THE ONTARIO TOBACCO RESEARCH UNIT
UNITÉ DE RECHERCHE SUR LE TABAC DE L'ONTARIO

Survey on Tobacco Control in Canada's Public Health Units and Health Regions

Survey Results Report

Alexey Babayan
Ahila Srikandarajah
Ashley Duncan
Robert Schwartz

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Executive Summary

This report presents the findings of a survey on tobacco control activities in Canada's public health units and health authorities. The survey was conducted under the aegis of the Canadian Public Health Association (CPHA) project *The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks*.

This report explores successful tobacco control practices, programs and policies relating to prevention, cessation, protection and enforcement at the regional/local level across Canada. A second focus is learning about gaps and challenges in these practices, programs and policies. The results of the survey will inform *The Next Stage* project and deliverables provided to Health Canada, the project funder.

Key Findings

1. Almost all health authorities have a role in all areas of tobacco control, including protection, prevention and cessation. However, there is considerable variation across health authorities regarding their level of engagement in these areas. High proportions of health authorities are heavily involved in enforcement of smoke-free legislation (59.0%) and youth access restrictions (47.0%), partnering with local community organizations (43.4%) and public education activities (41.0%). A somewhat lower proportion of health authorities are heavily engaged in the delivery of their own cessation and prevention programs (37.3% and 32.5% respectively). The role of health authorities in promoting/advocating for initiatives at the federal level is mostly minimal.

2. Only about 16% of health authorities across Canada have dedicated tobacco control units, while in the majority of health authorities, tobacco control staff (both dedicated and non-dedicated) work in health promotion and prevention units. Moreover, 23% of health authorities reported having no dedicated tobacco control staff. On average, dedicated and non-dedicated tobacco control staff make up respectively 2.3% and 3.2% of the total personnel (managers and staff) in health authorities.

3. There has been more progress in prohibiting or restricting smoking in indoor rather than outdoor places within health regions across Canada. Smoke-free legislation for recreational indoor facilities and restrictions on smoking in lobbies of MUDs are in place within the majority of health authorities' jurisdictions. Smoke-free school grounds policies are the only outdoor smoke-free policies adopted within most health authorities' jurisdictions. Health authorities indicated they do not anticipate the adoption of additional smoke-free policies in the near future.

4. There have been few achievements in enacting policies to limit the availability of tobacco products. Prohibition of sales of tobacco products in pharmacies is the only availability policy in place within most health authorities' jurisdictions (72.3%). Some jurisdictions have adopted policies to license tobacco vendors and prohibit sales of tobacco products on college and university campuses.

5. Enforcement activities by health authorities indicated relatively greater levels of compliance with smoke-free policies than with the total display ban policy and youth access restrictions. About half of health authorities (47.0%) have experienced an increase in enforcement activities in the past 3 years. Health authorities that have experienced a decrease in enforcement activities over time (12%) tend to explain this mostly by the achievement of full compliance. The majority of health authorities (71.0%) tend to perceive tobacco smuggling as a significant issue (both somewhat and very) in their respective jurisdictions.

6. The level of tobacco use prevention activities has increased in almost half of the health authorities (47.0%) in the past 3 years. The key reasons for this change in prevention activities are: an increase in dedicated funding and partnership with local community organizations and tobacco control coalitions; and increased priority for prevention activities. Somewhat more than a quarter of health authorities (26.5%) have experienced a decrease in prevention activities, which is mainly explained by funding cuts, competing priorities and a lack of dedicated staff.

7. Approximately 68% of health authorities reported an increase in cessation activities in the past 3 years. Increased funding and priority of tobacco cessation measures were identified as key factors determining the increase in cessation activities. A few health authorities (8.4%) have experienced a decrease in the level of cessation activities mainly due to funding cuts for tobacco cessation programming and low uptake of services.

8. Prevention and cessation initiatives are not adequately meeting the needs of the general population and various sub-populations. In the area of prevention, the needs of youth under 14, youth 15-19 years of age and young adults (20-24) are addressed only to a small and a moderate extent in 79.5%, 81.9% and 69.9% of health authorities respectively. The needs of young adults are not at all addressed within 22% of health authorities. In terms of cessation, the needs of the general smoking population are addressed only to a moderate and small extent in 86.8% of health authorities, while the needs of various high-risk sub-populations are addressed to a small extent in more than 40.0% of health authorities. Among sub-populations, the needs of youth under 18 and the aboriginal population are not at all addressed in just over a quarter of health authorities.

9. Access to grey literature and information about other jurisdictions' experiences/activities presents a challenge for at least 30.8% of health authorities. Most health authorities don't experience any significant difficulty in accessing published scientific research, provincial and federal tobacco control documents and smoking cessation guidelines.

10. Health authorities identified several common facilitating factors for successful tobacco control activities. These included community support, promotional campaigns, collaboration among health authorities and partnerships with community organizations, adequate funding and staffing. They also identified factors that specifically contributed to success in certain areas of tobacco control, including the use of evidence-based practice, compliance checks, youth buy-in, and access to NRT products.

11. The barriers that health authorities experience across many of the tobacco control areas include lack of: funding; dedicated staff, particularly enforcement officers; political support from all levels of government; and stricter legislation and regulations regarding vendor licensing, selling, purchasing and possession of contraband. Some major specific barriers identified by health authorities are: resistance from local businesses to smoke-free policies, lack of public awareness regarding smoke-free policies; the availability of contraband and the proximity of Aboriginal reserves to towns and cities; lack of authority to address contraband issues; lack of best practice guidelines in prevention; and lack of training and education opportunities for staff in the area of cessation.

12. Securing more adequate and sustainable funding for programs and hiring more dedicated staff are two common approaches to overcoming these barriers identified by health authorities. Key specific strategies to address the barriers include: the implementation of federal and provincial rather than local smoke-free policies; more legal actions and economic disincentives to limit availability of tobacco; greater collaboration with First Nation Communities; application of evidence-based approaches targeted to youth; and funding for NRT.

13. Health authorities perceive future strategic directions in tobacco control as focused on advocacy activities, stricter legislation and regulations by federal and provincial governments, partnerships and public education in each area of tobacco control. Some specific future strategic directions for certain areas of tobacco control are also suggested.

14. The majority of health authorities (94.0%) collaborate with community organizations and government agencies in planning and implementing tobacco control initiatives. The common partners of health authorities in all areas of tobacco control are: schools or school boards, municipalities, health care organizations, other health authorities within the province/territory, government agencies (both federal and provincial), provincial tobacco control coalitions, professional associations and other non governmental/not-for-profit organizations. Health authorities also cooperate with specific partners in certain areas of tobacco control, including tobacco vendors, police (local, provincial and federal), colleges and universities, sport and recreation organizations, and workplaces.

15. Health authorities' suggestions for provincial governments emphasize the need to strengthen policies to eliminate public exposure to second-hand smoke, expand cessation programs and provide coverage for NRT products, increase tobacco control funding and increase taxes on tobacco products. Among suggestions for the federal government, survey respondents mostly mentioned the need to address the contraband issue and further strengthen the provisions of Bill C-32.

16. Health authorities are connected mostly with health authorities in their province/territory rather than with health authorities outside of their province or territory. Communication among health authorities is mainly in the areas of knowledge exchange and collaboration on the promotion of tobacco control initiatives rather than program development and implementation.

17. Survey participants welcome the idea of creating a *Knowledge Centre* (Centre) within the context of *The Next Stage* project. The vast majority expect the Centre to facilitate new connections, enable collaboration and knowledge exchange and serve as a source of information on new and emerging programs and practices in tobacco control.

18. There is a wide range of information and knowledge gaps experienced by health authorities, which may inform the focus and scope of activities of the Centre. In general, health authorities lack information on best practices in tobacco control, successful tobacco control initiatives across Canadian jurisdictions, and emerging/promising practices in tobacco control. More specific needs include: information on programs for youth and young adults; access to regional/local data on tobacco use; design, implementation, and assessment of tobacco control programs; networking opportunities; and best practices in public education/tobacco counter-marketing campaigns.

