking as well as those who wish to help their friends or family to stop. - The central component of the initiative is a youth-designed and branded website that features dynamic, user-generated content and focuses on the use of social media. Other elements of the initiative include an interactive 'road show' at post-secondary institutions across the province, and a series of cessation contests.
TAR (Tobacco Addiction Recovery)	Pharmacists Association of Saskatchewan, Saskatchewan	Aboriginal communities	- TAR is a cessation program developed for use in Aboriginal communities. An important focus of the program is on sacred and traditional tobacco use. The program incorporates culturally relevant approaches to quitting in addition to providing a number of information resources.
Driven to Quit	Northwestern Health Unit; Simcoe Muskoka District Health Unit, Ontario*	General population	- Driven to Quit is an annual incentive-based program offering a potential prize (currently one of two hybrid cars, one of five vacation getaways, and one of seven MBNA credit card shopping sprees) for a successful quit for the contest period of 31 days. The program links with the Canadian Cancer Society's quit line and online quit services.
QuitPath	Department of Health and Social Services, Yukon	General population	- The QuitPath program evolved from Quit Pack as a more in-depth, evidence-based resource for cessation developed around stages of change. It includes: an introductory session; a guide to being smoke-free; quitting resources, including a website; telephone support from cessation staff; a weekly counselling session for four weeks; and, NRT (patch).

Initiative	Administered By	Target Population	Description/Objectives
Subsidized Nicotine Replacement Therapy Program	Elgin St. Thomas Public Health, Ontario*	General population	- The program is associated with the cessation domain of both the Smoke-free Ontario Strategy and the Chronic Disease section of the Ontario Public Health Standards. - The initiative adopts a two-sided approach: the first being provision of NRT products or subsidized NRTs through coupons; and, secondly the provision of counselling. Each client is assessed in a counselling session prior to NRT product or coupons being issued. The counselling component is administered through the continued smoking cessation groups, people coming in for appointments, and a periodic drop-in clinic model.

* This initiative was administered in multiple health units in Ontario; representatives of the identified health unit(s) served as key informants and provided information about the initiative in their jurisdiction.

C. Youth Initiatives

Initiative	Administered By	Target Population	Description/Objectives
High School Grants	Peel Public Health; Niagara Region Public Health, Ontario*	Youth	- All Ontario youth grant programs were initially administered by provincial grant money through health units and authorities for high school projects. - While this funding is no longer in place, many of the initiatives have sought alternate sources of funding to keep the work running; are now sustained through partnerships that developed over the course of the initiative; or both. - These grant programs fall into two categories depending on how the funding and programming are now administered by the health units: high school grant programs and community grant programs. - Examples of projects in the communities and schools included: poster contests, youth groups, health and wellness committees, and work associated with tobacco-free sports and recreation. - Many of the grant programs, both community and high school, emphasize youth engagement strategies and principles. In some cases, these elements have been emphasized through advocacy and leadership training.
Community Youth Grants	Toronto Public Health; Hamilton Public Health, Ontario*	Youth	

Initiative	Administered By	Target Population	Description/Objectives
DeFacto	Réseau du sport étudiant du Québec	Youth aged 12 to 25; secondarily, denormalization of tobacco use in the general population	- The primary objective is to prevent youth from starting to smoke by creating new social norms via denormalization. - Rather than treating behaviour, DeFacto addresses the problem of tobacco products in terms of the industry promoting, producing, and selling the product. - DeFacto creates awareness by using mass media to transmit non-traditional messaging and by branding its messaging and disseminating it as widely as possible in the environment.
Don't be a Butthead	Department of Health and Social Services, Northwest Territories	Youth aged 8 to 14	- A social marketing campaign centred on a mascot named Butthead who spreads prevention messaging. - The initiative is primarily school-based, and includes a number of elements including but not limited to: • An annual smoke-free promise form signed by the participating children. Upon receipt of the promise, the child receives a piece of promotional gear featuring Butthead. • Dynamic and interactive school presentations of between 30-40 minutes. • Affiliation with the annual Arctic Winter Games whereby the program partners with athletic associations to bring the coaches and athletes on board as role models. Includes poster campaign.
Flavour Gone	Northwestern Health Unit; Kingston, Frontenac and Lennox & Addington (KFL&A) Public Health, Ontario*	Youth	- Administered as an Ontario grant Youth Alliance Action (YAA) program, developed an advocacy campaign designed to counter the tobacco industry's targeting of youth using flavoured tobacco products. - Elements of this movement included the purchase and creation of a website (www.flavourgone.ca), an online petition, and appeals to the media. - Several YAAs from across the province joined in the Flavour Gone movement and worked with NGOs and Parliamentarians to bring attention to Bill C-32.

