Ontario

Comprehensive Tobacco Control

Guidance Document

Standards, Programs & Community Development Branch
Ministry of Health Promotion
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Vito Chiefari and Michèle Harding, Co-Chairs

on behalf of the Comprehensive Tobacco Control Working Group

Section 1. Introduction

The *Ontario Public Health Standards* (OPHS) are published by the Minister of Health and Long-Term Care under Section 7 of the *Health Protection and Promotion Act* (HPPA). These standards specify the mandatory requirements for boards of health to implement various public health programs and services. The Ministry of Health Promotion (MHP) has been assigned responsibility by Order in Council (OIC) for several of these standards: (a) reproductive health, (b) child health, (c) prevention of injuries and substance misuse, and (d) chronic disease prevention, which includes comprehensive tobacco control. The OPHS for health promotion identify the requirements for complex, multifaceted responsibilities of local boards of health in health promotion. The Ministry of Children and Youth Services has OIC responsibility for the oversight of the *Healthy Babies Healthy Children* section of the *Reproductive and Child Program Standards*.

The OPHS are based on four principles: need, impact; capacity and partnership/collaboration. One Foundational Standard focuses on four specific areas: (a) population health assessment; (b) surveillance; (c) research and knowledge exchange; and (d) program evaluation.

a) Development of MHP's Guidance Documents

The MHP has worked collaboratively with local public health experts to prepare a series of Guidance Documents. These Guidance Documents will assist the staff of boards of health to identify issues and approaches for local consideration and implementation of the standards. While the OPHS and associated protocols published by the Minister under Section 7 of the HPPA are legally binding, Guidance Documents that are not incorporated by reference into the OPHS are not enforceable by statute. These Guidance Documents are intended to be resources to assist professional staff employed by local boards of health as they plan and execute their responsibilities under the HPPA and OPHS.

In developing the Guidance Documents, consultation took place with staff of the Ministries of Health and Long-Term Care, Children and Youth Services, Transportation and Education. The MHP has created a number of Guidance Documents to support the implementation of the program standards for which it is responsible, e.g.:

- Child Health
- Child Health Program Oral Health
- Comprehensive Tobacco Control
- Healthy Eating/Physical Activity/Healthy Weights
- Nutritious Food Basket
- Prevention of Injury
- Prevention of Substance Misuse
- Reproductive Health
- School Health

This particular Guidance Document provides specific advice about the OPHS requirements related to COMPREHENSIVE TOBACCO CONTROL.

b) Content Overview

Section 2 of this Guidance Document provides background information relevant to comprehensive tobacco control, including its significance and burden, as well as a brief statement about the provincial policy direction and strategies that can help reduce the burden of tobacco use and the evidence and rationale supporting that direction. The section also addresses the value of mental well-being and social determinants of health considerations in the public health approach to the issue.

Section 3 provides an explanation of each Requirement, which includes a statement of the actual OPHS (2008) Requirement pertaining to comprehensive tobacco control; a further explanation of the Requirement based on evidence, innovations and suggested priorities; suggested actions (organized into various categories of public health practice including situational assessment, policy, program/social marketing and evaluation and monitoring); and some examples of how this has been done in Ontario or other jurisdictions with enough detail and guidance to adopt or adapt these examples and incorporate them into local health promotion plans.

In planning for monitoring and evaluation activities, health units should consider working with provincial research and evaluation partners (e.g., the Ontario Tobacco Research Unit and/or the Ontario Agency for Health Protection and Promotion) to identify and/or employ existing resources, consultative opportunities and/or an inventory of demographic and statistical information.

Section 4 identifies and examines areas of integration with other health promotion requirements. This section acknowledges elements and opportunities for multi-level partnership, including roles and responsibilities at each level (i.e., Provincial, Municipal/boards of health, community agencies and others) of public health governance. In addition, areas of integration with other requirements beyond health promotion and areas with other strategies and programs such as the *Smoke-Free Ontario Strategy* and *Healthy Babies Healthy Children* are identified.

Finally, **Section 5** lists the key tools, resources and organizations that may assist local public health agencies in their efforts to plan, implement and evaluate tobacco control interventions. **Section 6** is the conclusion.

c) Intended Audience and Purpose

This Guidance Document is intended to be a tool that identifies key concepts and practical resources that public health staff may use in health promotion planning. It provides advice and guidance to both managers and front-line staff in supporting a comprehensive health promotion approach to fulfill the OPHS 2008 requirements for the Child Health, Chronic Disease Prevention, Prevention of Injury and Substance Misuse, and Reproductive Health program standards.

Note: In the event of any conflict between this Guidance Document and the *Ontario Public Health Standards* (2008), the *Ontario Public Health Standards* shall prevail.

Section 2. Background

In spite of recent gains in the reduction of tobacco use, tobacco remains the leading public health problem in Ontario today. The epidemic of tobacco-caused diseases is far from being eradicated. Over 1.6 million Ontarians (17%) still smoke (1) and it is estimated that approximately 13,000 avoidable premature deaths take place annually in the province due to cancer, cardiovascular disease and chronic obstructive lung disease. In 2002, tobacco use was responsible for approximately 22% of premature deaths (before age 70). During that same year, the direct and indirect cost of tobacco-related problems was $6.1 billion or approximately $502 per person (including non-smokers) and 1.4% of the provincial domestic product. (2) These are conservative numbers and are likely underestimated, as they do not include private health care costs or even begin to estimate the cost of human suffering. Post-operative surgical complications (such as wound healing, effects on drug metabolism and direct impacts of tobacco use on health, lung and blood systems) also pose a substantial challenge to the delivery of quality health care and recovery from illness.

The consequences of tobacco use have been documented for more than a half century. (3) In addition to causing cardiovascular disease and 80–90% of lung cancer deaths, tobacco can lead to a range of cancers, respiratory diseases, poor wound healing, cataracts and infertility. (4, 5) Furthermore, babies born to mothers who smoke throughout pregnancy are at an increased risk of premature birth, sudden infant death syndrome and respiratory problems, such as asthma and reduced lung function. (5) The number of diseases causally associated with tobacco use continues to increase. For example, researchers recently established that active smoking can be causally linked to breast cancer in both pre- and post-menopausal women and second-hand smoke (SHS) can be linked to breast cancer in pre-menopausal women. (6) Evidence is also emerging that active smoking may be associated with Type 2 Diabetes. (7)

Second-hand smoke (SHS) also causes heart disease, lung cancer, nasal sinus cancer, middle ear infections, asthma and respiratory illnesses. (8, 9) It is estimated that in 2002, SHS exposure was responsible for 315 adult deaths and 17,104 acute hospital stays in Ontario. (2, 10)

Tobacco use also contributes to inequalities in health and mortality. (11) In Ontario, smoking prevalence decreases as educational achievement increases. (4, 12) As a result, smoking is likely to have a greater impact on lower socio-economic groups and can perpetuate disparities in health. Social inequalities in tobacco use are "likely to persist or even widen," despite overall declines in the prevalence of smoking. (13) While smoking prevalence among Ontario adults with a university degree declined substantially over the period 2000 to 2007 (16% versus 8% for those with a university degree), similar declines have not been observed among Ontario adults with a high school diploma (30% versus 27%) or blue-collar workers (32% versus 30%) over the same period. (12, 14)

Smoking rates within the Ontario population vary considerably. For example, smoking rates among men are significantly higher than for women (20% versus 14% in 2007). (14) Smoking rates are also higher among young adults and particularly young adult males aged 25–29 years of age (37%). (15) Current smoking rates among Ontario's Aboriginal population are at least two times higher than the provincial average. Ontarians living within northern and rural communities also tend to have higher smoking rates.

Smoking is correlated with a variety of other health risk factors and conditions (16): For example:

- Moderate or problem gamblers in Ontario have the highest prevalence of current smoking (45%).
- Ontario residents who reported being inactive or who ate less than five fruits or vegetables per day had a significantly higher prevalence of current smoking compared to the provincial average (22% and 23%, respectively vs. 19%).
- Ontario residents who reported drinking in excess of the low-risk drinking guidelines or who were clinically diagnosed with a mood disorder had a substantially higher prevalence of current smoking compared to the provincial average (27% and 34%, respectively vs. 19%).

In 2003, the Government of Ontario dedicated itself to reducing the burden of tobacco-attributed disease and avoidable death in the province. This commitment included a promise to deliver an aggressive mass media educational program to reduce tobacco use by children, youth and young adults, to make workplaces and public places smoke-free, to raise provincial tobacco taxes to be in line with other Canadian provinces and to make cessation counselling and nicotine-replacement therapy available to all smokers who want to quit.

As part of this commitment, the Government of Ontario passed legislation and regulations to ban smoking in public places and workplaces and to effect changes in tobacco retail marketing and sales, especially with respect to the access of minors to tobacco products. The first provisions of the *Smoke-Free Ontario Act* came into effect on *World No Tobacco Day* 2006 (May 31, 2006). At that time, the Government also introduced a series of graduated increases in the provincial taxation rate beginning in 2006. Funding for the *Smoke-Free Ontario Strategy* has ranged between $40 and $60 million annually and has been intended to supplement and enhance comprehensive tobacco control programs. Within this allocation, the Government has committed resources to a wide variety of programs to improve efforts to create a more comprehensive tobacco control program.

In Canada and in Ontario in particular, non-government organizations (NGOs) such as the Canadian Cancer Society, the Heart and Stroke Foundation of Ontario and the Ontario Lung Association have played a critical role in advancing tobacco control programs and policy. Since the 1970s, NGOs have been leaders in advancing many coordinated multi-level campaigns and events. Most significantly, in Ontario, during the early 1990s, the NGOs formed the Ontario Campaign for Action on Tobacco (OCAT). OCAT was a driving force behind the creation of a broad-based popular movement that led to a proliferation of by-laws across Ontario, which resulted in the passage of a variety of tobacco control legislation and paved the way for many further developments. NGOs were key members of the Minister's expert panel on "*Tobacco or Health*" in 1999 and also implemented key components of the provincial tobacco control strategy such as mass media public education campaigns, population-based smoking cessation programs (the *Smokers' Helpline*) and other core components, such as youth- and school-based programs.