Methodology

The survey focused on *The Next Stage* projects' objective, to generate information on "what works" in the key areas of tobacco control – protection (smoke free policies, enforcement), prevention, and cessation. The survey aimed to explore Canada's public health units'/health authorities' experiences in developing, coordinating, facilitating or implementing tobacco control initiatives. More specifically, the survey objectives were to identify:

- successful tobacco control practices, programs and policies at the regional/local level relating to prevention, cessation, protection and enforcement, including initiatives targeted to various high-risk vulnerable populations (youth, young adults; First Nations; low income population; people with mental health issues, etc)
- barriers/gaps and successes in practices, programs and policies, and in meeting the needs of high-risk, vulnerable populations
- strategies to address the identified barriers/gaps to implementing tobacco control activities at the regional/local levels
- perceived future strategic directions in tobacco control

The survey was conducted among public health professionals that represented public health units, health authorities or health regions across the provinces and territories of Canada. Different terms are used across Canada to refer to administrative units or organizations engaged in coordination, promotion, facilitation or delivery of tobacco control programs and activities. Throughout this document the terms "public health units", "health authorities' and 'health regions' are used interchangeably.

The survey was administered with the use of on-line survey technology (KEY SURVEY). Provincial public health associations coordinated the implementation and completion of the online survey within each health authority or public health unit in their respective province or territory. They collaborated with health authorities to identify public health professionals involved in tobacco control activities and interested to participate in the survey on behalf of their health authorities. Those willing to participate in the survey were further asked to provide their valid e-mail addresses in order to enable distribution of individual URL links to the on-line survey. Once the survey participants were identified e-mail invitations were sent to them. Table 1 provides a summary of the survey process.

Table 1: Summary of the survey process

Indicator	Data
1. Initial sampling frame (i.e. total number of health authorities across Canada, excluding Quebec)	97
2. Sample size, *n* (number of completed surveys)	83
3. Response rate:	85.6%

Implementing federally funded initiatives in the province of Quebec usually requires the approval of the provincial Ministry of Health and Social Services (MSSS). On behalf of CPHA, the Association pour la santé publique du Québec (ASPQ) sought to obtain approval from the MSSS

in order to invite local health regions to participate in the survey. However, MSSS officially declined participation of its health regions in the survey.

Table 2 summarizes the survey completion by Canada's provinces and territories.

Table 2: 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
Quebec	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.

The web survey questionnaire was developed in consultation with the CPHA Next Stage project staff and the Advisory Committee (see Appendix A). The survey contained a range of general questions, i.e. how tobacco control activities are organized in the health unit/region, and specific questions, i.e. those related to key areas of tobacco control, such as smoke-free policies, enforcement, availability of tobacco, tobacco prevention and cessation. For each tobacco control area participants were asked to: assess changes in the level of activity in the past several years; estimate the extent to which various population groups are served by existing tobacco control initiatives; provide examples of successful initiatives by outlining the role of the health unit in those initiatives, describing key outcomes and explaining why the initiatives have succeeded; specify challenges/barriers to implementing tobacco control activities and suggest ways to overcome those challenges/barriers; describe the health unit's partnership experience in addressing tobacco use problems; and provide suggestions on future tobacco control measures at the provincial and federal levels. Expectations from *The Next Stage* project were also explored. Finally, the questionnaire asked several questions for classification purposes, such as: location of

the health unit within a province, type of area (urban, rural) in which the health unit operates, and participant's position.

Due to the wide range of tobacco control related topics covered by the survey, health authorities were encouraged to ensure completion of the survey by a "response team" comprised of key professionals knowledgeable about tobacco control activities in their respective health regions (as opposed to a single individual). In the majority of cases, health authorities' responses represented input by 2 to 3 specialists. The primary roles of those involved in completing the survey are summarized in Table 3.

Table 3: Survey participants' primary positions within their health authorities (n=83)

Position	n	%*
Manager/Supervisor/Coordinator	65	78.3
Health Promotion Specialist/Project Officer/Program Developer	65	78.3
Enforcement Officer/Public Health Inspector	46	55.4
Public Health Nurse	30	36.1
Consultant	9	10.8
Tobacco Cessation Specialist/Counsellor	9	10.8
Evaluation Officer/Epidemiologist	1	1.2
Researcher/Program Analyst	3	3.6
Other	9	10.8

* Percentages may not add up to 100% as the survey participants could provide more than one answer

Limitations of the survey

1. Surveys may not be the most appropriate method to learn about effective tobacco control programs and practices as well as gaps and challenges at the regional/local levels. The limited direct communication with respondents in the on-line survey prevented exploring health units' unique experience in tobacco control in more detail. In contrast, a semi-structured interview method would allow for extensive probing by the interviewer and would give respondents the ability to elaborate their answers.
2. Survey findings are based on the study of health authorities' experience in tobacco control. However, not all the tobacco control initiatives and practices may have been captured in the survey due to variations in the structure and administration of public health services, including tobacco control activities, across Canada's provinces and territories. For example, in some provinces dealing with tobacco smuggling is beyond the mandate of health authorities and hence respondents found it difficult to comment on the progress in this area of tobacco control.
3. As mentioned earlier, the Quebec health authorities did not participate in the survey. As a result, the survey findings are not fully representative of all Canada's health authorities.

Results

1. Health authorities' mandate and scope of tobacco control activities

1. 1 Level of engagement in tobacco control activities

Survey respondents were asked to describe their health authorities' mandate and responsibilities in the area of tobacco control. The mandate and scope of tobacco control activities in health units/authorities are mainly informed by provincial tobacco control strategies and public health standards. The latter guide the provision of mandatory health programs and services by health units. In most cases tobacco control is included under the chronic disease prevention domain or, more generally, the health promotion and prevention domain.

Health authorities' mandates usually encompass activities in all tobacco control pillars, including prevention, cessation, and protection. However, the level of their engagement in each tobacco control area varies across the provinces and territories. Some health authorities coordinate cessation programs such as Quitline or distribution of free NRT, while others have greater focus on public education activities (in the areas of prevention and protection from second-hand smoke) at the local level and on referring smokers to provincial programs. In some provinces inspection and enforcement are provincial responsibilities, whereas in others they are included in health authorities' mandates.

The variation in the mandate and scope of tobacco control activities across health authorities is reflected in the findings on activity levels. While all health authorities across Canada are engaged in a range of tobacco control activities, the level of engagement varies by activity (see Table 4).

Table 4: Level of health unit/region engagement in tobacco control pursuits (n=83)

	To a great extent, %	To a moderate extent, %	To a small extent, %	Not at all, %
Promoting/advocating for new tobacco control policies/programs at the public health unit level	38.6	34.9	21.7	4.8
Promoting/advocating for new tobacco control policies/programs at the provincial level	22.9	44.6	30.1	2.4
Promoting/advocating for new tobacco control policies/programs at the federal level	1.2	19.3	50.6	28.9
Administration/delivery of provincial tobacco cessation programs	30.1	21.7	25.3	22.9
Administration/delivery of provincial tobacco use prevention programs	25.3	28.9	33.7	12.0

Delivery of own local tobacco cessation programs	37.3	21.7	28.9	12.0
Delivery of own local tobacco use prevention programs	32.5	38.6	18.1	10.8
Inspection and enforcement of smoke-free legislation	59.0	8.5	9.6	22.9
Inspection and enforcement of youth access restrictions	47.0	6.0	7.2	39.8
Public education	41.0	42.2	16.9	-
Partnering with community organizations in planning or implementing tobacco control programs/initiatives	43.4	26.5	27.7	2.4
Surveillance and monitoring	25.3	30.1	31.3	13.3

Table 4 indicates that the majority of health units (regardless of their level of engagement) are engaged in public education activities, the promotion of new tobacco control policies and programs at the provincial and local levels as well as collaboration/partnership with community organization. In contrast, enforcement of youth access restrictions is an activity, in which the highest proportion of health units (39.8%) is not engaged at all.

In terms of the level of engagement, it is evident that a substantial majority of health units are *to a great extent* engaged in enforcement activities, including enforcement of smoke-free legislation (59.0%) and youth access restrictions (47.0%). These are followed by partnership with local community organizations in the area of tobacco control (43.4%) and public education activities (41.0%). Only 1.2% of health units are engaged to a great extent in promoting/advocating for programs/initiatives at the federal level.