* This initiative was administered in multiple health units in Ontario; representatives of the identified health unit(s) served as key informants and provided information about the initiative in their jurisdiction.

D. Smoke-Free Area Initiatives

Initiative	Administered By	Target Population	Description/Objectives
Amendments to Smoke-Free Places Act	Council for a Smoke-Free Prince Edward Island is a collaborative group of stakeholders including: the Canadian Cancer Society; the Canadian Lung Association; the Heart & Stroke Foundation; the Canadian Medical Association; the Home & School Federation	General population	- In 2008, work towards amending the original PEI Smoke-Free Places Act was begun. Desired amendments included restrictions on smoking in schools, bars, restaurants, and doorways of public places. - Amendments were in response to public pressure for change, such as in the case of smoke-free vehicles; to bring PEI in line with other provincial smoke-free legislation; and, to regain a leadership role in smoke-free action such as the case with smoke-free patios and hospitals.
Smoke-Free Vehicles By-law, which led to a Smoke-Free Vehicles Amendment to the Smoke-Free Places Act	Smoke-Free Kings is a collaborative group of stakeholders, including Annapolis Health, Nova Scotia	Protection of youth; secondarily, denormalization of tobacco use in general population.	- This initiative seeks to protect those who can't protect themselves by advocating for smoke-free cars when a child under the age of 16 is present (this was changed to 19 years due to positive response). - Although the impetus for the project had been health policy modelling, fines and enforcement were later included as part of the initiative as it gained strong support.
Smoke-Free Places	New Brunswick Department of Health	General population	- The purpose of this new Act was to make both public places and work places smoke-free. - Compliance was ensured through a partnership whereby enforcement duties were divided as follows: 1) In work places – workplace safety 2) In liquor establishments – public safety 3) In all other spaces – public health inspectors - A media campaign was carried out jointly with the Canadian Cancer Society.

Initiative	Administered By	Target Population	Description/Objectives
Eastern Health Smoke-Free Environment Policy	Eastern Health Authority, Newfoundland	General population	- The Eastern Health Authority was the last of four provincial authorities to implement a smoke-free policy. The policies vary somewhat across the authorities, and each has its own experiences with implementation. Particular to Eastern Health is its large size. - The policy is organization-wide and ensures a smoke-free environment. Tobacco use is prohibited on all premises owned or leased by Eastern Health. - The policy is comprehensive, and extends cessation support to employees through the Employee Assistance Program and by linking with the Smokers Help Line.
Blue Light Program	Burntwood Regional Health Authority, Manitoba	General population	- The primary objective of the program is to ensure protection from second-hand smoke by generating awareness of its negative health impacts. The secondary outcome is behaviour change. - The smoke-free home obtains a blue light that is placed outside of the house, and residents sign a pledge to maintain a smoke-free environment. The more blue lights in the community, the stronger the awareness that smoking is detrimental.

Note: The focus is on specific initiatives and not to comprehensively portray all of the smoke-free initiatives of a particular jurisdiction.

I. Facilitating Factors for Success

The tobacco control success stories sub-project identified nine overall facilitating factors for success, as summarized below:

1. **Champions** – Overall, champions were important for increasing motivation for participation in the initiatives; providing evidence and disseminating messaging; and, securing buy-in for the initiative from public health workers, boards and senior management levels. Championing was also important in supporting two other facilitating factors: promotion and organizational support.

2. **Organizational Support** – Organizational support was needed at all levels: senior management support; middle management support by the provision of training and flexibility; and, front-line worker buy-in. The level of support needed, and the means of securing it, varied across categories and initiatives.