Local boards of health across the province of Ontario have also played an instrumental role in reducing tobacco consumption, protecting people from exposure to second-hand smoke and preventing youth from using tobacco products. Through the authority provided to the Minister of Health and Long-Term Care by the *Health Protection and Promotion Act*, the Ontario Government passes regulations and provides funds to local boards of health so they may comply with mandatory requirements. Since the 1980s, tobacco use prevention and control has been a core element of mandatory programs for local boards of health, and many local boards have made tobacco control a priority. Local boards of health have played and continue to play a pivotal role in the passage and enforcement of local tobacco control by-laws and/or policies, and their efforts have often gone far beyond their mandate. Since 2005, local boards of health have received dedicated SFO funding for specific, contractually defined, community-based tobacco prevention, protection and cessation services, and have substantially increased their reach and efforts in the area of tobacco control.

It is clear that although the Ontario Government and its partners have achieved a great deal, much more needs to be done. Currently, over 1.6 million Ontarians still smoke and smoking rates remain far too high among Aboriginal peoples, certain cultural groups, lower socio-economic groups, psychiatric, poly-drug users and other populations.

There is some evidence (mostly anecdotal) that suggests that smokeless tobacco use may be increasing, particularly among certain population sub-groups and in northern areas of the Province; however, at this time, smokeless tobacco products are a small component of Ontario's tobacco market. There are also concerns that the increasing availability of contraband and counterfeit tobacco, as well as illegal sales, may be undercutting taxation (17, 18) and prevention efforts. Several groups also pressed for lawsuits to recover health care costs associated with tobacco use, and in 2009, the Ontario Government took action to join with other provinces to sue tobacco companies to recover past and on-going health care costs.

Tobacco control advocates continue to remind governments that additional efforts must be made to protect the public and individuals (particularly children) from the effect of second-hand smoke and that, collectively, we must continue to reduce access to tobacco products and de-normalize tobacco use. Experienced tobacco control practitioners and advocates are mindful of the need to remain vigilant and to continue to pursue further controls on the tobacco industry, including de-normalizing the "tobacco industry."

a) Engaging Partners

Since its inception, Ontario's Tobacco Control Strategy has been a collaborative initiative involving government, NGOs, local community coalitions (such as Tobacco Area Networks) and local public health departments and their community partners, such as hospitals, community health centres and health practitioner organizations.

In 2005, responsibility for the management of the Smoke-Free Ontario and other health promotion programs was transferred from the Ministry of Health and Long -Term Care to a newly created Ministry of Health Promotion (MHP). The MHP's primary mandate is to coordinate and deliver programs designed to improve the health of communities. Smoke-Free Ontario programming occurs within a larger population health framework that takes into consideration and links with programming related to highly correlated health risk factors and the needs of sub-populations with high health risk burdens to achieve effective and sustainable health changes.

The Ministry of Health Promotion funds a number of programs designed to promote partnership. The *Tobacco Control Coordination Program* (TCC) funds a coordinator- or manager-level position who provides program leadership, coordination and collaboration both within the public health unit/department and externally within the community respecting tobacco control and other highly correlated risk factors, as they relate to chronic diseases. The program also initiates and carries out community-based activities and projects that will benefit the public and its health by contributing to the reduction of tobacco use as well as other highly correlated risk factors.

The MHP also funds seven regional Tobacco Control Area Networks (TCANs) that range in size from one to nine public health departments. TCANs facilitate coordination at the local and regional levels, ensure that the needs of public health departments are met and maximize the effective use of limited resources.

TCANs also play a lead role in identifying and facilitating opportunities for collaboration between different public health unit programs, particularly in the development of regional plans, programming and initiatives. Furthermore, TCANs assist in assessing public health department training and technical assistance needs, and communicating Ministry policies and activities. One of the most important roles TCANs play is to plan and execute large regional projects and coordinate regional media and public relations activities.

Each TCAN employs a regional Coordinator and Youth Development Specialist to work with the local public health departments, NGOs and with other networks and action groups in their region. Regional meetings are held monthly with all public health departments and local NGO partners to share information, problem-solve, plan and train. Area Coordinators and Youth Development Specialists teleconference weekly with the Ministry to ensure province-wide coordination.

Each Tobacco Control Area Network also has a Steering Committee that is comprised of 7 to 10 members. All Steering Committees serve advisory, planning and decision-making roles. Steering Committees provide an opportunity to identify and develop leadership at the local level. The Steering Committee and its sub-committees (i.e., cessation, enforcement, training, and media and public relations) participate in the following:

- Developing an annual area action plan that specifies joint area activity in cessation, youth tobacco use prevention, enforcement, training, and media and public relations.
- Identifying core training needs within the area.
- Determining joint activities in the areas of cessation, youth prevention and enforcement.
- Determining and coordinating regional public relations activities.
- Determining and administering funding for local media and public relations initiatives, as funding permits.
- Facilitating two-way communication between the Ministry and local programs.
- Planning for and assisting with the conduct of network meetings.
- Facilitating integration and collaboration with other chronic disease prevention programs and networks.

Ontario's 36 public health departments receive funding to implement a wide variety of tobacco control activities that represent internationally recognized best practices in comprehensive tobacco control. (19) This includes community education to promote tobacco control public policy initiatives, laws and regulation; enforcement of tobacco control laws and regulation; and the organization of youth activities in their area. Each comprehensive tobacco control (CTC) program has a specific set of deliverables defined in a funding agreement. Local public health departments submit an annual work plan for approval that situates planned activities within CTC logic models and provincial and regional plans. Work plans address both Ministry priorities, such as working with high-risk populations, e.g., Aboriginal, Francophone, blue-collar workers and other priority groups, and local priorities identified through a board of health planning process. Each public health department employs a full-time Tobacco Control Coordinator to coordinate tobacco control activities within the public health department and integrate tobacco control into other areas of chronic disease prevention.

b) Elements of the Smoke-Free Ontario Strategy

The Smoke-Free Ontario Strategy is a multi-level *comprehensive tobacco control* strategy. The goal of the Smoke-Free Ontario Strategy is to eliminate tobacco-related illness and death by

- Preventing experimentation and escalation of tobacco use among children, youth and young adults.
- Protecting the health of Ontarians by eliminating involuntary exposure to second-hand smoke.
- Increasing and supporting cessation by motivating and assisting people to quit tobacco use.

These objectives and associated strategies were supported by the following crosscutting strategies: public education/social marketing, resource and capacity development, and systemic monitoring and evaluation.

The Ontario Government, in planning for the Smoke-Free Ontario Strategy, utilized internationally accepted "best practices" in tobacco control. The expansion was based in large measure on *Best Practices for Comprehensive Tobacco Control Programs* published by the U.S. Centers for Disease Control and Prevention (CDC). The comprehensive approach articulated by CDC was modified to take advantage of the experiences and lessons learned from a number of jurisdictions with such an approach, the unique characteristics of Ontario, including the history of tobacco control in Ontario, the structure and organization of the public health system and direction received from the Government. (20–28)

In 2003, the Ontario Tobacco Research Unit, at the request of the Steering Committee of the Ontario Tobacco Strategy (the precursor of the Smoke-Free Ontario Strategy), developed a set of science-based logic models to guide the expansion of tobacco control activities in the Province, which led to the development of the Smoke-Free Ontario Strategy. These logic models utilized the three goals or pillars of the Smoke-Free Ontario Strategy to define evidence-based strategies and activities that logically lead to desired outcomes. They provide a visual picture to help ensure that all stakeholders understand the purpose and resources that are needed to meet the goals of this complex and multifaceted strategy. As articulated in the logic models, the Smoke-Free Ontario Strategy is integrated, dynamic and outcome-oriented.