Health authority involvement in the areas of prevention and cessation varies. In general, health units have greater engagement (moderate to great extent) in implementation of their own prevention and cessation programs than provincial ones. Within their local initiatives, they are relatively more engaged in the delivery of tobacco use prevention rather than cessation programs (71.1% (moderate and great extent) vs. 59.0%).

Engagement in surveillance and monitoring also varies among health units. More or less equal proportions of health units have either a moderate or minimal role in the surveillance and monitoring of tobacco control activities; fewer are involved in this activity to a great extent.

1.2 Organization of tobacco control activities and human resources

Three quarters (72.3%) of health authorities do not have a separate tobacco control unit but rather staff working within health promotion and prevention units. Currently, only 15.7% of health authorities have dedicated tobacco control units. In 6.0% of health authorities tobacco control staff is spread across more than one unit. A few other health authorities have adopted a hybrid model, i.e. have both dedicated staff and staff with shared responsibilities (see Table 5).

Table 5: Organization of tobacco control activities in health authorities (n=83)

	%
Integrated in a unit that deals with other health promotion and prevention activities	72.3
Dedicated tobacco control unit	15.7
Activities are integrated in more than one unit	6.0
Hybrid model (i.e. some staff are dedicated, while others have shared responsibilities)	6.0

The survey revealed that 22.9% of health authorities don't have dedicated tobacco control staff, i.e. personnel that is exclusively assigned to tobacco control programs and activities. The mean ratio of dedicated tobacco control staff to total FTEs (full-time equivalents) of all managers and staff in the health authority is 2.3%, while the mean ratio of non-dedicated staff to total FTEs (full-time equivalents) of all managers and staff is 3.2%. The ratio of dedicated tobacco control staff to total staff across health authorities ranges from 0 to 9.09%; in contrast, there is a greater variation in ratios of non-dedicated staff to total staff across health authorities, which ranges from 0% to 40.0%.

2. Progress in tobacco control across health authorities

2.1 Smoke-free policies

The survey data indicate greater achievement in prohibiting or restricting smoking in indoor rather than outdoor places within health regions/unit across Canada (see Table 6). In particular, among indoor smoke-free policies, the smoke-free legislation for recreational indoor facilities (e.g. arena) has been adopted within almost all health units' jurisdictions (97.6%) across Canada, followed by the restrictions of smoking in apartment lobbies within multi-unit dwellings (MUDs), which is now in place in 83.1% health units/regions. Prohibiting smoking on school grounds is the only outdoor smoke-free policy that is in place in most health units/regions (83.1%).

In some health regions other outdoor policies are being considered for adoption in the next 2 years, notably the policies to prohibit smoking in recreational outdoor places as well as parks and/or beaches. The same policies in other health regions are not even under active consideration. In particular, no further legislative measures are envisioned in the near future to strengthen several smoke-free outdoor provisions, including, most importantly, prohibiting smoking in parks and/or beaches (48.2% of health units), outdoor recreational facilities (30.1%), bar and restaurant patios (27.7%), and within entrances to all workplaces and public places (21.7%). Total smoke-free MUDs policy is the only indoor policy, for which a relatively higher proportion of health units (16.9%) tend to think that this policy is not considered for adoption at all in the nearest future.

Table 6: Smoke-free policies in Canada's health authorities (n=83)

Policy	1.Adopted, %	2. In the process of adoption, %	3. Under consideration for adoption within the next 2 years, %	4. Neither adopted nor under active consideration, %
Smoke-free bar and restaurant patios	62.7	4.8	4.8	27.7
Smoke-free public building entrances (office, bank etc.)	48.2	14.5	15.7	21.7
Smoke-free recreational outdoor places (e.g. playgrounds)	22.9	16.9	30.1	30.1
Smoke-free recreational indoor places (e.g. arenas)	97.6	1.2	1.2	-
Smoke-free parks and/or beaches	10.8	10.8	30.1	48.2
Smoke-free motor vehicles	60.2	13.3	18.1	8.4
Smoke-free school grounds	83.1	10.8	1.2	4.8
Smoke-free apartment lobbies within multi-unit dwellings (MUDS)	83.1	10.8	1.2	4.8
Total smoke-free MUDS	60.2	10.8	12.0	16.9

2.2 Tobacco control policies to limit availability of tobacco products

Compared to protection from second-hand smoke, there have been fewer achievements in enacting policies to limit availability of tobacco products. As reported by health units, prohibition of sales of tobacco products in pharmacies is the only availability limiting policy in place in most of the units (72.3%). 44.6% and 34.9% of health units reported having other policies in place, including respectively the policy of licensing tobacco vendors and prohibiting sales of tobacco products in college and university campuses (see Table 7).

Other policies aimed at restricting availability of tobacco products have not yet been adopted and are not under active consideration. These policies include: prohibition of sales within a certain distance from school (not in place in 91.6% health regions), restriction of sales of tobacco to specialty stores (91.6%), and decrease in retail tobacco outlet density (86.7%). Although there is some progress in adoption of policies to license tobacco vendors and prohibit sales of tobacco on colleges and university campuses, substantial proportions of health units still lack these two policies (respectively 48.2% and 57.8%)

Table 7: Policies to limit availability of tobacco products in Canada's health authorities (n=83)

Policy	1.Adopted, %	2. In the process of adoption, %	3. Under consideration for adoption within the next 2 years, %	4. Neither adopted nor under active consideration, %
Tobacco retail licensing	44.6	1.2	6.0	48.2
Prohibiting the sale of tobacco within XX km of schools	1.2	1.2	6.0	91.6
Prohibiting the sale of tobacco products in pharmacies	72.3	8.4	9.6	9.6
Prohibiting the sale of tobacco products on college and university campuses	34.9	-	7.2	57.8
Decreasing the retail tobacco outlet density	2.4	-	10.8	86.7
Restricting sale of tobacco to specialty stores.	4.8	-	3.6	91.6

2.3 Enforcement

About 60% of health authorities reported that they had experienced changes in the level of enforcement activities in the past 3 years. 47% of health authorities observe an increase (both significant and somewhat) in enforcement activities in their jurisdiction, which they tend to associate mainly with two related factors: passage or amendments to provincial smoke-free policy/legislation and availability of funding (see Table 8). In 32 health authorities, the passage of provincial smoke-free policies established (or enlarged) health authorities' scope of services and compliance protocols. The provincial and territorial governments, in their turn, provided funding for health units to hire necessary enforcement staff to implement compliance checks. A few health units (n=2) connect an increase in enforcement activities to an increase in public reporting of violations of the smoke-free provisions.

Table 8: Changes in the level of enforcement activities (n=83)

	n	%
Significantly increased	16	19.3
Somewhat increased	23	27.7
Stayed the same	34	41.0
Somewhat decreased	6	7.2
Significantly decreased	4	4.8

The health authorities which had experienced a decrease in the level of enforcement activities (12.0%) tend to connect it to decreased funding (n=2). One health unit mentioned that because of

the decreased funding, the unit was forced to lay off an enforcement officer. The majority, however, associate the decrease in enforcement with the achievement of full compliance (n=8). Health units explain that public awareness of and support for tobacco control resulted in greater compliance and less enforcement activity.

Table 9 below indicates that the current enforcement activities in health units' jurisdictions ensure the greatest level of compliance (to a great extent) with the total display ban policy. However, when considering a broad continuum of compliance estimates (from a moderate to a great extent), it becomes evident that the perceived compliance with the smoke-free policies is relatively greater (84.4% of health units) than with the total display ban policy (75.9%) and youth access restrictions (67.5%).

Table 9: Perceived level of compliance by health authorities (n=83)

	To a great extent, %	To a moderate extent, %	To a small extent, %	Not at all, %	Don't know, %
Smoke-free policies	43.4	41.0	10.8	2.4	2.4
Youth access restrictions	38.6	28.9	18.1	7.2	7.2
Point of sale advertising restrictions/total display ban	57.8	18.1	7.2	9.6	7.2

2.4 Tobacco smuggling (contraband)

In most health units tobacco smuggling is considered an issue; 36.1% and 34.9% respectively, consider that smuggling is a very significant or a somewhat significant issue (see Table 10).