3. **Partnerships –** Partnerships were perceived as the most important of all the facilitating factors for success. Partnerships referred to linkages between organizations, between sectors, and between local units. Broadly, they served three main roles: facilitating resource sharing, including research and information; strengthening promotion and the reach of the initiatives; and, assisting in identifying and meeting population health needs.

4. **Coordinating Mechanisms –** Various structures including councils, committees and working groups were noted as key to supporting the initiatives throughout various stages from development through to implementation. Often they contributed to the strength of other success factors, including promotion and partnerships. Broadly, coordinating mechanisms were used to problem solve; gather together stakeholders and identify needs; and facilitate communication between various organizational levels, workers, and partnerships. [Note: This factor was called 'infrastructure' in the sub-project report.]

5. **Time** – Time was identified most often in reference to patience, timing, and sustainability. The relative importance of these factors differed across categories of initiative. Further, timing was a factor in organizational support given the iterative process of demonstrating successes to secure more support and trust from senior management.

6. **Promotion, Provision of Information to the Public** – Promotion and provision of information were based on the objectives of the initiatives and their perceptions of success. They contributed to ensuring buy-in and support for policy change from public and stakeholders; effective enforcement of policy or legislative change; and, strengthening participation and the effective dissemination of messaging-oriented and incentive-based programs.

7. **Creative Design** – Across the categories, youth initiatives noted the importance of creative design. In this context, creative design supported efforts to effectively reach younger audiences.

8. **Funding** – Funding was cited as supporting three important components of the programs: the provision of information and messaging; resources such as NRTs; and, the early phases of projects oriented to needs identification.

9. **Engagement** – Engagement was said to be an important success factor in those initiatives addressing the needs of priority populations. Specifically, it permitted programs to effectively identify and meet the needs of target populations, and provide suitable information and messaging to them.

B. Key themes for the Facilitating Factors for Success, overall and by type of initiative

	Overall	Category			
		Smoke-free areas	**Cessation**	**Training**	**Youth**
Champions	•Increasing motivation for participation •Providing evidence and disseminating messaging •Securing buy-in from all organizational levels (senior and middle management, front-line worker)	•Expert spark for initiative •Political leadership and effective messaging to public and stakeholders •Enthusiastic participants that were especially motivated/ committed	•Critical to securing buy-in and trust within one of the cessation programs, including bridging different fields of workers	•Securing support for the practice change •Need to be respected within all of the fields and levels involved •Careful choice of who and when •Importance of peer-to-peer influence	•Not specifically identified; congruent with perspective that youth themselves are champions

	Overall	Category			
		Smoke-free areas	**Cessation**	**Training**	**Youth**
Organizational Support	•Three levels identified and all important •Senior management support (1) •Staff support and willingness (2) •Provision of training and flexibility for work (3)	•Role of Minister to provide health-based justification and messaging for provincial legislation change (1) •Senior management to support staff and to secure public buy-in for policy change (1)	•NRT is expensive and so requires prioritization of cessation by management (1) •Need front-line support as well, which was linked with being provided with training and education from the organization (2) – (3)	•Buy-in crucial from front-line staff who will be modifying practice based on training received (2) •Need to tailor to audience (e.g., health professionals) to secure buy-in/ participation, by engaging champions in those audiences and by offering flexibility with hours, accreditation, etc. (2) •Support required from middle management to facilitate staff putting training into practice (3)	•Front-line workers need to support youth by allowing them to proceed with their vision for the projects (2) •Senior management must provide sufficient flexibility and supports for staff to work effectively with youth (1) and to allow youth to guide their projects
Partnerships	•Sharing of resources, including research and information •Identifying and meeting population needs •Promotion	•Formation of passionate committees of stakeholders to create high-impact promotion and dissemination of information •Enforcement by leverage existing partnerships, and sharing resources	•Important to leverage well-entrenched partnerships with key stakeholders •Facilitates resource sharing, promotion and extended reach	•Development-stage support to identify and understand learner needs •Coordination of motivated workers to disseminate training and resources •Allowing communities to adapt trainings to their needs	•Strategic partnerships to facilitate rapid uptake, efficient promotion •Linking with NGOs, health units to enable effective youth advocacy •Demonstrating alignment of goals fostered stakeholder and in turn senior management buy-in