Chart 1. Smoke-Free Ontario System Logic Model

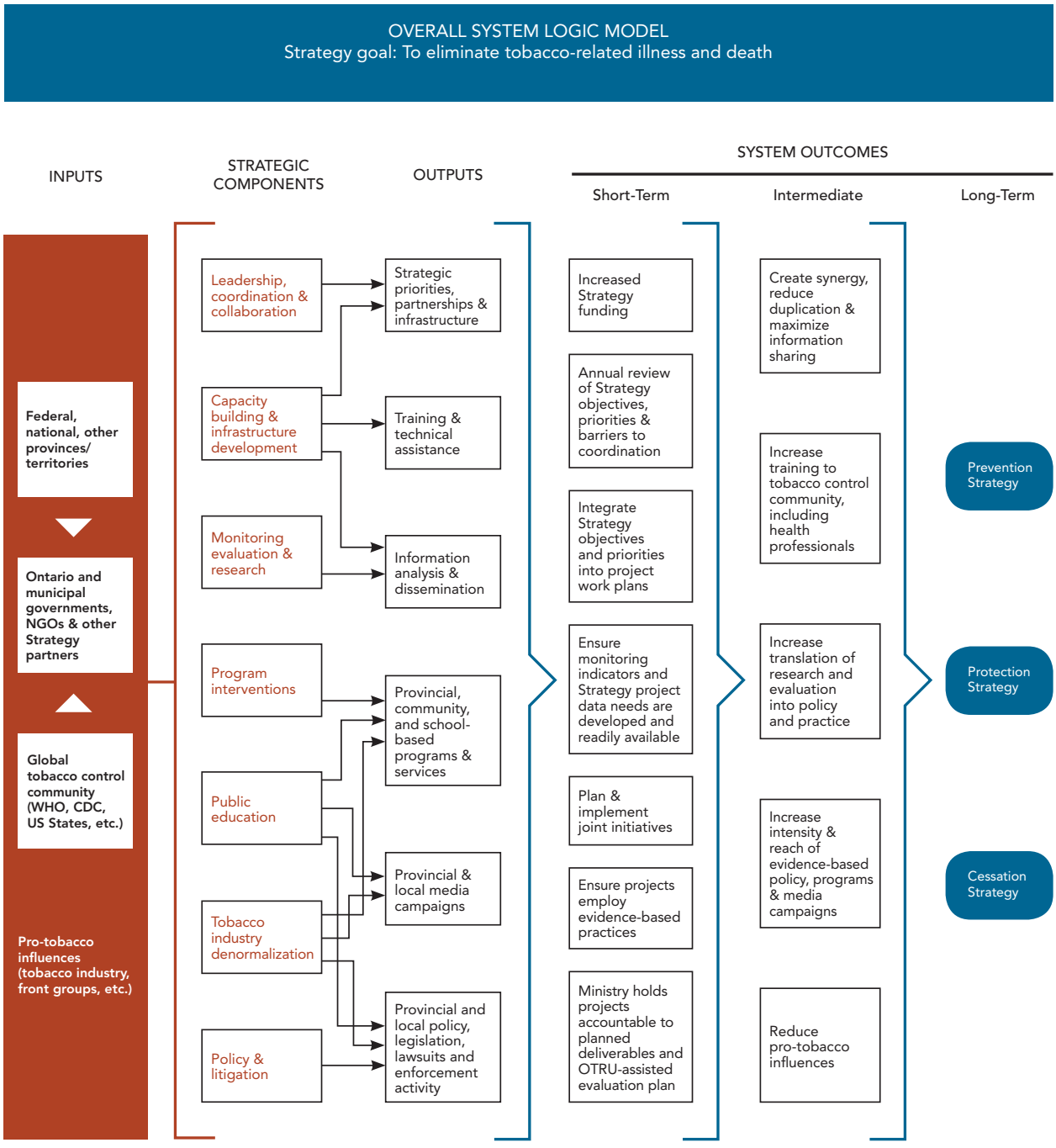


Chart 2. Smoke-Free Ontario Prevention Logic Model

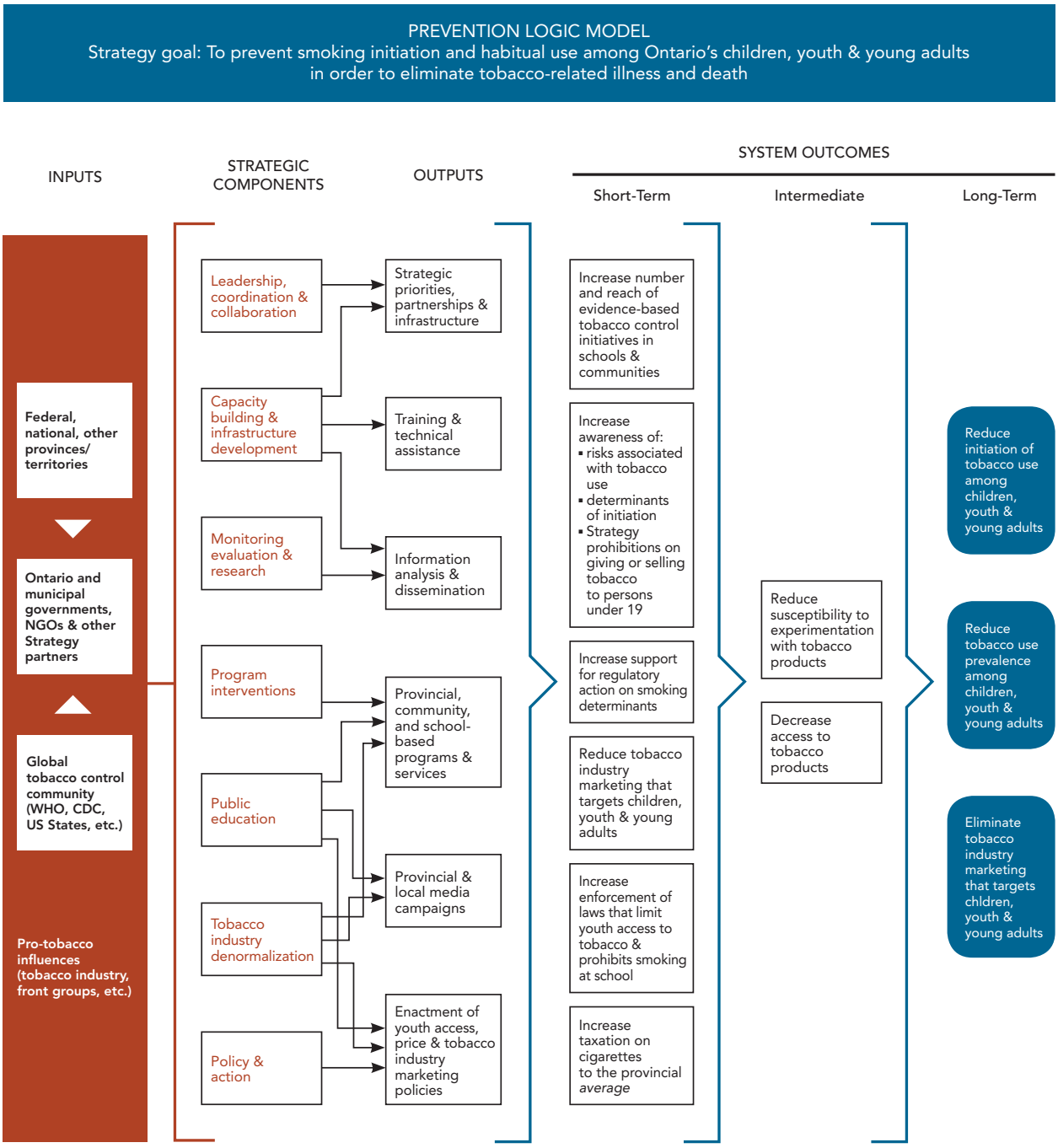


Chart 3. Smoke-Free Ontario Cessation Logic Model

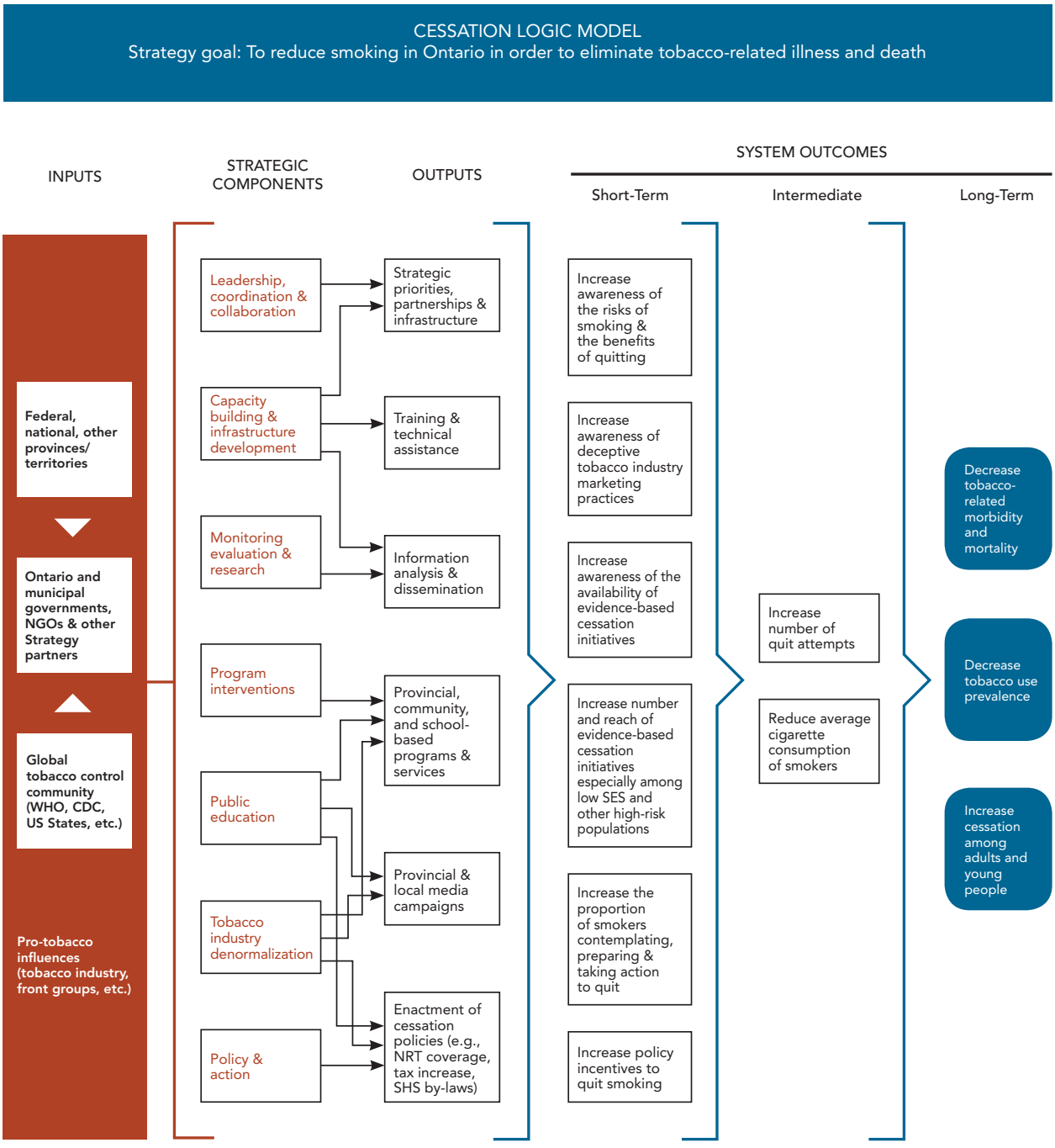
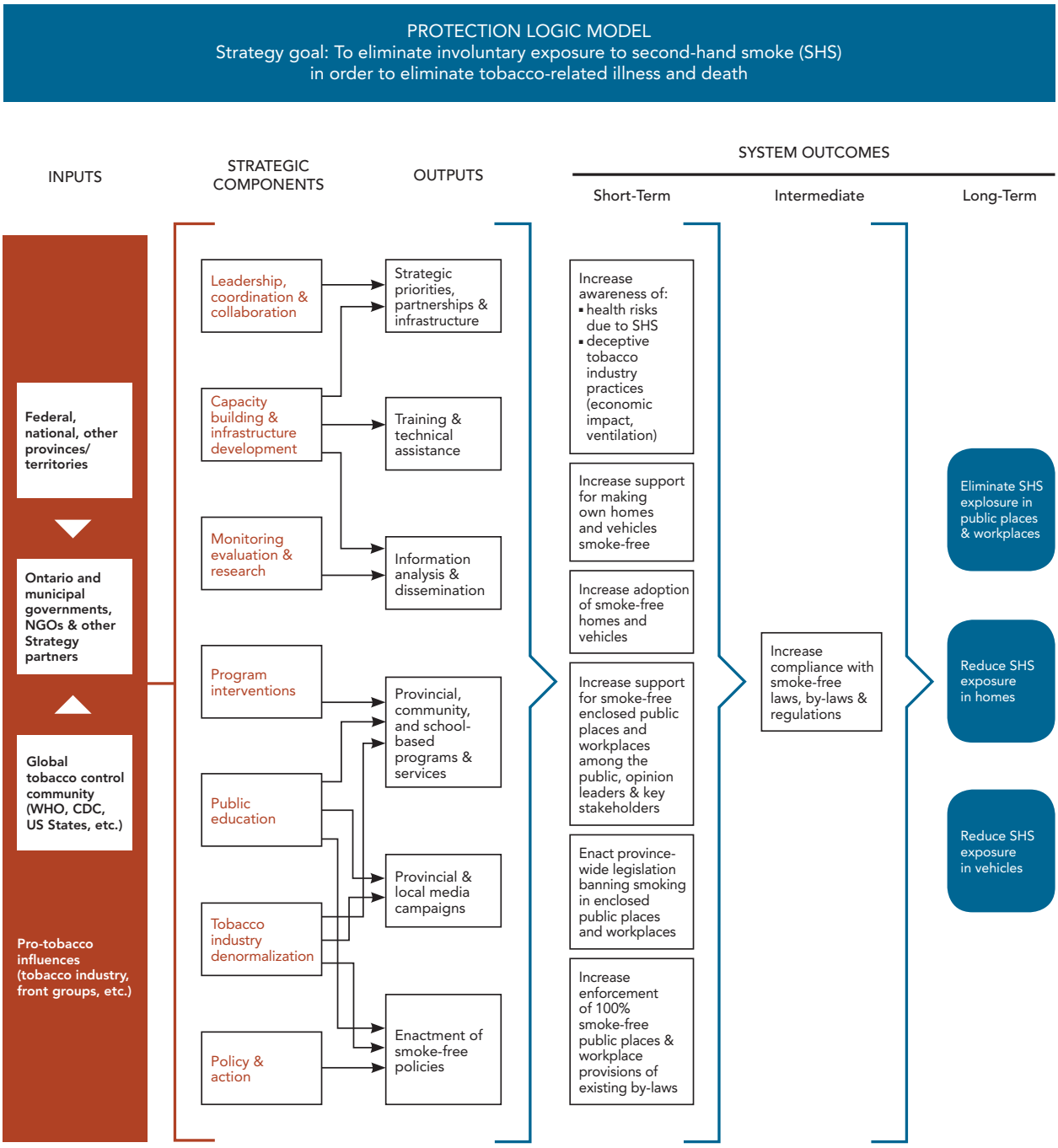