Table 10: Perception of tobacco smuggling as an issue by health authorities (n=83)

	n	%
It is a very significant issue	29	34.9
It is a somewhat significant issue	30	36.1
It is not a significant issue	24	28.9

2.5 Prevention

Changes in the level of prevention activities

Compared to the area of enforcement, more health units (73.5%) have undergone changes (either increase or decrease) in the level of prevention activities (see Table 11). 47.0% of health units reported having an increase in the level of prevention activities in the past 3 years (see Table 11). This increase was possible mainly due to an increase in dedicated funding (n=15) and partnership with local community organizations and tobacco control coalitions (n=12) and, generally, an increase in the priority of prevention tobacco control activities for health authorities (n=8).

Table 11: Changes in the level of prevention activities (n=83)

	n	%
Significantly increased	13	15.7
Somewhat increased	26	31.3
Stayed the same	22	26.5
Somewhat decreased	15	18.1
Significantly decreased	7	8.4

26.5% of the health units have experienced a decrease in prevention activities in the past 3 years. They provided various explanations why this had occurred, among which funding cuts is the most frequently mentioned (n=7). Some health units had to decrease the number of prevention activities because of redirection of resources to other priority areas (n=5), such as immunization programming, and the lack of staff (n=4) within health authorities to implement prevention programs.

Addressing the needs of youth and young adults

According to survey participants, current tobacco control prevention programs do not fully address the needs of youth and young adults at the local level. In most cases, the needs of youth under 14 and youth 15-19 years of age as well as the needs of young adults are addressed mainly to a moderate or small extent. About 22% of health units reported the absence of any prevention programming for young adults (see Table 12).

Table 12: Prevention programs to address the needs of youth and young adults (n=83)

	To a great extent, %	To a moderate extent, %	To a small extent, %	Not at all, %	Don't know, %
Youth under 14 years of age	16.9	37.3	42.2	2.4	1.2
Youth 15-19 years of age	14.5	44.6	37.3	2.4	1.2
Young adults 20-24 years	4.8	21.7	48.2	21.7	3.6

Accessing evidence to inform planning and implementation of prevention programs

In general, most health units don't experience any significant difficulty in accessing published evidence necessary for developing, coordinating or delivering preventions programs. From 85.6% to 92.8% of health units find it very easy or easy to access published scientific research as well as provincial and federal tobacco control documents. It is relatively difficult for many health units to access grey literature and experiences from other jurisdictions. The lack of access to those sources of information is currently experienced by respectively 32.5% and 38.5% of health units (see Table 13).

Table 13: Access to sources of evidence in the area of prevention by health authorities (n=83)

	Very easy, %	Easy, %	Difficult, %	Very difficult , %
Evidence from published scientific research	38.6	54.2	6.0	1.2
Evidence from grey literature (reports, unpublished research and evaluation studies, etc.)	14.5	53.0	27.7	4.8
Experience from other jurisdictions (communities, provinces, countries) in implementing similar programs	18.1	43.4	36.1	2.4
Provincial tobacco control documents (strategy, goals, policies and programs)	44.6	48.2	7.2	-
Federal tobacco control documents (strategy, goals, policies and programs)	21.7	63.9	12.0	2.4

2.7 Cessation

Changes in the level of cessation activities

24.1% of health units have maintained the same level of cessation activities over the past 3 years. The rest of health units have experienced changes, with the majority (67.9%) reporting an increase (significant or somewhat) in the level of cessation activities in the past 3 years.

Similar to the area of prevention, the increase in cessation activities was possible mostly due to an increase in dedicated funding (n=17) and generally, an increase in the priority of cessation measures at the local level (n=5). Other important reasons mentioned by the health units and which are related to the above two reasons, include: hiring designated staff (n=4), provision of training opportunities for the staff (n=11) and most importantly, the expansion of cessation services at the health unit level (n=17).

Table 14: Changes in the level of cessation activities (n=83)

	n	%
Significantly increased	19	22.9
Somewhat increased	37	44.6
Stayed the same	20	24.1
Somewhat decreased	5	6.0
Significantly decreased	2	2.4

Only a few health units/regions (8.4%) have experienced a decrease in the level of cessation activities, which they tend to associate mainly with funding cuts for tobacco cessation programming (n=2) and low uptake of the programs (n=2) by tobacco users.

Addressing the needs of the general smoking population and sub-populations

As reported by health units, the needs of the general smoking population are mostly addressed to a moderate and small extent at the local level (see Table 15).

Table 15: Cessation programs to address the needs of the general population (n=83)

	n	%
To a great extent	6	7.2
To a moderate extent	32	38.6
To a small extent	40	48.2
Not at all	3	3.6
Don't know	2	2.4

In terms of existing cessation services, the needs of sub-populations are not well met in a large number of health authorities. Very few health authorities, ranging from 2.4% to less than 10%, report that the needs of any sub-population are being met to a great extent. In about 30% of health authorities only, the needs of several sub-populations, such as pregnant and post-partum women, low-income population, youth and young adults (18-24 years of age), people with addiction issues, are met to a moderate extent. In most health authorities, however, the needs of sub-populations are addressed to a small extent. Youth under 18 and the aboriginal population are two sub-populations whose needs are not at all addressed in respectively 25.3% and 27.7% of health authorities (see Table 16).

Table 16: Cessation programs to address the needs of sub-popualtionsn (n=83)

	To a great extent, %(*n*)	To a moderate extent, %	To a small extent, %	Not at all, %	Don't know, %
Youth (under 18 years of age)	3.6	10.8	54.2	25.3	6.0
Youth and young adults (18-24 years of age)	2.4	27.7	54.2	7.2	8.4
Pregnant and post-partum women	9.6	30.1	44.6	7.2	8.4
People suffering from mental health diseases	7.2	19.3	51.8	10.8	10.8
People suffering from addictions	8.4	26.5	41.0	16.9	7.2
Aboriginal population	2.4	13.3	42.2	27.7	14.5
Low-income population	7.2	28.9	41.0	13.3	9.6

Accessing evidence to inform planning and implementation of cessation programs

Similar to the prevention area, health units do not encounter any significant problems in accessing scientific published research, provincial and federal tobacco control documents to gather information necessary for developing, coordinating or delivering tobacco cessation

programs. The majority of health units (92.5%) also find it very easy or easy to access existing tobacco cessation guidelines. Grey literature and experience from other jurisdictions are two sources of evidence to which a substantial proportion of health units (30.5% and 32.1%) currently lack access (see Table 17).

Table 17: Access to source of evidence in the area of cessation by health authorities (n=83)

	Very easy, %	Easy, %	Difficult, %	Very difficult , %
Evidence from published scientific research	36.6	53.7	8.5	1.2
Evidence from grey literature (reports, unpublished research and evaluation studies, etc.)	17.3	51.9	25.9	4.9
Experience from other jurisdictions (communities, provinces, countries) in implementing similar programs	19.8	48.1	32.1	-
Formal tobacco cessation guidelines (e.g. US guidelines, Ontario Medical Association Guidelines)	40.0	52.5	7.5	-
Provincial tobacco control documents (strategy, goals, policies and programs)	37.8	47.6	12.2	2.4
Federal tobacco control documents (strategy, goals, policies and programs)	25.0	56.3	15.0	3.8

3. Perceived successes in tobacco control

The survey sought to explore which tobacco control initiatives are working and why at the regional/local level, including initiatives targeted to various high-risk vulnerable populations (youth, young adults; First Nations; low income population etc). For this purpose, survey participants were asked to provide examples of successful tobacco control practices and programs relating to prevention, cessation, protection and enforcement, which have been implemented within the jurisdiction of their health authorities.

It should be noted that these are health authorities' perceived successful initiatives, which may or may have not undergone formal evaluation. Since the method employed (i.e. on-line survey) prevented exploring "success stories" in more detail, the examples provide only a high level description of how and why certain initiatives have been successful. A more detailed examination of successful initiatives is warranted.

The section below describes some characteristics of successful initiatives (issues addressed, populations targeted, roles of health authorities) explored in the survey. Perceived outcomes of prevention and cessation initiatives are also presented in this section. Common and specific

factors that were perceived to have contributed to successful implementation of the initiatives are described in the next section.

