

EXPLORING ISSUES OF EQUITY WITHIN CANADIAN TOBACCO CONTROL INITIATIVES: AN ENVIRONMENTAL SCAN

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Principal Investigator (PI):

Benita Cohen RN, PhD
University of Manitoba

Co-PI:

Annette Schultz RN, PhD
University of Manitoba

Co-Investigator:

Robert Walsh
Executive Director,
Canadian Council for
Tobacco Control

Research Manager:

Lesley Anne Fuga

Research Assistants:

Caitlan Bartmanovich
Sarah-Jane Eves

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UNIVERSITY
OF MANITOBA

Faculty of Nursing

This report provides an overview of key findings from our study of how equity is considered in Canadian federal, provincial, and territorial tobacco control (TC).

Why is an Equity Focus Important?

Health inequities are a subset of health disparities or inequalities associated with underlying social disadvantage—for example, living in poverty or being a member of a marginalized group.¹ They represent unequal opportunities to be healthy and are avoidable. In 2008, the World Health Organization called on all nations to eliminate inequities in health outcomes within a generation, stating that this is “an ethical imperative; a matter of social justice.”²



Achieving health equity requires addressing both the health-damaging *effects* related to social disadvantage *and the inequalities* among populations in the underlying social and economic conditions necessary to be healthy³—known as the ‘social determinants of health.’^{4,5} Many of the social determinants identified in the literature are presented in boxes throughout this report.

Why Consider Equity in TC?

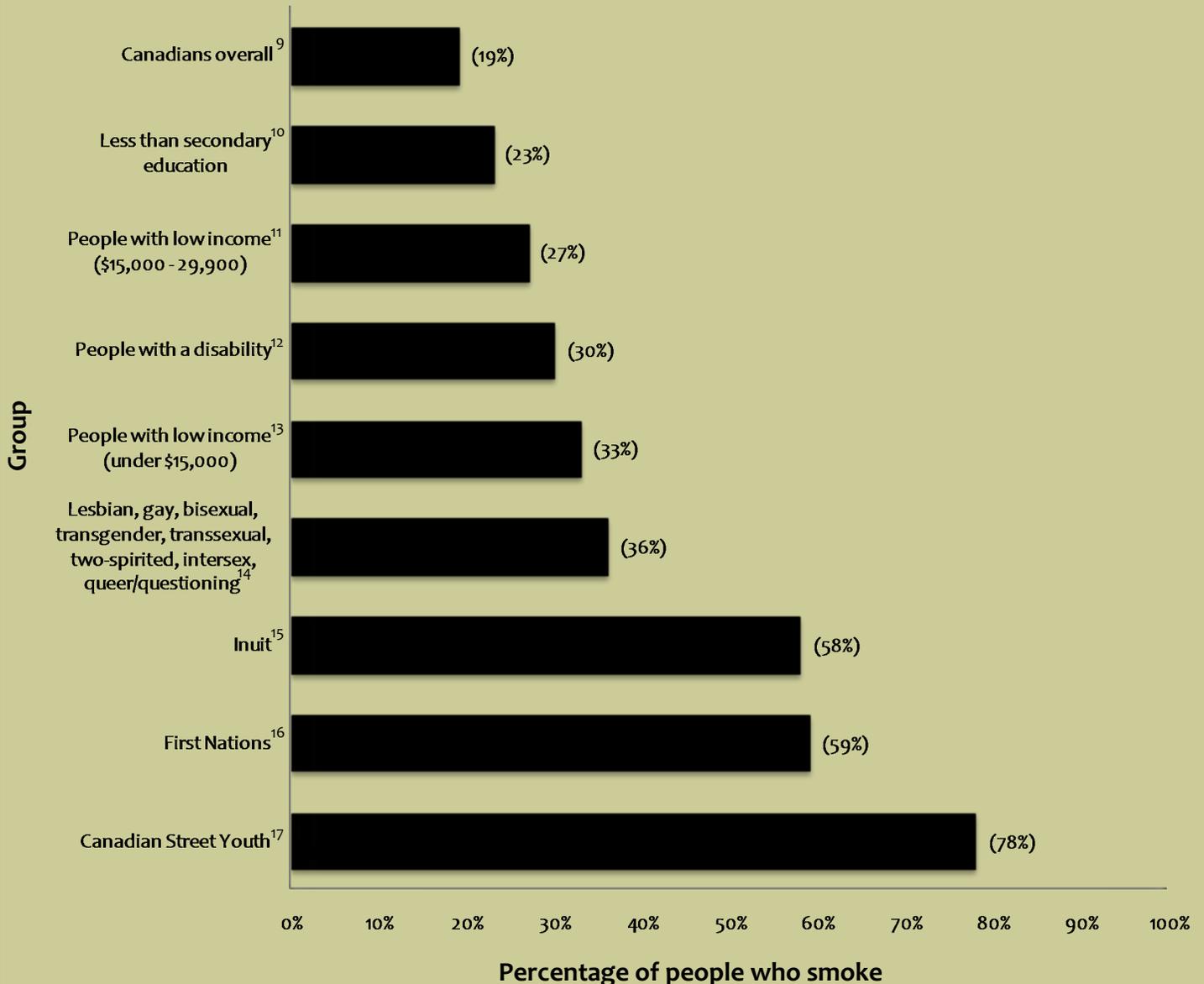
Evidence shows that socially disadvantaged populations suffer relatively more tobacco-related disease than the general population,⁶⁻⁸ and this health disparity is associated with higher smoking rates among these groups (see Fig. 1). Consideration of equity in TC involves not only acting on these tobacco-related inequities, but also addressing the social determinants that contribute to them.