Chart 4. Smoke-Free Ontario Protection Logic Model



Seven important strategic components are identified in the logic models.

1. *Leadership, coordination and collaboration* – including working together to articulate a vision and an actionable plan in all areas.
2. *Capacity building and infrastructure development* – including assessments of skills, and organizational and system changes that are necessary to execute comprehensive, integrated and sustained strategies.
3. *Monitoring, evaluation and research* – including tracking progress, learning from experience and determining a research agenda that will inform future action.
4. *Program interventions* – including the design and implementation of programs; development and distribution of educational resource materials; and behavioural, environmental (e.g., policy) and system interventions to facilitate change.
5. *Public education* – including the development of media campaigns with integrated messaging within programs and services in specific settings, such as educational, health care and work settings, to bring about change among defined priority populations and targeted audiences.
6. *Tobacco industry de-normalization* – including informing the public about the tobacco industry's role in the development and perpetuation of the epidemic and that these practices are not normal, legitimate business practices. (It also implies a social and corporate, as opposed to solely an individual, responsibility orientation to policy and program formation and execution.)
7. *Policy and action* – including a focus on government statutory and regulatory reforms, including taxation to affect price, but also broader policies and actions to include private and voluntary policies to restrict and eliminate smoking in various settings (e.g., personal policies to ban smoking in the home, etc.).

c) Evolution of the Smoke-Free Ontario Strategy

In 2009, the Ministry of Health Promotion initiated processes to renew/reframe and extend Ontario's *tobacco control* strategy, including the Smoke-Free Ontario Strategy. These processes are expected to update the Strategy's objectives and logic models. Towards this end, the Ministry has engaged the assistance of the Ontario Agency for Health Protection and Promotion in establishing a Scientific Advisory Committee to review the evidence base for future action, as well as the following:

- The Tobacco Strategic Advisory Group, which consists of key stakeholder and government representatives, is mandated to make recommendations respecting a new five-year plan for tobacco control.
- A Review Team undertaking the development of a Smoking Cessation Action Plan to facilitate the establishment of comprehensive integrated smoking cessation systems.

In addition, building on experience gained from tobacco-specific youth programming, the MHP is exploring other and more sustainable models of youth engagement that will allow programming that is both tobacco-specific and based on correlated risk factors.

Section 3. OPHS Comprehensive Tobacco Control Requirements

NOTE: Requirements 2 (monitoring food affordability in accordance with a nutritious food basket); 8 (enhancing food-handling skills and healthy eating practices); and 10 (promotion of screening programs) do not apply directly to Comprehensive Tobacco Control and are not covered in this Guidance Document.

Requirement 1: Surveillance and Needs Assessment

The board of health shall conduct epidemiological analysis of surveillance data including monitoring of trends over time, emerging trends and priority populations in accordance with the ***Population Health Assessment and Surveillance Protocol****, 2008 (or as current), in the areas of:*

- *Healthy eating;*
- *Healthy weights;*
- ***Comprehensive tobacco control;***
- *Physical activity;*
- *Alcohol use; and*
- *Exposure to ultraviolet radiation.*

The board of health should:

- Access, collect and manage quantitative and qualitative information, analyze and interpret information, using multiple sources of information to inform planning and decision-making related to the development and implementation of a comprehensive tobacco control program. Information should include data sources that will assist programs to 1) conduct needs and *situational assessments*; 2) identify and monitor *policy implementation*; 3) inform *program and social marketing* activities; and 4) *evaluate and monitor* programming.

  Examples of data sources include the following:

  - Federal and provincial reports and publications;
  - Tobacco inspection data collection systems;
  - Performance evaluation and monitoring systems;
  - Ministry of Health and Long-Term Care (MoHLTC) reports – public health profiles
  - Surveys (CCHS, RRFSS, public opinion surveys, OSDUS, SHAPES);
  - Geo-Spatial Information Systems (GIS);
  - Situational assessments undertaken by the local municipality, PHU or social planning council;
  - Literature reviews (e.g., peer-reviewed and/or grey literature, including but not limited to OTRU and SFO resource centre publications, such as PTCC evidence resources);
  - Policy and program documents; and,
  - Monitoring of telephone calls to PHUs to gather community intelligence.
- Monitor smoking prevalence, consumption and industry advertising trends, identifying priority target groups for programs and services.
- Assess the program's reach and impact, using an approach that considers the program and its context.
- Assess tobacco use in relation to other correlated health risk behaviours to identify opportunities for alignment and collaborative action.
- Develop reports and presentations to inform the board of health and its community partners about emerging trends in tobacco control.

EXAMPLE I: Assessing Gaps in Smoking Cessation Services

Assessing service gaps is an essential first step in smoking cessation service planning. An assessment method was pilot tested in the Simcoe-Muskoka District Health Unit in 2007-2008 with the assistance of the Ontario Tobacco Research Unit. Special attention was paid to understanding the cessation service needs of high-risk populations. The assessment methods included the following:

- An environmental scan;
- Key informant interviews;
- A telephone survey with smokers and recent smokers;
- Intercept surveys with smokers from priority subpopulations (e.g., young adults, blue-collar workers); and,
- Semi-structured interviews with smokers and managers from relevant community organizations and workplaces.

The results of the needs assessment have helped the Simcoe Muskoka District Health Unit understand the reach of currently available cessation services and opportunities for expanding partnerships with smoking cessation providers. This assessment also underscored and documented the need to expand cessation services within Simcoe-Muskoka. The assessment provides important information that will help the Health Unit better target services to young adults and other underserved populations.

Requirement 3: Educational Settings (29–31)

The board of health shall work with school boards and/or staff of elementary, secondary and post-secondary educational settings, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and the creation or enhancement of supportive environments to address the following topics:

- *Healthy eating;*
- *Healthy weights;*
- ***Comprehensive tobacco control;***
- *Physical activity;*
- *Alcohol use; and*
- *Exposure to ultraviolet radiation.*

These efforts shall include:

a. *Assessing the needs of educational settings, and*
b. *Assisting with the development and/or review of curriculum support.*

Clarification: Educational settings include primary and secondary schools and post-secondary settings, such as trade schools and apprenticeship programs, colleges and universities, and adult learning programs. The term *educational setting* is used interchangeably with the term *schools*.