3.1 Characteristics of successful initiatives by areas of tobacco control

Smoke-free policies

Analysis of "success stories" in the area of protection relate largely to promoting the adoption of various indoor and outdoor smoke-free policies. Among outdoor smoke-free policies, health authorities reported successfully promoting the banning of smoking on restaurant/bar patios (n=7), in school yards (n=5), and in public building entrances (n=5). Health authorities have been successful in promoting the adoption and implementation of indoor smoke-free policies, such as total smoking bans in workplaces (n=14), hospitals and/or at health region properties (n=8), as well as restrictions on smoking in private homes (n=3) and vehicles (=4).

In the area of adopting smoke-free policies, the key role of health authorities has been advocacy both at the community and the provincial levels. Other roles frequently mentioned by health authorities are public education, including educating employees at workplaces and the general public about smoke-free legislation, and enforcement of current provisions of the legislation. Although some health authorities reported leading these initiatives, in most cases they actively participated through collaboration, co-ordination or partnership with local or provincial governments and law enforcement agencies.

Policies to limit availability of tobacco

Among policies to limit availability of tobacco, health authorities most often reported successfully supporting the implementation of retail display bans (n=15), followed by initiatives aimed at preventing the sale of tobacco to minors (n=8), and prohibiting sales of tobacco products in other locations such as pharmacies, stores that contain pharmacies, health institutions, and educational facilities (n=3).

Health authorities' roles in this area are similar to those identified in the area of smoke-free policies. Their key roles include advocacy (n=13), enforcement (n=12), and public education (n=10). Further, health authorities' experience suggests that initiatives are more likely to be successful if implemented in partnership/coordination with other organizations/stakeholders (n=7).

Enforcement

A significant proportion of health authorities report that their enforcement activities have successfully improved compliance with regulations pertaining to smoke-free public places (n=17), point of sale tobacco promotion (n=9) and youth access to tobacco (n=18). As perceived by health authorities, a high level of compliance is achieved mainly through educating tobacco vendors about current legislative provisions (n=27) and regular compliance checks. In particular, enforcement officers make personal visits to tobacco vendors and provide educational binders to them. Among various methods of compliance checks, a number of health authorities have successfully utilized test shopping with participation of youth (n=18).

Tobacco Smuggling

Relatively few health authorities appear to be directly involved in initiatives to address tobacco smuggling. Only sixteen health authorities provided examples of successful initiatives in this area. Examples of successful initiatives included education (n=3), sharing of information with law enforcement agencies (n=5), and control of contraband through various ways, such as collecting and analyzing cigarette butts to determine whether or not they are contraband, holding educational workshops about the dangers of contraband, and reporting to law enforcement when contraband is discovered (n=8).

Health authorities noted that addressing tobacco smuggling is beyond their responsibility and therefore they rarely lead any initiatives in this area (n=4). In most cases (n=12), they act as local level coordinators of provincial and federal initiatives.

Prevention

Health authorities' successful prevention programs have focused on various age groups, including youth 14 years of age and under (n=21), youth aged 15-19 (n=19), youth aged 20-24 (n=5) as well as youth from all or overlapping age categories (n=24)

Partnering with schools to educate youth is the most frequently mentioned function carried out by health authorities in the area of prevention. Health authorities also occasionally noted providing funding for various local initiatives (n=9), such as training teachers or youth volunteers implementing smoking prevention programs within school environments or communities as a whole. The major perceived outcomes of those prevention initiatives include: an increase in the level of youth awareness of the health effects of tobacco use (n=30), youth engagement (n=13), a decrease in uptake of smoking (n=10), youth skill development (e.g. learned social advocacy skills) (n=7), and legislative or policy changes (n= 6).

Approximately half of all respondents noted the initiation of emerging/promising programs by their health authorities in the areas of prevention and cessation. However, it should be noted that perceived success stories tend to describe any new prevention or cessation initiative currently being implemented rather than initiatives with application of innovative approaches/interventions, for which evidence of effectiveness is still emerging.

A substantial proportion of promising prevention programs were aimed at children and youth (n=27), while other prevention programs were designed for prenatal and postnatal young women (n=4), immigrant populations (n=1) and aboriginal populations (n=1). In many cases, these programs employed various creative ways of delivering the key tobacco control messages to target populations. For example, a prevention program designed for prenatal and postnatal women made use of baby blankets and fridge magnets with Born Smoke Free written on them. One school-based prevention program incorporated posters and teaching calendars with key messages on the health effects of smoking. Many survey participants stated that they could not determine the effectiveness of emerging/promising programs for both prevention and cessation as many of them are still in progress.

Cessation

Health authorities provided examples of successful cessation initiatives for the general smoking population and various sub-populations. Health authorities reported being successful in improving or expanding tobacco cessation services for the general smoking population through partnering with community and provincial organizations to promote cessation services at the local level or developing and implementing their own cessation program. The latter most often took the form of providing counselling services and/or delivery of free NRT products (n=15).

The perceived outcomes reported were an overall increase in the number of smoking cessation services available to the general smoking population (n=15), an increase in the reach and utilization of smoking cessation services (n= 11) and proportion of smokers successfully quitting (n=20). Additionally, health authorities noted an increase in the number of trained health professionals delivering smoking cessation interventions.

Initiatives undertaken to expand tobacco cessation services for sub-populations have been geared towards pregnant and/or post-partum women (n=10), persons with mental health issues (n=7), people with low-income (n=5), the aboriginal population (n=5), youth (n=6) and young adults (n=5).

As with initiatives aimed at the general population, health authorities either work in a partnership/co-ordination role to promote current programs available for specific sub-populations (n=19) or lead their own initiatives (including the development of the program, the funding of the program and the implementation of the program) (n=19). They tend to report outcomes similar to those mentioned above, such as an increase in the level of awareness of existing cessation services and number of smokers referred to provincial and community cessation programs (n=3), increased number of cessation services offered to sub-populations (n=15), and increased quit attempts, successful quitting, and decreased consumption of cigarettes (n=18).

Health authorities also have experience in providing cessation services in specific settings, such as workplaces, health institutions, and schools. Workplace is the most frequently mentioned setting where cessation services are delivered (n=20). Health authorities report providing minimal and intensive counselling on-site, distributing quit kits, holding workshops to disseminate knowledge on tobacco use and cessation strategies, as well as referring employees to existing cessation services. The key perceived outcomes reported include: a reduction in the number of employees who smoke, an increased number of employees making quit attempts as well a decrease in consumption of cigarettes.

About half of health authorities are currently engaged in the delivery of what they perceive as emerging/promising tobacco cessation programs/initiatives. These programs target various sub-populations, such as people with low socio-economic status (n=7), pre-natal/post-natal women (n=4), health care professionals (n=5), hospitalized patients (n=5), high school students (n=5), adults in general (n=6), blue collar workers (n=1), aboriginal people (n=1) and people experiencing mental health issues (n=2). The majority of health authorities describe the content of interventions as including some form of counselling, delivery of free NRT, workshops (at schools) or trainings (for health professionals). They participate in these programs through either partnering/coordination with other organizations (n=11) or taking a leading role, i.e. designing,

funding, and implemented the program (n=15). Given early stages of program implementation, many of the survey participants could not comment on the key outcomes of promising tobacco cessation initiatives.

3.2 Facilitators to successful implementation of tobacco control practices, programs and policies

When describing successful initiatives, survey participants were also asked to explain why these initiatives were successful. Analysis of qualitative data revealed common and specific factors determining successful implementation of tobacco control initiatives, which are presented below.

Facilitating factors common across areas of activity

Health authorities identified several common facilitating factors for successful protection, prevention and cessation initiatives: community support, promotional campaigns as well as collaboration among health units and partnership with community organizations. Although adequate funding and staffing were identified, they were mentioned less frequently.

Community support was mentioned by the largest number of participants as an important facilitating factor, specifically in the areas of smoke-free policies, restricting availability of tobacco, prevention and cessation programs. Promotional campaigns, which in turn increase public awareness and education, emerge as the second most commonly mentioned facilitating factor. Collaboration across health units as well as strong partnerships with school boards, municipalities, workplaces and other key stakeholders were highlighted as essential facilitating factors in achieving successful implementation of programs in each pillar (protection, prevention and cessation).