Equity in Canadian Tobacco Control:

Background

Figure 1

Percentage of People who Smoke by Group



These data are presented as a general illustration of the difference in reported proportions of people who currently smoke among various groups. Except where otherwise indicated, aggregate data are presented for both sexes, aged 15 plus, and are reported for years between and including 2002-2006. All data are Canadian, excluding the statistic for "people with a disability." Due to differences in sampling and survey methods, these data are not directly comparable. Data limitations are a serious consideration in understanding equity issues in Canadian TC; the numbers of people who smoke are often under-reported due to sampling constraints. This figure does not represent all populations who suffer inequitable opportunities for health due to social or economic exclusion.

Equity in Canadian Tobacco Control:

Study Design

Our research team set out to discover the extent to which an equity lens is part of current Canadian TC initiatives, and what factors influence the capacity to address tobacco use among vulnerable populations and reduce tobacco-related health inequities. We focused our questions within the social justice discourse and defined the study populations of interest as “vulnerable to health inequities by virtue of being a member of a disadvantaged group.”

In addition to related academic literature, we used two main sources of information:

(1) Review of the Canadian TC frameworks and strategies that guide federal, provincial, and territorial government TC initiatives, as well as a sample of those produced by national and provincial civil society organizations dedicated to the reduction of tobacco use. (Documents were current at Nov. 2009.) We applied a series of questions to see how issues around tobacco use were framed, whether and how vulnerable populations were identified, and the degree of emphasis on addressing the social determinants.

(2) Interviews with 41 leaders in Canadian TC (key informants) at the federal, provincial, and territorial levels, including representatives of government and non-governmental organizations. These included a ‘second wave’ of respondents whom we consulted for further insight on some of our early findings with respect to TC issues and Aboriginal communities. Interviews were conducted between June and November 2009. We heard the views of all participants on whether and how the needs of vulnerable populations are being met by TC initiatives, and what helps and hinders progress on this front.



**SOCIAL DETERMINANT OF HEALTH:
INCOME SECURITY**



“(T)he underlying factors that influence people’s smoking have to do with societal structures and societal barriers around for example[...] social and economic exclusion[...] You know if we could eradicate poverty, if we could eradicate racism, people would have a lot easier time to quit smoking I think.”

Key Informant, Govt.

Equity in Canadian Tobacco Control:

Findings

Who is vulnerable?