Cross-reference with the School Health Guidance Document, and liaison and collaboration with school health and other colleagues, such as those providing oral health services, are encouraged to identify opportunities for collaborative programming. In addition, in appropriate settings, consider linking programming respecting tobacco use and misuse of alcohol (cross-reference to Prevention of Substance Misuse Guidance Document).

i) Situational Assessment

- Assess the needs of educational settings for policy and program change (e.g., SHAPES, OSDUS and informal student surveys) in collaboration with school officials and students.

ii) Policy

- Develop and promote by-laws and policies related to second-hand smoke exposure; sale of tobacco products in proximity to educational settings (e.g., establishing "tobacco-free zones around schools"); social supply of tobacco products; and tobacco use (e.g., chew and cigarettes) on school property (Public Policy).
- Ensure compliance with provincial legislation and regulations that prohibit smoking on school property (Public Policy).
- Develop a consensus within the local public health department and school board (using evidence of the social and financial burden of disease related to tobacco use) about the importance of providing assistance to youth, young adults and their parents to quit smoking (Organizational Policy).

iii) Program/Social Marketing

- Liaise with school boards and engage school officials on the need to address tobacco use through evidence-based approaches.
- Develop/facilitate youth-led prevention activities; actively engage youth in implementing school and community-based policies and programming.
- Link tobacco use and its negative consequences to other youth interests, such as sport and recreation.
- Provide smoking cessation referral and assist families with school-aged children and young adults to access services, whenever possible.
- Engage with provincial programs/agencies to provide support and services to schools and post-secondary educational and other adult learning settings.
- Provide cessation training opportunities for school-based health professionals.
- Develop a collaborative approach to deliver public health department health services in educational settings. Promote tobacco control as a priority within comprehensive school health programming.
- Partner with schools and post-secondary educational settings to develop and implement tobacco control activities.
- Support schools to implement tobacco control policies relevant to school activities (e.g., "Code of conduct" and tobacco-free sports policies for school sports teams).
- Align activities with regional Tobacco Control Area Network (TCAN) campaigns.

iv) Evaluation and Monitoring

- Create information links to useful resources so that schools and post-secondary educational settings may become fully informed of emerging trends in tobacco control.
- Assist schools in evaluating the impact of their tobacco control efforts (e.g., review school and school board policies and policy compliance with the SFOA, etc.).

v) Social Determinants of Health and Mental Well-being

- Work with schools to reach youth and young adults using evidence-informed intervention strategies that are likely to prevent first use and/or interrupt habitual use. Target and reach out to at-risk youth and young adults (e.g., low SES, Aboriginal youth; those lacking social skills, having difficulty with school work, exhibiting poor health and coping skills, etc.) at the time that an intervention is most likely to have an impact.

EXAMPLE II: Building Healthy Schools: Hamilton's Comprehensive School Health/Health Action Teams

Regularly scheduled school board liaison meetings are held between the Hamilton Public Health Services' management and staff, the Public, Catholic and French school board Superintendents and consultants. Data from 2006/07 SHAPES supported a collective dialogue with school boards. Communication of SHAPES results helped to:

- Clarify misconceptions about student tobacco use (e.g., smoking on school property).
- Identify higher risk schools for intervention.
- Illustrate the importance of school-based tobacco control and promote Hamilton Public Health Services' programs (e.g., HCAAT, Teen Tobacco Summit, High School Grants, etc.).

The partnership with school boards has resulted in many positive developments including the following:

- One hundred per cent participation of schools in the former SFO High School Grants program.
- Complimentary grants provided for grades six, seven and eight in response to needs identified by boards of education and Public Health Services staff (15 schools participating in 2008/09).
- Development and dissemination of electronic resource materials to assist teachers to integrate tobacco use prevention within the school curriculum.
- School newsletters that provide information on emerging tobacco control issues and present new data (from SHAPES, OSDUS) for a variety of audiences (e.g., practitioners, teachers and parents).

EXAMPLE III: Building Healthy Schools: School Partnerships in Ottawa

In Ottawa, SHAPES results were used to help build relationships with high schools. SHAPES survey results support communication between the public health department and schools, facilitating information exchange, planning and acting on student tobacco use at multiple levels (school, board and community). For example, in 2005, SHAPES data revealed low student awareness of rules and consequences regarding smoking on school property. Ottawa Public Health Department staff discussed these issues with school staff and provided signage to the schools. Schools specified no smoking on school grounds in rental contracts, reviewed discipline codes and developed educational materials. The results have also been used to prompt student engagement and action on tobacco control issues within Ottawa high schools.

Requirement 4: Workplace Settings (22–32)

The board of health shall use a comprehensive health promotion approach to increase the capacity of workplaces to develop and implement health policies and programs and create or enhance supportive environments to address the following topics:

- *Healthy eating;*
- *Healthy weights;*
- ***Comprehensive tobacco control;***
- *Physical activity;*
- *Alcohol use;*
- *Work stress; and*
- *Exposure to ultraviolet radiation.*

These efforts shall include:

a. *Conducting a situational assessment in accordance with the proposed Population Health Assessment and Surveillance Protocol 2008 (or as current).*
b. *Reviewing, adapting, and/or providing behaviour change support resources and programs.*

i) Situational Assessment

- Assess the needs of the workplaces in the PHU's geographic catchment area (workplaces should be defined broadly to include health care facilities, services, manufacturing, mining and forestry businesses, etc.) for policy and program change. Work collaboratively with local/regional PHU workplace health teams to:
  - ✔ Develop an inventory of existing work sites in the area: start with worksites that are likely to yield the greatest impact (e.g., large employers, blue-collar employers, etc.), but also develop a strategy to identify small employers and work sites.
  - ✔ Assist employers and/or unions/employee groups, as appropriate, to conduct workplace assessment surveys and business cases for tobacco control, addressing worker needs and organizational-level tobacco control policy and supports. Identify a local workplace smoking cessation champion. If available, collaborate with workplace health and safety committees to identify the need for tobacco control (protection/cessation) initiatives.

ii) Policy

- Enforce the SFOA prohibition on smoking indoors at work sites (Public Policy).
- Promote smoke-free/tobacco-free outdoor workplace environments (e.g., patios, smoke-free hospital and university grounds, 9M rule around exits/entrances) (Organizational and Public Policy).
- Develop and promote by-laws and policies that reduce tobacco product availability at work sites that are not normally retail outlets for tobacco products (e.g., worksite cafeterias, restaurants, etc.) (Public Policy).
- Encourage employers and unions to include smoking cessation counselling services and pharmacotherapy in their employee health care benefits (Organizational and Public Policy).
- Encourage employers and unions to include smoking cessation counselling in their Employee Assistance Program (EAP) (Organizational Policy).

iii) Program/Social Marketing

- Educate the public and business community about the SFOA provisions requiring indoor smoke-free work sites, including workplace vehicles.
- Provide technical assistance to worksite management and/or unions/employee groups to establish and maintain smoke-free workplaces.
- Engage managers and employees through, for example, occupational health and safety committees, unions and trade associations to promote smoke-free and tobacco-free worksites and refer smokers to cessation services.
- Identify and support a workplace smoking cessation "champion" who can assist in policy development and implementation, including promoting tobacco use prevention and smoking cessation opportunities.
- Provide referral to cessation services for worksite employees that need assistance with nicotine addiction (e.g., referrals to the Smokers Helpline or local community health programs or providers).
- Promote smoking cessation contests at work sites (e.g., "Quit and Win") in collaboration with management and employee groups.

iv) Evaluation and Monitoring

- Conduct workplace surveys (e.g., prevalence of tobacco use at work sites and evaluation of worksite policies and other environmental supports) to determine the need and timing for policy and program interventions. Share the information gathered to foster understanding of issues and needs.
- Assist work sites to evaluate the efficacy of their policies, programs and benefits related to tobacco control and cessation services.

v) Social Determinants of Health and Mental Well-being

- Reach out to work sites that employ workers with a high smoking prevalence, such as blue-collar work sites, to assist them in implementing smoke-free work sites in accordance with the SFOA. Foster understanding of tobacco use and exposure within the context of workplace health and safety.
- Link with unions, trade associations, migrant worker organizations and other professional or trade-related organizations to identify issues related to compliance with the SFOA and to promote smoke-free workplaces in the context of worker health.

Requirement 5: Food Premises (32)

The board of health shall collaborate with local food premises to provide information and support environmental changes through policy development related to healthy eating and protection from ***environmental tobacco smoke****.*

i) Situational Assessment

- Assess/analyze the extent of tobacco control policies that are not covered under the SFOA regarding exposure to second-hand smoke on food premises (e.g., patios, mobile vendors, outdoor spaces, etc.).
- Assess/analyze the extent of tobacco control policies that are not covered under the SFOA regarding the sale of tobacco products on food premises (e.g., restrictions on the sale of tobacco products in proximity to schools, etc.).
- Assess/analyze opportunities where tobacco control objectives may be serviced by food inspection and healthy eating initiatives.

ii) Policy

- Develop and promote by-laws or organizational policies for smoke-free patios (Organizational and Public Policy).
- Develop and promote by-laws or organizational policies that eliminate the sale of tobacco products in restaurants and other food premises (Organizational and Public Policy).
- Develop and promote by-laws that restrict the sale of tobacco products in proximity to schools (Public Policy).

iii) Program/Social Marketing

- Educate the public and business community about the SFOA and other laws, regulations and by-laws.
- Promote public awareness of exemplary tobacco-free policies (e.g., restaurants with smoke-free patios, restriction on the sale of tobacco products in proximity to schools, etc.), using paid and earned media when possible.
- Educate employers with employees who smoke to encourage them to offer smoking cessation opportunities (Organizational Policy).

iv) Evaluation and Monitoring

- Track media coverage of second-hand smoke and retail sales policy development.
- Monitor policy development (see situational assessment above).

v) Social Determinants of Health and Mental Well-being

- Assist First Nations and Aboriginal-owned food premises to implement smoke-free policies and practices.
- As the health unit considers interventions with the food industry, consider potential issues relating to the demographics of food industry employees (e.g., youth taking their first jobs; new immigrants with language barriers; low-wage workers, etc.), and the opportunities for providing education and support regarding smoke-free workplaces and public places, smoking uptake and cessation (cross-reference: Requirement 4 respecting Workplaces).