Specific facilitating factors

Smoke-Free policies, Availability of Tobacco, Enforcement, and Tobacco Smuggling

According to health authorities (n=15), use of evidence-based practices and lessons learned from other jurisdictions is a facilitating factor for the successful implementation of smoke-free, tobacco availability limiting, and compliance initiatives, as well as cessation programs for sub-populations.

Legislation such as the Tobacco Control Act that is enforceable by law and active compliance checks were identified as two important facilitating factors (n=27) for compliance, tobacco smuggling and tobacco availability limiting initiatives.

Facilitating Factors for Prevention Programs

The survey results indicate (n=14) that youth buy-in is a facilitating factor for the success of youth-specific prevention programs. Several health units (n=3) also highlighted the importance of having youth involved in the design and promotion of programs. Using youth-specific approaches and models such as peer-to-peer mentoring and mascots were also identified as

facilitating factors to encourage greater participation for prevention programs among young adults.

Facilitating Factors for Cessation Programs

Increased accessibility to cessation programs and services including NRTs was identified by most health units (n=23) as a crucial facilitating factor to a successful initiative. Respondents also described the usefulness of one-on-one discussions with cessation counsellors and the availability of personal support through these programs. Also, employer and management support was identified (n=4) as a facilitating factor for cessation programs in workplaces.

4. Perceived barriers/challenges in tobacco control

Common barriers

Findings from the survey identified some common barriers encountered by health authorities in the areas of smoke-free policies, restricting availability of tobacco, enforcement, tobacco smuggling as well as prevention and cessation activities. The most frequently mentioned barrier is the lack of resources, specifically funding and staff. According to survey participants, there is a lack of funding available to hire additional staff, including enforcement officers, and to invest in programs and promotional materials to increase public awareness. This poses a significant challenge in not only achieving full compliance with the policies but it also limits the reach of existing services.

The lack of dedicated, full-time staff to provide services and programs was highlighted as a common barrier across protection, prevention and cessation activities. The majority of respondents believe that building capacity with respect to human resources is critical in providing more programming and relieving some of the workload of current staff.

Many survey participants noted the lack of enforcement officers as a significant barrier to implementing and achieving full-compliance with smoke-free and tobacco control policies as well as contraband prevention activities.

Another barrier identified by respondents is the lack of political support from the municipal, provincial and federal governments for tobacco policies and activities. Survey results indicate that tobacco is not viewed as a top priority for governments.

Many participants cited the lack of legislation and direction from all levels of government as a challenge for enforcing restrictions and implementing activities. Specifically, there is a need for more legislation regarding vendor licensing and the selling, purchasing and possession of contraband.

Most participants felt that the geographical distances and access to transportation often preclude enforcement officers from performing their duties. These issues also pose a barrier for community members who want to access cessation services.

Specific barriers

Barriers to Implementing Smoke-Free Policies

Findings from the survey indicate (n = 9) that there is a lot of resistance from local businesses, particularly restaurants and bars, to smoke-free policies due to the potential loss of business. Respondents (n = 13) also highlighted as a potential barrier the lack of public support which stems from a lack of public awareness regarding smoke-free policies. They believe it is important to ensure that the public understands the significance of these policies as a means to reducing the effects of second-hand smoke.

Some participants (n = 9) believe that the lack of enforcement is a significant barrier to achieving full compliance with smoke-free policies.

Barriers to policies aimed at limiting availability of tobacco

Respondents (n= 9) indicate that the availability of contraband as well as the proximity of Native reserves to towns and cities undermines the effectiveness of tobacco control policies. Further, the lack of political will to develop legislation regarding retail licensing, restriction of sale and contraband were highlighted as additional barriers. Most participants believe that such legislation could help limit the availability of tobacco.

Some participants (n = 9) believe that the campaigns produced by tobacco companies in collaboration with retailers such as the Atlantic Convenience Store Association to lobby, for instance, against stronger access laws is a significant challenge to tobacco control efforts.

A few respondents (n = 4) noted that tobacco control policies are outside of the authority of public health units/authorities.

Barriers to enforcement activities

A few respondents (n = 5) indicated that language is often a barrier for some tobacco vendors, since English is their second language. Thus, achieving full compliance with tobacco control policies is a challenge in these situations. Some suggested providing more education and training in different languages.

Current social norms and attitudes were highlighted by several participants (n = 11) as a challenge to achieving compliance with policies and restrictions. Participants believe that there is still a need to change social norms such that smoking is not viewed as an acceptable behaviour.

Respondents (n = 11) also highlighted the availability of contraband is a significant barrier to achieving full compliance with tobacco control policies.

A few participants (n = 3) cited loopholes in existing tobacco control legislation, such as the use of tobacco in hookah pipes in enclosed dining establishments, as another barrier to achieving full compliance.

A small portion of survey respondents (n = 8) also noted challenges with achieving compliance of smoke-free policies by patients/visitors on hospitals grounds and by vendors.

Barriers to Contraband Prevention Activities
Survey results indicate that there are two significant barriers to implementing contraband prevention activities: jurisdictional conflicts and a lack of legislation. More than one quarter (n = 26) of respondents believe that they do not possess the authority to address issues relating to contraband; instead many believe these issues fall under the jurisdiction of the provincial and federal governments. Consequently, since public health units are not the primary enforcement agencies for contraband, any education on contraband that they do provide is limited.

As noted earlier, respondents also cited a lack of provincial and federal legislation regarding the selling, purchasing and possession of contraband as a significant barrier to implementing contraband prevention activities.

Barriers to Prevention Activities
Survey participants (n=9) noted the lack of evidence-based materials as well as best-practice guides as a potential challenge to prevention activities. They cited a need for sharing successful initiatives, especially those targeting rural, at-risk populations and youth (n=4).

According to health units (n=34), the lack of funding precludes the development of effective prevention programming for youth. Most people surveyed suggest that funding for youth directed programming is needed in order to successfully engage youth in tobacco control activities. Further, a few participants (n = 7) also indicated that schools and teachers do not view smoking as a priority any more. The lack of prevention activities in elementary and high school curriculums was highlighted as a barrier by respondents (n=7).

Barriers to Cessation Activities
The survey indicates that almost half (n = 37) of health units believe that a lack of funding is the primary barrier to cessation activities. A part of them (n = 18) believe that the lack of funding for Nicotine Replacement Therapies (NRT) restricts health units' abilities to increase the number of people who quit smoking. Respondents feel that it is important to make free NRT available to smokers in the communities.

While lack of staff was noted by some respondents (n = 24) as a barrier, a few (n = 8) indicated that a lack opportunities for staff training and education on smoking cessation, as well as a lack of cessation counsellors, were also barriers.

5. Overcoming barriers to implementing tobacco control policies and programs

Common strategies

Survey participants highlighted a few strategies to overcome many of the barriers mentioned in the previous section. The two most frequently mentioned approaches include securing more adequate and sustainable funding for programs as well as hiring more dedicated staff. Participants also feel that in order to address some of the challenges they currently face such as lack of legislation and insufficient funding, it is important for all levels of government to identify

tobacco and tobacco-related policies as a priority. Findings indicate that greater public education, community mobilization and grass root efforts are all needed to increase awareness of and support for such policies. Respondents frequently cited developing collaborations between agencies and organizations such as schools boards as a strategy not only to share information and resources but also to increase enforcement of restrictions. In addition, several participants indicated that more staff training and education are needed to help ensure greater compliance with the restrictions.

Specific strategies

Smoke-Free Policies

Several participants (n= 15) believe that implementing federal or provincial rather than local smoke-free bylaws would provide health units with more direction and leadership. Specifically, respondents indicated that areas not covered by current legislation should be addressed first. They feel this approach will create greater buy-in across the province.

Restricting availability of tobacco

In order to address tobacco control barriers, survey participants (n = 11) believe that more legal action and other economic disincentives such as higher taxes should be placed upon tobacco manufacturers who do not comply with legislation. Respondents also cited the need for more stringent enforcement by police and other authorities.

Enforcement

Findings from the survey indicate that more advertising/signage (n = 7) is one approach to increase compliance with restrictions. Further, participants believe that increased legislation (n = 13), specifically around possession, and enforcement (n = 17) are needed in order to ensure greater compliance.