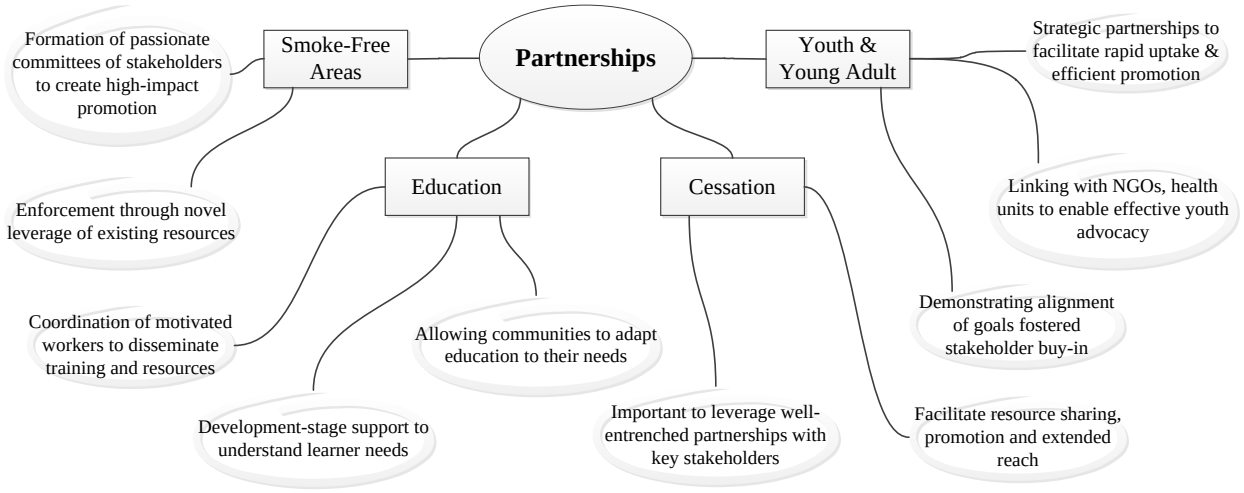
	Overall	Category			
		Smoke-free areas	**Cessation**	**Training**	**Youth**
Coordinating Mechanisms (infrastructure)	•Facilitate promotion and partnerships •Facilitate joint planning and problem solving •Facilitate communication	•Crucial role of collaborative group of stakeholders in researching and sharing info with public and government decision-makers •Core bodies of partners identify needs, and provide initial and ongoing planning and problem-solving	n/a	n/a	•Value of experienced youth, work staff supporting those less experienced, including dedicated co-ordinator •No "gatekeeper" allows open communication and support
Time & Persistence	•Patience •Timing •Sustainability	•Strategic timing offers political opportunities •Leveraging topics of current public interest •Ensuring adequate time for policy planning, developing, and implementation	•Long-term success developed through consistent messaging and increasing brand recognition over time	n/a	•Allowing for youth to foster their own ideas; effective engagement •Building reciprocal, trusting partnerships to secure buy-in support •Ideal to allow program momentum to build over several years

	Overall	Category			
		Smoke-free areas	**Cessation**	**Training**	**Youth**
Promotion & Provision of Information to Public	•Ensure buy-in and support for policy change and its enforcement •Foster participation	•Health-outcome, evidence-based messaging key to winning support of senior management, government decision-makers, and public •Communications to increase public awareness and support	•Engaging youth through branding, peer-generated content and social media •Increasing participation for incentives and contest-based programs •Establishing referral systems with a variety of health professionals	•Effective marketing to improve reach and increase participation	•Adapting messaging to appeal to youth needs using novel methods (e.g., social media) •Youth input on design, face-to-face promotion important elements
Creative Design	•(Youth) Engagement •User-generated materials •Use of social media •Focus group and audience testing	n/a	n/a	n/a	•Branding, incentive-based approaches appealing to youth •Engaging youth through creative and fun themes •Avoiding traditional health promotion messaging, seen to be ineffective with youth audiences
Funding	•Reaching populations •NRT •Grants	n/a	•High cost of subsidized NRT programs •Enabling factor for promotion-based programs	•Significance of federal funding (i.e., Health Canada) •Improving programs through ability to develop resources and increase reach	•Provincial start-up funding earmarked specifically for youth •Later sustainability through partnerships formed during project