Requirement 6: Healthy Public Policies (32–35)

The board of health shall work with municipalities to support healthy public policies and the creation or enhancement of supportive environments in recreational settings and the built environment regarding the following topics:

- *Healthy eating;*
- *Healthy weights;*
- ***Comprehensive tobacco control;***
- *Physical activity;*
- *Alcohol use; and*
- *Exposure to ultraviolet radiation*

i) Situational Assessment

- Assess and compare other jurisdictions' municipal policies relating to outdoor recreational settings (e.g., smoke-free patios, smoke-free parks and recreation facilities, etc.).
- Assess public support for expanded tobacco-free policy, using, for example, RRFSS, informal surveys, etc.
- Conduct stakeholder opinion analysis for expanded tobacco control policies.
- Assess trends in the community related to the sale, promotion and use of tobacco products (e.g., contraband, compliance with SFOA, tobacco industry sponsorship, etc.).

ii) Policy

- Support the enforcement of the SFOA (Public Policy).
- Develop and promote by-laws and policies that both protect children, youth and adults from tobacco use and second-hand smoke, and that contribute to changing social norms, including by-laws or policies that address:
  - ✔ Tobacco-free outdoor recreational areas (e.g., parks, beaches, playgrounds and other outdoor sports areas). Consider policies regarding use of all forms of tobacco (Public and Organizational Policy).
  - ✔ Smoke-free municipal outdoor events and festivals (Public Policy).
  - ✔ Community events using municipal facilities and properties (Public Policy).
  - ✔ Smoking within nine metres of health care facilities, public buildings and other work sites.
  - ✔ Smoking on restaurant patios (Organizational Policy).
  - ✔ Smoking in hotels/motels (Organizational and Public Policy).
- Encourage the voluntary adoption of policies that promote smoke-free homes (both single- and multi-unit dwellings) to protect non-smoking residents and the public from the harmful effects of environmental or second-hand smoke[1] (Public Policy).
- Promote compliance with smoke-free vehicles laws that protect the public from the harmful effects of second-hand smoke (Public Policy).
- Limit the number of tobacco retail outlets through zoning and licensing, especially in proximity to primary and secondary schools (Public Policy).
- Develop strategies to encourage compliance with tobacco control policies and laws, including revoking licenses and progressively increasing fines (Public Policy).
- Investigate opportunities within existing municipalities to support smoking cessation (e.g., reserve municipally owned advertising space for smoking cessation ads to encourage smokers to quit, play a leadership role as a workplace employer to promote an employee benefit for smoking cessation counselling and pharmacotherapy, etc.) (Organizational Policy).
- Encourage community partners to adopt policies that prohibit accepting money from the tobacco industry (Organizational Policy).

iii) Program/Social Marketing

- Promote awareness of the need for tobacco-free policies and environments through paid and earned media.
- Educate (public and private) decision-makers (e.g., city officials, business leaders, landlords, service clubs, etc.) about the need for specific changes to policy.
- Encourage municipalities to subsidize smoking cessation pharmacotherapy for priority populations.
- Promote and support planning of tobacco-free municipal festival and events.
- Engage youth and support their participation and leadership in policy change efforts.
- Partner with other health units, such as those within the local TCAN, to foster economies of scale in undertaking common actions and programming and maximizing limited resources to achieve healthy public policies.
- Work with First Nations and other Aboriginal community partners to support education and public policy development respecting tobacco use within their communities.

iv) Evaluation and Monitoring

- Track media coverage of healthy public policy development.
- Conduct formal and informal surveys that track compliance with smoke-free vehicles laws and the adoption of smoke-free homes policies.
- Monitor changes in public opinion supporting tobacco control in the area.
- Monitor policy and by-law developments.

[1]Resources on smoking in multi-unit dwellings are available from the Smoking and Health Action Foundation.

v) Social Determinants of Health and Mental Well-being

- Work with municipalities and cooperative housing sponsors to develop policies that support smoke-free public or community housing options for public housing residents (e.g., designated smoke-free floors, buildings or housing projects, etc.).
- Support the provision of cessation services and pharmacotherapy for low SES populations and individuals with co-addictions, such as alcohol abuse and problem gambling.

EXAMPLE V: Woodstock's Healthy Public Policy

An outdoor space by-law was passed in Woodstock, Ontario. The new smoking by-law prohibits the following:

- Smoking within 30 metres of playground equipment in city parks.
- Smoking within 15 metres of a recreational field while in use.
- Smoking within nine metres of the door(s) to a municipal building.
- Smoking within four metres of a city bus stop or shelter.
- Schedule A: For private business owners to apply to have their property included in the by-law for purposes of enforcement.
- Schedule B: For organizers of community events to apply to make the event smoke-free for purposes of enforcement.

Woodstock's new by-law was achieved through a coordinated effort between the Oxford Interagency Council on Smoking and Health, the Oxford County Public Health Department, the City of Woodstock and Smoke-Free Ontario.

The University of Waterloo obtained a research grant to conduct a longitudinal study of smokers and non-smokers to evaluate the impact of the by-law.

This project builds on by-law amendment experience in the Town of Collingwood and is being replicated in other Ontario communities. In Toronto alone, over 830 playgrounds will become smoke-free when its amendment is brought into force.

EXAMPLE VI: Engaging Youth in Healthy Public Policy

The North West Area Youth Coalition organized 13 events to gather community support for tobacco-free parks and beaches. Events were part of a summer-long regional education campaign to change social norms around tobacco use in communities. Events included community marches and rallies, butt litter clean-ups, a variety of children's activities and tree-planting ceremonies. The events received significant earned media attention (17 radio and print media hits as well as multiple editorials and letters to the editor in the largest community newspaper, *The Chronicle Journal*).

A postcard campaign collected more than 5,000 signatures as part of a face-to-face municipal council lobby strategy. In October of 2008, YAA – YATI, along with community partners, (including Tobacco Free Thunder Bay and the local Medical Association) presented to Thunder Bay City Council. In the spring of 2009, the City Council approved a by-law supporting tobacco-free parks and beaches.

Requirement 7: Community Partners (36)

The board of health shall increase the capacity of community partners to coordinate and develop regional/local programs and services related to:

- *Healthy eating, including community-based food activities;*
- *Healthy weights;*
- ***Comprehensive tobacco control;***
- *Physical activity;*
- *Alcohol use; and*
- *Exposure to ultraviolet radiation.*

These efforts shall include:

a. *Mobilizing and promoting access to community resources;*
b. *Providing skill-building opportunities; and*
c. *Sharing best practices and evidence for the prevention of chronic diseases.*

i) Situational Assessment

In collaboration with community partners:

- Map community organizational assets. Assess and reassess the interest and capacity to work in partnership, including the alignment of comprehensive tobacco control with organizational mandates (e.g., primary mandate addresses a highly correlated risk factor or condition), the identification of potential champions and/or early adopters of innovative and/or evidence-based and/or evidence-informed practices.
- Assist and support key organizations and groups in developing their capacity to engage in aspects of comprehensive tobacco control and related issues.
- Seek opportunities to build understanding of linkages between chronic disease issues and objectives.

ii) Policy

- Engage in partnership building to achieve specific, mutually identified outcomes (Organizational Policy).
- Use evidence-based practices for tobacco control in policy and program development (Organizational and Public Policy).
- Promote innovation that is guided by theory in the absence of specific evidence (Organizational Policy).
- Build capacity by sharing training opportunities (Organizational Policy).
- Provide value-added support to partners in order to achieve mutual benefits and facilitate shared objectives and outcomes (Organizational Policy).
- Partner with community agencies in the development of healthy public policy for comprehensive tobacco control and other chronic disease prevention outcomes and strategies (Organizational and Public Policy).

iii) Program/Social Marketing

- Provide or share training and professional development opportunities in subject areas that support the development and implementation of comprehensive tobacco control (e.g., cessation counselling, appropriate use of pharmacotherapy, peer leadership, evidence-based practices in tobacco control, media advocacy, program planning and development, etc.) for staff and volunteers of partner agencies in the community.
- Develop and strengthen linkages to provincial programs and resources (e.g., TEACH, the Smokers' Helpline, etc.) that support comprehensive tobacco control programming.
- Participate in and support community coalitions that address tobacco control and chronic disease prevention.
- Partner on regional actions/initiatives through active participation in regional structures (TCAN).
- Partner on multi-jurisdictional initiatives (e.g., prevention, protection, cessation, etc.).
- Build the capacity of community partners to implement relevant tobacco control interventions: e.g., technical assistance to help implement evidence-based clinical practices to identify and assist smokers in health care settings.
- Work with First Nations and other Aboriginal community partners to support education and public policy development respecting tobacco use within their communities.

iv) Evaluation and Monitoring

- Monitor community partnerships and resulting actions/outcomes.
- Assess capacity changes among community partners.
- Work with partner organizations to monitor and evaluate the efficacy of joint initiatives.

v) Social Determinants of Health and Mental Well-being

- Develop partnerships with organizations that serve priority populations, including cultural organizations and clubs, trade associations, unions, youth groups and organizations serving youth, substance abusers and the mentally ill.

EXAMPLE VII: Partnering with Community Mental Health Agencies to Respond to the Smoking Cessation Needs of Mental Health Clients

An innovative partnership for tobacco cessation was developed between three community mental health agencies and York Region Community and Health Services. The following components of a comprehensive, evidence-based cessation plan were designed, implemented and evaluated:

- *Training of mental health staff* on brief contact intervention (BCI) and enhancing the understanding of tobacco addiction as it relates to mental health clients;
- *Policy development* to enhance staff implementation of BCI, related documentation/record keeping, accessibility to self-help resources for clients;
- *A champion model* was used to identify champions to obtain intensive cessation training (TEACH); to act as best-practices resources; to deliver cessation counselling to clients; and to collaborate through a community of practice; and,
- *A group smoking cessation program* was offered to clients along with access to no-cost nicotine replacement therapy.

All components were evaluated to inform practice and guide ways to support staff and clients.