Tobacco smuggling (contraband)

Greater collaborative agreements with First Nation Communities were highlighted by participants (n = 6) as a crucial step in limiting the availability of contraband. Increased buy in by governments (n = 5) and improved federal/provincial programming (n = 7) were also cited as important factors.

Prevention

When asked how barriers to improving or expanding tobacco use prevention programs for youth and young adults be addressed, most respondents (n =46) cited the need for more funding for such programming.

Respondents also indicated that more evidence-based strategies (n = 11) as well as more social marketing targeted towards teens (n = 8) are needed.

Cessation
The survey results indicate (n=17) that funding for NRT or subsidized NRT can help increase the effectiveness of cessation services and can increase the reach of these programs to sub-populations.
Further, respondents believe that more culturally sensitive resources as well as best practices for specific populations are needed (n=10).

6. Future Strategic Directions at the health unit level

Common strategic directions

When asked about future strategic directions (regarding smoke-free and availability limiting policies, enforcement, prevention and cessation initiatives) participants indicated these should include more advocacy, policies and direction by federal and provincial governments, partnerships and public education in each area. Representatives of some health units believe that more support by communities, especially for smoke-free spaces such as parks, playgrounds and for tobacco retailer licensing is necessary. Specific policies cited by survey respondents are described in each section below. While several participants felt that a comprehensive strategy and more direction from provincial and federal governments were crucial, they also highlighted the importance of having more alignment between federal and provincial strategies.

Findings from the survey indicate that partnerships between public health agencies, schools, municipal leaders, community groups and businesses are important to support the development and implementation of policies and programs. A combination of partnerships and public education campaigns are believed to help increase awareness and should be included in future strategic directions.

Specific strategic directions

Smoke-Free Policies
Some participants (n= 19) believe that more smoke-free policies need to be included in future strategic directions. Specifically, participants cited policies for MUDs, entrances to public buildings, outdoor public places, and health-care facilities. A few people (n= 5) also highlighted the importance of developing a comprehensive approach to tobacco control such that in addition to increasing the number of places that are smoke-free, best practice cessation resources are developed to support those affected by policy implementation.

Restricting availability of tobacco
Findings (n= 30) from the survey indicate that more tobacco control policies need to be included in future strategic directions. Policies that prohibit the sale of tobacco near schools, college campuses, recreational facilities, vending machines, etc and advertisement of tobacco as well as policies regarding contraband, vendor licensing and minors were cited most frequently.
Some participants (n= 9) feel that in order to help secure more funding, the money raised from any litigation against tobacco manufacturers should be used to improve public health programming, specifically for prevention and cessation programs.

Enforcement
Similar to tobacco control policies, participants (n= 10) suggest that more policies which limit the availability and accessibility of tobacco need to be included in future strategic directions. Respondents (n= 14) also believe that more dedicated enforcement officers are needed and should be included in future strategies.

Prevention
Some participants (n= 9) believe that greater social marketing/advertising, that appeals to various age groups, and promotes healthy decision making and de-normalization of smoking and the tobacco industry should be included in future strategic directions for prevention initiatives at the public health unit level.

A few survey respondents (n = 5) believe that it is important for future strategic directions to prioritize prevention programs and services. Participants (n = 12) also felt it was important to integrate tobacco/smoking with other chronic disease strategies and across all disciplines, in order to extend the reach of existing cessation services.

Findings from the survey indicate that some participants (n= 29) believe initiatives that target at-risk populations, including young adults and low socio-economic status need to be incorporated into future strategic directions.

Cessation
The survey results show that participants believe (n=11) that future strategic directions should include a province-wide plan to provide universal access to free or subsidized NRTs to those who are interested in quitting smoking. Further, respondents (n=7) feel more funding for staff and resources should also be included.
A few health units (n=5) also consider development of a comprehensive approach to tobacco cessation as a future strategic direction.
According to participants the continued provision of cessation-specific training and education for staff (n=8), as well as a greater focus on sub-populations (n=9) should all be taken into consideration when determining future strategic directions.

7. Partnership

The survey data show that the majority of health units (94.0%) collaborate with community organizations and government agencies in planning and implementing tobacco control initiatives.

Health units collaborate with a variety of organizations. The common partners of health units in all areas of tobacco control are: school boards, municipalities, health care organizations, other health units within the province/territory, government agencies (both federal and provincial), and non-governmental/not for-profit organizations, such as provincial tobacco control coalitions, professional associations, the Canadian Cancer Society, the Heart Stroke Foundation and the Lung Association. However, some of those organizations become more frequent partners of health units depending on the area of tobacco control. In particular, in the area of prevention health units mostly collaborate with schools/school boards; in the area of cessation – with health

care organizations (e.g. hospitals, family health teams); in promotion of smoke free policies – municipalities, tobacco control coalitions; in the area of restricting availability of tobacco – with tobacco control coalitions and governmental agencies; in the area of enforcement – with government agencies and municipalities.

Health units also have specific partners in certain areas of tobacco control only. In particular, health units collaborate with: tobacco vendors and police (local, provincial and federal) in the areas of prevention and promotion of policies to limit availability of tobacco products; colleges and universities, sport and recreation organizations in the areas of prevention and smoke-free policies; smokers' helplines in the area of cessation; and workplaces in the areas of cessation and smoke-free policies.

Survey participants identify several common and specific contributions of their health units to the collaborations/partnerships. The health units' common contribution across all the areas of tobacco control has been in the form of:

- Sharing knowledge and expertise, providing consultations at the stage of program planning and development
- Providing resources, such as in-kind staff support and funding
- Promoting programs at the local level
- Leading, coordinating program implementation
- Providing training opportunities
- Participating in evaluation of programs and initiatives

Some specific contributions of health units include:

- Delivery of local cessation services
- Referrals to provincial cessation programs
- Advocacy activities in the areas of smoke-free policies and restriction of availability of tobacco
- Delivery of enforcement activities at the local level

8. Role of provincial and federal tobacco control initiatives

Provincial and federal impact

Survey respondents identified a range of provincial measures that in their opinion are having a positive impact on tobacco use reduction at the health unit level. These measures include (ordered from most to least mentioned by survey respondents):

- Provincial smoke–free legislation (n=58)
- Prohibiting/restricting promotion and advertisement of tobacco products (n=19)
- Provincial cessation programs (n=14)
- Taxation of tobacco products (n=12)
- Restricting access/sales to minors (n=7)
- Social marketing campaigns (n=3)

Health units perceive the following federal measures as having an impact on tobacco use reduction at the local level (ordered from most to least mentioned by survey respondents):

- Bill C-32, and more specifically, the recently passed legislation imposing a ban on flavoured tobacco products, restricting advertisement of tobacco products, and minimizing package sizes for cigarillos (n=34)
- Legislation related to health warning messages (n=8)
- Taxation of tobacco products (n=7)
- Health Canada resources, e.g. Quit 4 Life (n=6)
- Federal funding (n=5)

Suggestions for provincial and federal governments

In most cases, survey participants' suggestions for future strategic directions at the local level mirror their suggestions for future tobacco control measures to be undertaken at the provincial and federal levels. A list of measures includes:

- Strengthening policies to eliminate public exposure to second-hand smoke, more specifically:
    - Smoke-free outdoor facilities (n=16)
    - Prohibiting smoking in MUDs (n=13)
    - Ban smoking in vehicles (n=12)
    - Smoke-free entrances at all public buildings (n=8)
    - Smoke-free patios (n=6)
    - Prohibit smoking on health services properties (n=3)
    - Smoke-free school grounds (n=2)
- Provision of coverage for NRT (n=26)
- In general, expansion of cessation programs/increasing accessibility of services (n=22)
- Increasing funds for tobacco control (n=21)
- Increasing taxes on tobacco products (n=15)
- Addressing contraband (n=18)
- Make possession of tobacco for youth under 19 illegal (n=8)
- Further limit availability of tobacco products through:
    - Retail licensing (n=9)
    - Limiting locations/stores selling tobacco products (n=10)
    - Passing flavoured tobacco legislation (n=9)
- Public education/Social marketing campaigns (n=8)
- Cost recovery from tobacco industry for health care expense (n=9)
- Expanding prevention programs (n=5)

Among suggestions for the federal government, survey respondents mostly mentioned the need to address the contraband issue (n=44) and further strengthen the provisions of Bill C-32 (n=34). The latter, in participants' opinion, should include provisions to totally eliminate advertising of tobacco products and ban flavoured smokeless and spit tobacco products. Other measures suggested for implementation at the federal level, include:

- Taxation of tobacco products (n=19)
- Introduction of plain packaging (n=13)

- Smoke-free legislation related to workplaces and buildings under the federal jurisdiction (n=15)
- Mass media campaigns at the national level (n=8)
- Increase funding for tobacco control measures (n=7)
- Expanding programs/initiatives for the Aboriginal population (n=7)
- Cost recovery from tobacco industry for health care expense (n=5)
- Controlling tobacco ingredients (n=3)
- Smoking in movies (n=3)

9. Networking

Health authorities tend to network/be connected mostly with health units in their province/territory rather than with health units outside of their province or territory.