When asked which, if any, groups are recognized as vulnerable populations within the TC context, our key informants mentioned five groups most frequently:

- Youth
- Aboriginal/Inuit
- People with mental health issues & addictions
- Low socioeconomic status
- Women

**SOCIAL DETERMINANTS
OF HEALTH:
SOCIAL SUPPORT
NETWORKS
AND INCLUSION**



Current Populations of Interest

- The vast majority of TC efforts are directed to policies, programs and services that serve as a disincentive to smoking and support smoking cessation among the general public and youth.
- Following youth, the populations most frequently identified for targeted TC attention were Aboriginal peoples and women. While the general population of women was historically one of the earliest priority populations identified, the focus now appears to have narrowed to pregnant women.
- There appears to be a growing recognition of the disproportionate toll of tobacco use on two populations that experience social disadvantage: people with mental health issues and addictions, and those with low income. Some program and policy interventions directed at these groups were reported. However, in TC overall, there was a noted absence of an equity lens and a corresponding hesitancy to increase resources to meet the needs of vulnerable groups.
- Some respondents perceive that vulnerable groups make up most of the remaining population of people who smoke. Others referred to data that show the greatest numbers of those who smoke are not identified as belonging to the sub-groups under discussion. When talking about the ways in which data are generated and presented, respondents acknowledged that an equity lens is rarely applied.

Equity in Canadian Tobacco Control:

Findings

The Priority to Address Aboriginal Peoples

High smoking rates among Aboriginal, Inuit and First Nations (FN) populations received a lot of attention both in discussion with key informants as well as in the TC documents we reviewed. Indigenous populations were often seen as atypical cases and prioritized for action for a number of reasons:

- Cultural use/values associated with tobacco (with acknowledgement of differences between and among FN and Inuit communities)
- Lack of culturally competent service delivery, including language issues
- Isolation (as it relates to accessibility and higher cost of service delivery)
- Issues of policy and legislation (e.g., no taxes paid on cigarettes in FN communities; some FN communities have not adopted smoke-free places; strength of values related to autonomy)

‘Upstream’ issues of historical injustice and current experiences of economic and social disadvantage that contribute to high rates of smoking were rarely discussed. With respect to tailored approaches, there seems to be more willingness to support FN in development of self-directed approaches and this appears linked to acknowledgement and respect for jurisdictional and cultural matters.

“So they need to come up with their own strategies based on their own population, based on their own experience and their own reality because their reality is not our reality...”

Key Informant, NGO

Who is less visible?

Many populations known to suffer from tobacco-related health inequalities were infrequently identified for targeted TC interventions.

People who are:

- Homeless
- Elderly
- Newcomers
- Living with physical disabilities
- Lesbian, Gay, Bisexual, Transgender/ Transsexual, Two-Spirited, Intersex, and Queer/Questioning
- Medically vulnerable (e.g. HIV/AIDS, hospitalized)
- Living in rural communities
- Members of minority language/cultural groups



SOCIAL DETERMINANTS OF HEALTH:

**EMPLOYMENT SECURITY
AND WORKING CONDITIONS**

Equity in Canadian Tobacco Control:

Findings

Approaches to Vulnerable Populations

- Expanded access and language options for quit lines as well as tailored cessation programming for specific populations were the most commonly noted means of outreach to vulnerable groups. Underlying issues such as poverty, social exclusion, sub-standard housing, and limited employment opportunities generally were not addressed within the TC context.
- Rather than attempting to modify existing programs to better suit sub-groups, respondents said that it is preferable to tailor interventions from the ground up. Some respondents and documents identified the need for more widespread use of population health approaches involving community engagement, capacity development, and advocacy by and on behalf of vulnerable populations. These opportunities can be used to tap into a group's unique knowledge base to generate new and perhaps more effective tobacco solutions.
- There is an awareness among some TC leaders that solutions for sub-groups might differ substantively from those that have been effective for the general population.

SOCIAL DETERMINANT OF HEALTH:

FOOD SECURITY



SOCIAL DETERMINANTS OF HEALTH:

HOUSING AND PHYSICAL ENVIRONMENT



“Although one can argue that the health and well-being of an individual largely depends on the lifestyle choices he or she makes, solely relying on this tactic to advance the population’s health is too narrow a view. Ignoring social context, i.e. social determinants of health, avoids the influence of socioeconomic indicators, marketing tactics that target vulnerable communities and discriminatory policies and practices that often affect individual choices.”