Requirement 9: Cessation for Priority Populations (37–39)

The board of health shall ensure the provision of tobacco use cessation programs and services for priority populations.

i) Situational Assessment

- Identify priority populations that experience a high prevalence of tobacco use and related diseases.
- In collaboration with community partners, assist in updating a resource directory of smoking cessation services in the area.
- Determine what gaps exist between community needs (e.g., population smoking profiles) and available services. Implement cessation gap assessment methods (e.g., Example 1: Simcoe-Muskoka/Ontario Tobacco Research Unit (OTRU) cessation gap assessment).

ii) Policy

- Encourage governmental and non-governmental employers to include smoking cessation counselling services and pharmacotherapy in their employee health care benefits packages (Organizational and Public Policy).
- Encourage employers and unions to include smoking cessation counselling in their employee assistance programs (EAP) (Organizational Policy).

iii) Program/Social Marketing

- Work with community and provincial partners to develop and institutionalize evidence-based cessation practices within health care settings.
- Motivate smokers to quit through public education campaigns conducted locally, regionally and provincially (e.g., quit-and-win contests).
- Refer smokers to the Smokers' Helpline and other community smoking cessation resources.
- Promote awareness of services and link smokers to cessation resources within the community.
- Educate health providers about the Ontario Health Insurance Plan's fee codes for reimbursement to physicians for providing cessation counselling.
- Facilitate the training of practitioners on smoking cessation by encouraging links with local and provincial training resources.
- When cessation services are limited, boards of health could consider providing best-practice cessation services that are accessible and affordable to priority populations. This could include regularly scheduled individual or group counselling or periodically scheduled services, for example, during significant times such as National Non-Smoking Week.
- Provide cessation information and assistance to other public health unit programs (e.g., prenatal education, Healthy Babies Healthy Children, oral health, etc.) (cross-reference: Child Health and Reproductive Health Guidance Documents).

iv) Evaluation and Monitoring

- Assess program effectiveness (e.g., quit attempts, duration of quit attempts, etc.).
- Assess the reach and impact of social marketing campaigns on priority populations.
- Assess the reach and accessibility of cessation programming for priority populations.
- Monitor cessation partnerships and the institutionalization of cessation policies and protocols within the health unit jurisdiction.

v) Social Determinants of Health and Mental Well-being

- Develop or support development of cessation services (counselling and pharmacotherapy) for priority populations (e.g., low SES, Aboriginal, Francophone, blue-collar workers, GLBT, etc.).

EXAMPLE VIII: Hamilton Public Health Services Quit Smoking Clinic

Hamilton Public Health Services' (PHS) *Becoming Smoke-Free: A Quit Smoking Clinic* was launched in January 2008 and initially operated one half day per week. The clinic provides counselling by TEACH-trained Public Health Nurses (PHN) to priority populations within the City of Hamilton.

The clinic service expanded to three half days per week in the spring/summer of 2009. Issues around access and equity were considered in developing the services provided. Services that promote increased access and equity include the following:

- A client-centred care approach to counselling;
- Pharmacotherapy at no cost for clients in financial need, without medical contraindications;
- Locations on major bus routes with bus tickets available at no cost;
- Child minding services at no cost for clients with small children; and,
- Wheelchair accessible room.

A second site is located within an Ontario Early Years Centre and operates for one half day each week. PHS is confident that this second clinic location will serve identified priority populations of pregnant women and blue-collar and retail workers.

The referral base for potential clinic clients has also expanded from the initial three agencies: Hamilton Public Health Services Healthy Babies Healthy Children Program, Juravinski Cancer Centre and the AIDS Network (Hamilton). Public Health Services staff is now accepting referrals with direct client contact and local hospital partners.

EXAMPLE VIX: Developing Partnerships with Peel Hospitals

The Peel Region Health Department's Smoking Cessation Counselling Program has been operating since 2001. In 2006 and 2007 combined, 255 clients were served.

Weekly clinics are held at four sites (located at the Brampton, Mississauga and Trillium Hospitals) and smoking cessation counselling is provided by a TEACH-trained public health nurse.

The Trillium Hospital Clinic serves high-need patients with COPD and/or heart disease. A screening program was instituted that identifies smoking status in cardiac and COPD programs. Follow-up support was provided through the Public Health Department.

A steering committee was organized with representation from three regional hospitals to inform collaborative cessation planning. A group smoking cessation program was launched in the spring of 2009.

EXAMPLE X: Toronto Provides Cessation Services to Underserved Populations

The Toronto Health Department recruits foreign-trained health care professionals to deliver smoking cessation counselling to clients in their native language (adapted from the Region of Waterloo's *Tobacco Treatment for New Canadians* program). Partnerships were developed with Flemingdon and New Heights community health centres (CHC) and CHCs are responsible for program management. Foreign-trained health care professionals are TEACH trained and take on the role of Peer Tobacco Educators (PTEs). PTEs receive an honorarium.

EXAMPLE XI: Ottawa's Youth Smoking Intervention

"smokers' section" supports youth who use tobacco in the Ottawa area through an innovative, high school-based triage program (A LEARN project resource[2]).

"smokers' section" is a one-hour interactive workshop for students who use tobacco products. It provides information about addiction, tobacco control legislation and available supports. Consisting of a 20-minute presentation and discussion using the Audience Response System (ARS), students are triaged into breakout groups based on their self-identified readiness to quit. ***"smokers' section"*** is led by a youth facilitator and supported by public health staff. Interventions are provided specifically to the group's self-identified stage of change. Students who attend ***"smokers section"*** are supported post workshop by a website, teacher training in Minimal Contact Interventions (MCI), quit-and-win contests, individual and group counselling, and subsidized nicotine replacement therapy (NRT).

Requirement 11: Public Awareness/Social Marketing

The board of health shall increase public awareness in the following areas:

- *Healthy eating, including community-based food activities;*
- *Healthy weights;*
- ***Comprehensive tobacco control;***
- *Physical activity;*
- *Alcohol use;*
- *Exposure to ultraviolet radiation;*
- *Benefits of screening for early detection of cancers and other chronic diseases of public health importance; and*
- *Health inequities that contribute to chronic diseases.*

These efforts shall include:

a. Adapting and/or supplementing regional and provincial health communications, social marketing and public education strategies, and/or

b. Developing and implementing regional/local health communications/social marketing strategies.

[2]LEARN is a project partnership between the Program Training and Consultation Centre (PTCC), the University of Waterloo's Propel Centre for Population Health Impact and Ontario's tobacco control practitioners. The goal is to cultivate and facilitate knowledge exchange across Ontario.

i) Situational Assessment

- Assess the knowledge, attitudes and behaviours related to tobacco use of different population groups within the jurisdiction of the local public health department.
- Assess the characteristics of priority audiences (demographics and psychographics). Assess/analyze opportunities to collaborate with other chronic disease prevention programming provided to the same or similar audiences based on, for example, clustering of characteristics or risk factors.
- Identify opportunities for integrated multi-level social marketing campaigns (e.g., by participating in TCAN and Healthy Community planning structures and by engaging with community partners, including local chronic disease prevention partnerships and healthy community partnerships).

ii) Policy

- Promote consensus to support and encourage evidence-based tobacco control public policy within the jurisdiction of the board of health (Organizational and Public Policy).
- Develop consensus to support and promote the voluntary adoption of tobacco control policies in the absence of legislative or regulatory policy (e.g., smoke-free homes), within the jurisdiction of the board of health (Organizational and Public Policy).

iii) Program/Social Marketing

- Educate the public and business community about tobacco control laws and regulations addressing comprehensive tobacco control.
- Educate the public, as well as landlords, developers and tenant organizations about the benefit of voluntarily adopting a multi-unit dwelling/smoke-free home policy.
- Support/participate in Ministry-led public education/social marketing initiatives.
- Identify and implement the most appropriate and effective methods for reaching target populations (e.g., youth, Aboriginal, blue-collar workers, seniors, etc.) with tobacco control messages.
- Design public awareness strategies directed at key opinion leaders and at the community at large.
- Engage in the planning and execution of public awareness campaigns that are initiated through Tobacco Control Area Networks (TCANs). Educate the public about the importance of comprehensive tobacco control.
- Raise public awareness of the harmful effects of tobacco use and encourage smokers to quit.
- Raise public awareness of the tobacco industry's marketing practices that target youth and other high-risk populations.
- Develop earned and/or paid media strategies when designing social marketing campaigns.

iv) Evaluation and Monitoring

- Assess the reach and impact of social marketing campaigns on target populations.
- Collaborate with community, regional and provincial partners on social marketing campaign evaluation and monitoring activities.

v) Social Determinants of Health and Mental Well-being

- Develop public education and social marketing campaigns that target priority populations, such as youth, young adults and GLBT populations that are the target of tobacco industry advertising; low SES populations, ethnic and linguistic minorities; blue-collar workers; pregnant and parenting women, etc.

EXAMPLE XII: North Bay Parry Sound's Quit Heroes Radio Campaign

Newspaper ads and radio public service announcements were printed and aired encouraging ex-smokers to call the health unit and share their experiences in quitting smoking. Four "Quit Heroes" were chosen as campaign stars. Radio ads were written for each of the four "Quit Heroes." The ads ran for two weeks in May. The "Quit Heroes" Campaign continued with successful media coverage concluding on May 31 (World No Tobacco Day) with "Quit Heroes" interviews on live morning radio (Moose FM and CBC).

Requirement 12: Information and Referral

The board of health shall provide advice and information to link people to community programs and services on the following topics:

- *Healthy eating, including community-based food activities;*
- *Healthy weights;*
- ***Comprehensive tobacco control;***
- *Physical activity;*
- *Alcohol use;*
- *Screening for chronic diseases and early detection of cancers; and*
- *Exposure to ultraviolet radiation.*

i) Situational Assessment

- Maintain a current inventory of comprehensive tobacco control community resources, especially cessation services.
- Monitor comprehensive tobacco control information requests.

ii) Program and Social Marketing

- Link smokers to cessation resources within the community, e.g., Smokers' Helpline, community health centres/ Aboriginal health access centres or services provided by the PHU.
- Link local health professionals to and promote cessation counselling training opportunities.
- Assure that smokers are appropriately linked to other chronic disease prevention programs, such as cancer and diabetes screening, nutrition and physical activity (exercise, active recreation and sport) programs.
- Link the public to health promotion programs that incorporate a tobacco component (e.g., Eat Smart!, diabetes screening and management, etc.).

iii) Evaluation and Monitoring

- Track and assess information and referral requests.

iv) Social Determinants of Health and Mental Well-being

- Ensure that information and referral resources are appropriate for priority populations, that is, that they reach priority populations and that their materials are culturally and linguistically appropriate to the population.