	Overall	Category			
		Smoke-free areas	**Cessation**	**Training**	**Youth**
Engagement	• Recognize unique needs of target population • Tailor approach	n/a	• Need for ongoing interaction and trust-building with clients • Addressing (sub-populations) needs in sensitive way • Use of best practices evidence-based approaches	n/a	• Need to 'facilitate without leading' in youth projects • Keep program moving to hold youth interest • Front-line staff flexibility and openness to youth ideas • Senior management support

The following Figures present selected information from the preceding Table in diagrammatic form. Figure 18 demonstrates that the nature of the partnerships tends to vary by the category of the initiatives.

Figure 18: Ways that Partnerships Facilitated Success in Different Categories of Initiatives (n=22)



Figures 19-22 show the most common facilitating factors for the following categories of initiatives: smoke-free areas, youth, cessation, and education and development. Key themes regarding how facilitating factors contributed to success for those categories of initiatives are also shown. The sub-project report provides additional details.[51]

Figure 19: Most Commonly Identified Facilitating Factors for Smoke-Free Area Initiatives (n=5)

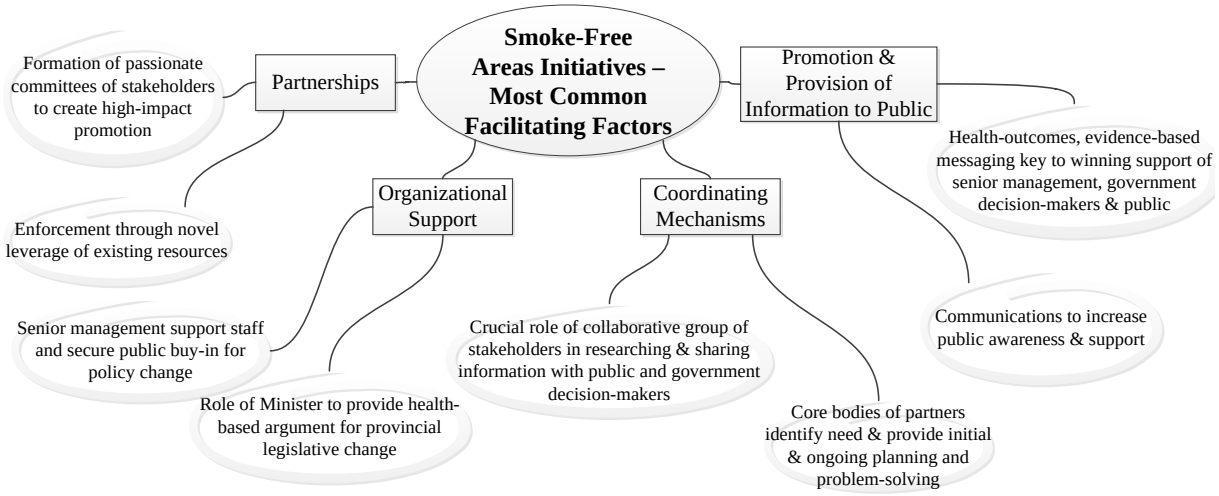


Figure 20: Facilitating Factors for Youth Success Stories (n=7)