Within their province they tend to be in touch with each other primarily to exchange experiences and expertise and collaborate on the promotion of tobacco control initiatives. Somewhat less networking is done for program development and implementation (see Table 18).

Table 18: Networking with health authorities within the province/territory (n=83)

	To a great extent, %	To a moderate extent, %	To a small extent, %	Not at all, %	N/A, %
Knowledge exchange (learning from experience and expertise)	54.9	32.9	9.8	-	2.4
Collaborative efforts to promote tobacco control initiatives	53.7	29.3	13.4	1.2	2.4
Program development	36.6	35.4	17.1	8.6	2.4
Program implementation	26.8	43.9	20.7	6.1	2.4

Networking with health authorities from other provinces/territories is fairly limited. Some 13% of health units have no connection to health authorities outside of their own province/territory. Where health units are connecting with others outside of their jurisdiction, network activities are very limited in the areas of knowledge exchange, collaboration, program development and implementation (see Table 19).

Table 19: Networking with health authorities outside the province/territory (n=83)

	To a great extent, %	To a moderate extent, %	To a small extent, %	Not at all, %	N/A, %
Knowledge exchange (learning from experience and expertise)	-	28.0	43.9	14.6	13.4
Collaborative efforts to promote tobacco control initiatives	-	18.5	34.6	33.5	13.4
Program development	-	7.3	39.0	37.8	15.9
Program implementation	-	8.6	32.1	43.3	15.9

10. Expectations from *The Next Stage* project

The survey participants generally welcome the idea of creating a Knowledge Centre within the context of the Next Stage project. Their key comment is that the Knowledge Centre should not duplicate resource centres that already exist (e.g. CCTC, CAN-ADAPTT).

The absolute majority tend to agree that the Centre should facilitate new connections and strengthen existing ones in the area of tobacco control, enable collaboration and knowledge exchange between health units as well as serve as a source of information/knowledge on new and emerging programs and practices in tobacco control (see Table 20).

Table 20: Expectations' from the Knowledge Centre (n=83)

	Agree, %	Disagree, %	Don't know, %
The Knowledge Centre should facilitate new connections to others working in tobacco control	96.4	1.2	2.4
The Knowledge Centre should strengthen existing connections with our tobacco control colleagues	93.8	2.5	3.7
The Knowledge Centre should enable new collaborations with others	96.3	1.2	2.5
The Knowledge Centre should enable sharing of knowledge and experience with others	97.5	-	2.5
The Knowledge Centre should provide knowledge on new and emerging programs and practices in tobacco control	98.8	-	1.3

The survey participants also described their pressing information/knowledge needs that they would expect the Knowledge Centre to address. Table 21 summarizes the general and specific needs identified by the survey participants.

Table 21: Health authorities' knowledge and information needs (n=83)

Information/knowledge needs	n	%
Best practices in tobacco control	24	28.9
Information on successful tobacco control initiatives/programs across Canadian jurisdictions	21	25.3
Best practices for specific sub-populations	11	13.3
Emerging/promising practices in tobacco control	9	10.8
Programs/interventions for:		
youth and young adults	11	37.3
the Aboriginal population	7	8.4
blue collar/service workers	3	3.6
pregnant and postpartum women	2	2.4

people with mental illness	2	2.4
immigrants	2	2.4
Access to regional/local data on tobacco use and related characteristics	9	10.8
Design, implementation, and assessment of tobacco control programs (e.g. tools, forms, plans etc)	9	10.8
Networking opportunities (e.g. contact information for health units from other jurisdictions)	6	7.2
Best practices in public education/tobacco counter marketing campaigns – 7.2%	6	7.2
Database on successful smoke free by-laws/initiatives	5	6.0
Costing of tobacco control programs	4	4.8
Access and use of contraband tobacco, measures to control tobacco smuggling	4	4.8
Basics of tobacco control for new learners	4	4.8
Programs/interventions for rural settings	3	3.6
Information about funding opportunities	3	3.6

There is a wide range of information and knowledge gaps experienced by health units/regions. In general, health units would like the Centre to provide information on best practices in tobacco control, successful tobacco control initiatives/programs across Canadian jurisdictions, and emerging/promising practices in tobacco control. They would be also interested in information on programs/initiatives for specific sub-populations and most importantly, for youth and young adults. Other relatively frequently mentioned specific needs include: access to regional/local data on tobacco use; design, implementation, and assessment of tobacco control programs; networking opportunities; best practices in public education/tobacco counter marketing campaigns.

Discussion

This survey explored the experiences of Canada's health authorities in developing, coordinating, facilitating and implementing tobacco control initiatives. It provides a snapshot of tobacco control polices and activities in Canada's provinces and territories[i], challenges and success at the regional/local levels and help to inform further activities and deliverables of *The Next Stage* project, such as the development and functioning of the *Knowledge Centre* and elements of a 'public health approach' to tobacco control. Several implications of the findings are outlined below.

Access to best practices in tobacco control and experiences from other jurisdictions
The survey has found that health authorities lack information and knowledge on a wide spectrum of tobacco control topics. Their knowledge and information needs range from general information on successful tobacco control initiatives across Canadian jurisdictions and emerging/promising practices in tobacco control to more specific information such as effective programs/initiatives for youth and young adults, access to regional/local data on tobacco use, design, implementation, and assessment of tobacco control programs. These needs may potentially inform the focus and scope of activities of the Knowledge Centre.

The need for knowledge transfer among health authorities is supported by the analysis of health authorities' perceived successes in tobacco control. The review of examples suggests that health authorities have accumulated substantial experience in various areas of tobacco control. Although these success stories provide only a high level description of how and why these initiatives have been successful, it appears that these success stories could represent important practical knowledge, which may be beneficial for health authorities across Canada.

Focus on specific sub-populations
The survey results may help to identify and prioritize populations within the context of a public health approach to tobacco control. In the area of prevention, current tobacco control prevention programs do not fully address the needs of youth under 14, youth 15-19 years of age and young adults (20-24) at the local level. In the area of cessation the needs of the general smoking population and various vulnerable sub-populations are not adequately addressed. This is especially the case for youth under 18 and the Aboriginal population, as more than a quarter of health authorities do not address the needs of these groups.

Support for promoting new policies to restrict availability and outdoor smoking
Health authorities recognize the importance of restricting both the availability of tobacco products and opportunities to smoke in outdoor public places. Yet, they do not anticipate much progress in these key areas. External support and coordination would likely be very helpful for advancing local efforts to restrict availability and outdoor smoking.

Expanding network opportunities for public health practitioners

[i] With the exception of Quebec which, as noted earlier, did not participate in the survey.

The project may also consider focusing on expanding networking opportunities and partnerships among health authorities, especially between provinces and territories. Health units' pressing knowledge/information needs could further inform particular areas of networking and communication among health practitioners.

Sustained investment in tobacco control

Health authorities perceive funding as a key factor facilitating successful implementation of tobacco control activities, and they still experience lack of adequate funding across many of the tobacco control areas, especially in prevention and cessation. Research demonstrates that increases in tobacco control expenditures are independently associated with declines in adult smoking prevalence.[ii] Thus, effective tobacco control requires substantial and sustained funding to implement.

[ii] Farrelly MC, Pechacek TF, Thomas KY, Nelson D. The impact of tobacco control programs on adult smoking. *American Journal of Public Health* 2008;98:304-309