Equity in Canadian Tobacco Control:

Findings

“How could people who are functionally illiterate access any kind of existing cessation program? How could people who have no medical coverage access nicotine replacement therapy or other medications that have been shown to double or triple the likelihood of success when combined with a group program?”

Key Informant,
NGO

Universal and Targeted Approaches to TC

- The primary focus of TC in Canada has tended to be on universal approaches to reduce the total number of people who smoke in the general population. Wide introduction of legislation to limit smoking areas, social marketing campaigns, and taxation policy were cited as the prime drivers of positive changes in norms around smoking. Many respondents noted these methods deliver benefits to vulnerable populations as well. There was only limited discussion of how universal approaches may widen the health gap between populations who are more and less advantaged.
- Many of the TC leaders with whom we spoke believe that much more could be done to meet the needs of those who bear a disproportionate burden of tobacco-related consequences (e.g., Aboriginal peoples, people with mental illness and other populations identified earlier in this report). Many recognize the potential to employ more targeted approaches.
- Only a few respondents discussed ways in which the TC community might affect the social conditions that underlie smoking and poor health outcomes. They told us the future success of TC would come from looking upstream and collaborating with other government sectors and civil society groups outside of health, such as those involved with justice, housing, income security, and family services.

SOCIAL DETERMINANT OF HEALTH:

EDUCATION



SOCIAL DETERMINANT OF HEALTH:

EQUITY IN HEALTH CARE

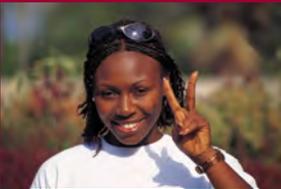


Equity in Canadian Tobacco Control:

Findings

SOCIAL DETERMINANT OF HEALTH:

PEACE



SOCIAL DETERMINANT OF HEALTH:

HEALTHY EARLY YEARS THROUGH ADOLESCENCE



Constraints to Addressing Health Inequities

- Characteristics of the **organizational structure surrounding TC can affect the focus of TC programs and services**. For example, whether TC is positioned as a stand-alone initiative or within another portfolio (such as healthy living, chronic disease, or mental health and addictions) can impact budget options, access to information, and program orientation (among other things). Potential collaborations within and across sectors are also affected by TC's place within structures as jurisdictional issues and the formation and maintenance of relationships are central to collaborative efforts.
- Generally, **TC funding appears threatened**, more so amid undercurrents that TC is no longer a priority public health issue. Many important opportunities to reduce tobacco use remain underutilized and there is a widespread focus on methods with the greatest short-term return on investment. Resource-intensive programs involving meaningful consultation, relationship-building, and reformulation of solutions often are not prioritized. Interview participants expressed concern that the only funding available for vulnerable populations would be as a result of re-allocation of funds away from general population measures.
- Some respondents believe that both those who smoke and leaders in **vulnerable populations show less interest in tobacco issues** because they have other, more important concerns. Other key informants noted that while it may appear that smoking and its consequences are not important to these groups, good health for one's self, family, and community is a widely shared goal and is likely to be equally common among members of disadvantaged groups. It was also pointed out that communities may focus on issues for which direct funding is readily available; if more funds were allocated to a greater range of TC options, perhaps there would be more attention paid to it in these vulnerable communities.

Equity in Canadian Tobacco Control:

Findings

- Respondents reported that a sustained focus on the general population is required to counter ***the power and stealth of tobacco marketing***. Respondents were less likely to note the tobacco industry's strategic focus on marginalized groups who may be most susceptible to the specialized distribution, packaging, pricing, and promotion of tobacco products.
- Other than the call for a focus on youth, indigenous populations, and women, ***government documents revealed rare references to “vulnerable,” “at risk,” or “special” populations, equity issues or the social determinants of health***. This finding may explain the position of key informants who reported that addressing inequities is beyond the scope of their mandate.
- Respondents identified the ***need for more evidence to support equity-oriented initiatives*** such as demonstrated promising practices specific to the needs of priority populations, and quantitative data that illustrate inequities. They also felt TC would benefit from: an increased internal capacity to generate, manage and understand the data; better information sharing; and greater involvement from priority communities in scoping issues and solutions.
- We were told that grassroots, organizational, and political leadership is key and that current ***leadership against health inequities is limited***. Respondents identified the following strategies to facilitate TC action to address health inequities: Those who understand the issues should take every opportunity to share information on the linkages between the determinants and health with all audiences, including the general public. Members of the populations under discussion should be encouraged and supported to advocate on their own behalfs and to determine and implement solutions. Decision-makers should clearly prioritize this issue and follow up with corresponding distribution of resources.