Requirement 13: Tobacco Control Compliance

The board of health shall implement and enforce the Smoke-Free Ontario Act in accordance with provincial protocols, including but not limited to the Tobacco Compliance Protocol, 2008 (or as current).

Note: The Ministry of Health Promotion also provides *Enforcement Policy Directives* to assist in implementing this Requirement.

i) Situational Assessment

- Develop an inventory of premises where tobacco products are sold within the public health department's geographic boundaries.
- Assess the needs of local tobacco retailers and their staff for education and information (consider also linking to assessment local employers' needs).
- Collect compliance information in accordance with established protocols.
- Monitor youth access to tobacco products via social and retail sources (link to Requirement 3 – Educational Settings, and Requirement 4 – Workplaces).

ii) Policy

- Implement tobacco control laws and regulations in accordance with established protocols, laws and regulations (Public Policy).
- Conduct inspections of premises where tobacco products are sold with a view to limit the sale of tobacco products to minors (Public Policy).
- Conduct inspections of workplaces to assure the public is not exposed to the harmful effects of environmental or second-hand tobacco smoke (Public Policy).

iii) Program/Social Marketing

- Educate the public about the laws and regulations that limit youth access to tobacco products and protect the public from the harmful effects of second-hand/environmental tobacco smoke (link to Requirements 3, 4 and 11).
- Educate tobacco retailers and their staff about laws and regulations that limit youth access to tobacco products (link to Requirement 3).
- Educate the public about industry marketing practices, especially practices that target youth and young adults (link to Requirements 3 and 11).
- Educate the public about the need to de-normalize tobacco use and the tobacco industry.

iv) Evaluation and Monitoring

- Within the jurisdiction of the board of health, monitor/report on retailer compliance with SFOA laws that limit youth access to tobacco products in accordance with established protocols.
- Within the jurisdiction of the board of health, monitor and report compliance with other provisions of the SFOA, as well as other tobacco control laws and regulations.

v) Social Determinants of Health and Mental Well-being

- Protect youth from the illegal advertising and sale of tobacco products.
- Develop and promote passage of by-laws that prevent the proliferation of the retail sale of tobacco products in proximity to schools.

Section 4. Integration

Integration is a term that is generally used to imply alignment and coordination of a number of strategies and initiatives or interventions to achieve objectives, such as increasing economies of scale in the use of limited program resources; reducing unnecessary duplication; and leveraging key opportunities for health promotion interventions, especially in the context of highly correlated or clustered risk factors and conditions. Some examples include tobacco use and diabetes, lung dysfunction, cardio-vascular disease, etc., as well as comprehensive community research to identify priority populations.

Requirement 1: Surveillance and Needs Assessment

- Coordinate public health department research, evaluation and surveillance activity with the Public Health Research, Education and Development Program (PHRED), the Ontario Tobacco Research Unit (OTRU) at the University of Toronto and the University of Waterloo's Propel Centre for Population Health Impact.

Requirement 3: Educational Settings

- Work within the public health department to coordinate school-based activities whenever possible.
- Work with schools to implement a comprehensive school health program with an evidence-based tobacco use prevention component.
- Work with schools to develop strong tobacco control policies and enforcement strategies, and apply learning to other risk factors to prevent chronic disease.

Requirement 4: Workplace Settings

- Coordinate activities with public health departments' workplace health promotion program.
- Leverage or build on existing employer/union programming to promote workplace health.

Requirement 5: Food Premises

- Coordinate tobacco inspection with other inspections of food premises.
- Promote the Eat Smart! healthy restaurant program (healthy food plus healthy environments).

Requirement 6: Healthy Public Policies

- Work in an integrated fashion coordinating public health department activity to influence municipal planning and decision-making to ensure healthy public policies and healthy communities.

Requirement 7: Community Partners

- Cultivate partnerships with community-based agencies, providing opportunities to add value and promote joint planning and decision making.

Requirement 9: Cessation for Priority Populations

- Coordinate activities with other chronic disease prevention and screening programs administered by the local public health department and other agencies.

Requirement 11: Public Awareness/Social Marketing

- Coordinate public awareness campaigns with other related chronic disease prevention programs to ensure that appropriate messages reach their target populations.
- Work cooperatively with voluntary organizations to assure their support of public education campaigns. Jointly sponsor campaigns whenever possible.

Requirement 12: Information and Referral

- Ensure that information and referral resources are cross-referenced to other relevant chronic disease prevention and screening services.

Requirement 13: Tobacco Control Compliance

- Ensure that compliance information is shared with public health department staff and that public awareness campaigns provide information about tobacco control compliance related to the sale of tobacco products to minors.
- Coordinate tobacco control inspections with other inspections in order to increase the number of tobacco control inspections of retailers (e.g., inspections of premises where food is sold or served).

Section 5. Resources

Requirement 1: Surveillance and Needs Assessment

- University of Toronto, Ontario Tobacco Research Unit (OTRU)
- University of Waterloo, Propel Centre for Population Health Impact
- Public Health Research, Education and Development Program (PHRED)
- Ontario Agency for Health Protection and Promotion (OAHPP)

Requirement 3: Educational Settings

- Identify gaps in knowledge, needed resources, services and programs
- Leave The Pack Behind (LTPB), Brock University, tobacco control at colleges and universities
- Program Training and Consultation Centre (PTCC), Cancer Care Ontario, training and technical assistance in tobacco control in educational settings
- Youth Advocacy Training Institute (YATI), The Lung Association, tobacco control and youth empowerment training
- Smokers' Helpline, Canadian Cancer Society (CCS) for referral to telephone counselling and web-based assistance with smoking cessation
- Tobacco Control Area Networks (TCANs) to facilitate joint action planning and shared resources

Requirement 4: Workplace Settings

- Identify gaps in knowledge, needed resources, services and programs
- Program Training and Consultation Centre (PTCC), Cancer Care Ontario (CCO), technical assistance in tobacco control in workplace settings
- Smokers' Helpline, Canadian Cancer Society for referral to telephone counselling and web-based assistance with smoking cessation
- Tobacco Control Area Networks (TCANs) to facilitate joint action planning and shared resources

Requirement 5: Food Premises

- Program Training and Consultation Centre (PTCC), Cancer Care Ontario (CCO), enforcement training
- Tobacco Control Area Networks (TCANs) to facilitate joint action planning and shared resources

Requirement 6: Healthy Public Policies

- Identify gaps in knowledge, needed resources, services and programs
- Program Training and Consultation Centre (PTCC), Cancer Care Ontario (CCO), training and technical assistance in tobacco control policy development.
- Smoking and Health Action Foundation/Non-Smokers' Rights Association for information, training and technical assistance in tobacco control and public policy applications
- Media Network project, Program Training and Consultation Centre (PTCC), Cancer Care Ontario (CCO) tracking of tobacco control media activity in communities
- Tobacco Control Area Networks (TCANs) to facilitate joint action planning and shared resources

Requirement 7: Community Partners

- Disseminate appropriate resources to community partners
- Identify gaps in knowledge, needed resources, services and programs
- Program Training and Consultation Centre (PTCC), Cancer Care Ontario (CCO), technical assistance in partnership development and stakeholder involvement
- Tobacco Control Area Networks (TCANs) to facilitate joint action planning and shared resources

Requirement 9: Cessation for Priority Populations

- Smokers' Helpline, Canadian Cancer Society (CCS), *Resource Directory for Smoking Cessation Referral*
- Registered Nurses' Association of Ontario (RNAO), *Best Practice Guidelines, Integrating Smoking Cessation into Daily Nursing Practices*
- Training Enhancement in Applied Cessation Counselling and Health (TEACH), Centre for Addiction and Mental Health (CAMH), University of Toronto, cessation intervener training and certification, training francophone service providers
- Community Health Centres, Aboriginal Health Access Centres and CAMH's STOP on the Road/PHU initiatives
- Learning through Evidence, Action and Reflection Networks (LEARN) Program Training and Consultation Centre (PTCC), Cancer Care Ontario (CCO), communities of practice and knowledge exchange
- Aboriginal Tobacco Strategy, Cancer Care Ontario (CCO), working with Aboriginal populations
- *Tobacco Control Reference Catalogue*, Canadian Council for Tobacco Control (CCTC.)
- Tobacco Control Area Networks (TCANs) to facilitate joint action planning and shared resources

Requirement 11: Public Awareness/Social Marketing

- Media Network, Cancer Care Ontario (CCO) for media tracking and technical assistance about developing earned and paid media campaigns
- Tobacco Control Area Networks (TCANs) to facilitate joint action planning and shared resources

Requirement 12: Information and Referral

- Smokers' Helpline, Canadian Cancer Society (CCS), *Resource Directory for Smoking Cessation Referral*
- Ensure that complete, regularly updated and cross-referenced local tobacco control information and referral resources are available to the public

Requirement 13: Tobacco Control Compliance

- Program Training and Consultation Centre (PTCC), Cancer Care Ontario (CCO), enforcement training
- University of Toronto, Ontario Tobacco Research Unit (OTRU)
- Tobacco Compliance Protocol, 2008

Section 6. Conclusion

This Guidance Document is one of a series that have been prepared by the Ontario Ministry of Health Promotion to provide guidance to boards of health as they implement health promotion programs and services that fall under the 2008 *Ontario Public Health Standards* (OPHS). This Guidance Document has provided background information specific to comprehensive tobacco control including its significance and burden.

In addition, this Guidance Document has provided information about situational assessments for each OPHS Requirement relevant to comprehensive tobacco control and included related information about policies, program/social marketing, evaluation and monitoring issues and the social determinants of health. It has also suggested policy direction and strategies for consideration, and examined evidence and rationale.

Achieving overall health goals and societal outcomes will depend on the efforts of boards of health working together with many other community partners such as non-governmental organizations, local and municipal governments, government-funded agencies and the private sector. By working in partnership towards a common set of requirements, Ontario can better accomplish its health goals by reaching for higher standards and adequately measuring the processes involved.

The health of individuals and communities in Ontario is significantly influenced by complex interactions between social and economic factors, the physical environment and individual behaviours and conditions. Addressing the determinants of health and reducing health inequities will also ensure that boards of health are successful in their efforts.

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