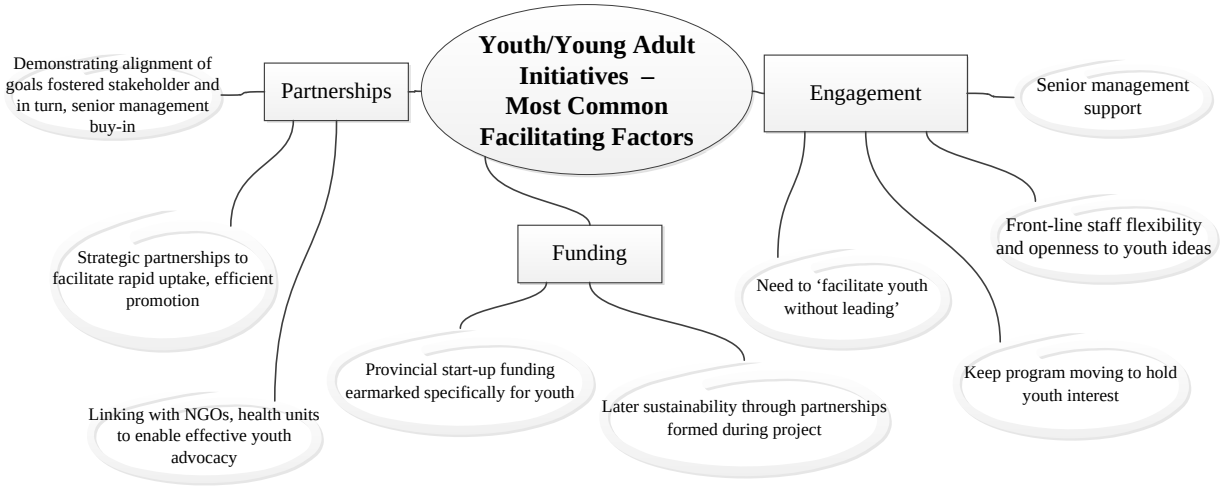


Figure 21: Facilitating Factors for Cessation Success Stories (n=5)

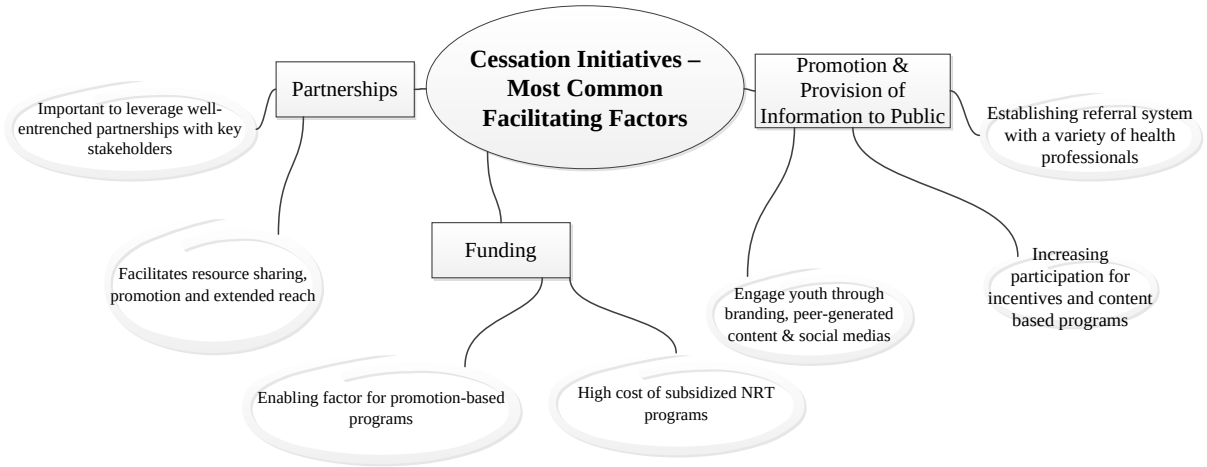
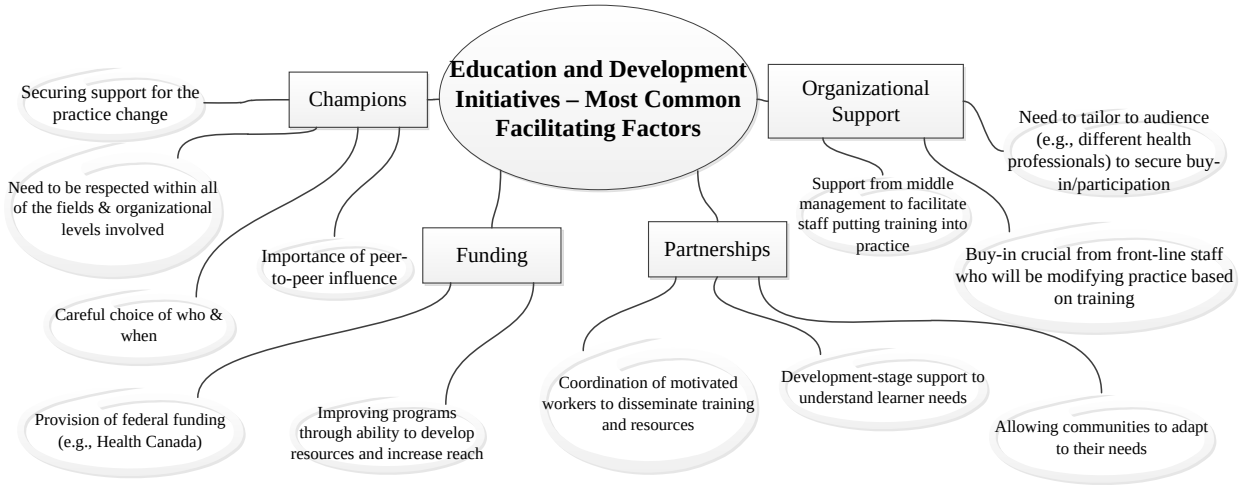


Figure 22: Facilitating Factors for Education-Related Success Stories (n=5)



APPENDIX 6: TOBACCO CONTROL EDUCATION RECOMMENDATIONS

The following recommendations were included in the sub-project report addressing tobacco control education and are more detailed than those appearing in the main body of this report.

Tobacco control examples and concepts should be embedded within the orientation and continuing education of all public health staff. CPHA should encourage the Public Health Agency of Canada to embed tobacco examples within the relevant *Skills Enhancement for Public Health* online modules, which are an important source of orientation and continuing education for public health staff across the country. In addition, CPHA should ensure that tobacco control is addressed in its annual conferences.

Public health organizations should assess opportunities for systematically incorporating brief-contact cessation interventions into existing 1:1programs and services. On a national basis, RNAO's best practice smoking cessation initiative offers e-learning and regional workshops. There are also region- and jurisdiction-specific training opportunities.

New tobacco control staff should be supported and required to take OTRU's free, online, bilingual course: *Tobacco and Public Health: From Theory to Practice*. The federal government should support its periodic updating.

Recognizing the unique provincial/territorial (P/T) context and evolution of training needs over time, training needs should be routinely identified on a P/T and national basis.

Recognizing the geographic dispersion of local/regional tobacco control staff across the country, the federal government should support:

i. **Regional tobacco control training workshops on a periodic basis; and**

ii. **Routine information sharing and exchange among local/regional staff whose experiences and practical knowledge may be beneficial for other local/regional organizations across Canada.**

CPHA should seek the engagement of Canadian Schools and Programs of Public Health[xvii] in establishing a tobacco control working group to develop a coordinated approach to comprehensively integrate tobacco control concepts and examples throughout the public health graduate curriculum among institutions. The

[xvii] At the time of writing this report, there is an emerging network of Canadian Schools and Programs of Public Health, which may facilitate collaborating with these institutions.

experience of other public health academic institution networks such as the Association of Schools of Public Health may be helpful in fostering increased incorporation of tobacco control within institutions. Canadian Schools and Programs of Public Health may also be of assistance in encouraging dissemination of the existing elective course *Tobacco and Health: From Cells to Society*.

In fostering involvement of academic programs/institutions, attention should be given to the principles of innovation within organizations (e.g., role of organizational leadership, internal champions, clarity/benefits of the 'innovation' such as teaching examples, resources, etc.).

The federal government can serve as a catalyst for this work by financially supporting the project work of the academic tobacco control working group, funding demonstration projects, and funding students' tobacco control practica and scholarships.

APPENDIX 7: KEY ELEMENTS TO NETWORK SUCCESS

According to a recent review by the National Collaborating Centre for Methods and Tools (NCCMT), the key elements to network success include the following:

- Establish clear purpose and goals;
- Address the 'hierarchy of needs;'
- Include a culture of trust in stated core values;
- Fulfill specific role functions such as effective leadership, sponsorship, knowledge brokerage and community membership;
- Maintain a flexible infrastructure;
- Establish supportive processes;
- Balance homogeneity and heterogeneity;
- Secure adequate resources; and
- Demonstrate value.[68]

The cited reference provides narrative summaries and further background information regarding each of these success criteria.

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