“How can you look at smoking amongst the lower socioeconomic population without addressing the factors that may perhaps keep them smoking more[...] I’ve had people tell me I’m not going to give up this, I can’t afford to do this [...] but it’s the only comfort I have.”

Key Informant,
NGO

Equity in Canadian Tobacco Control: *Reflections*

A Strong Equity Perspective is Missing in Canadian TC

While several key informants expressed interest and concern about equity issues, populations known to suffer health inequalities are under-served by TC interventions and the root causes of tobacco use are mostly not addressed.

Canadian TC policies appear to favour a strong focus on smoking cessation at the level of universal programs for individual behaviour change. Success is defined as a reduction in the overall number of people who smoke. Even where resources are directed toward the needs of specific groups, there is insufficient attention to the most vulnerable (for example, youth who are not in school or pregnant women with low socioeconomic status). Respondents identified multiple constraints to addressing the needs of vulnerable populations but these generally were not embedded within a social justice discourse about equity.

SOCIAL
DETERMINANT
OF HEALTH:
CULTURE

Hello
Hola
Guten Tag
Bonjour
Zdravo

SOCIAL
DETERMINANT
OF HEALTH:
GENDER



Key informants suggested that greater use of specialized methods would be required if the intention were specifically to meet the needs of populations that experience social and economic disadvantage. Developing these methods through participatory processes with multiple distinct populations of limited size may result in higher up-front costs per person than universal approaches to prevention and cessation of tobacco use. (However, it was also noted that these costs would be minimal when compared with the amount of revenue generated from tobacco excise duties and sales taxes.) A limited number of respondents saw how TC could play a role in changing the social conditions that underlie high smoking and low cessation rates. Many key informants identified the challenge as how to advance public and political awareness that investment in the broad determinants of health will produce universal benefits.

“There is a role for advocacy, for influencing, for putting forward recommendations and pursuing policies.”

Key Informant, Govt.

Equity in Canadian Tobacco Control:

Conclusion

A Social Justice Approach to TC

The National Conference on Tobacco or Health, held in Edmonton in 2007, generated a recommendation to reposition tobacco use as a social justice issue. This would mean viewing health holistically—as the physical, mental, spiritual and social well-being of individuals and communities—and seeing tobacco use as an outcome of unhealthy social conditions. The question then is how to move beyond buffering the health-damaging effects of social disadvantage to equalizing the underlying social and economic conditions that support good health.

Simultaneous application of the following approaches would reduce the gap in health status between general and disadvantaged populations: ^{18,19}

- Direct TC resources, programs, and services toward vulnerable communities.
- Supplement projects that focus solely on supporting individual lifestyle and behavioural changes with projects that mobilize communities to implement strategic actions for improving social conditions.
- Advocate for policy changes to address the social context that contributes to and reinforces tobacco use amongst vulnerable populations, and support the development of advocacy skills within priority populations.
- Decrease environmental factors that promote tobacco-related health inequity (e.g., targeted tobacco marketing to marginalized populations).

With the authentic engagement and active support of populations who experience social and economic disadvantage, the TC community could promote wider understanding of the factors that make these groups more susceptible to tobacco use and its ill effects, and reshape the existing frame around TC. Expanding goals beyond general population smoking rates and accessible cessation programs to include actions that create and support healthy social conditions could ultimately yield longer-term social, health, and economic benefits to Canada.

“Reposition tobacco use as a social justice issue”

[Recommendation from the National Conference on Tobacco or Health,
Advancing TC in Canada, Learnings from World Café, 2007]

Equity in Canadian Tobacco Control:

References

Contact Information

Dr. Benita Cohen
Associate Professor,
Faculty of Nursing
University of Manitoba

377 Helen Glass Centre
89 Curry Place
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Phone: 204-474-9936

Email:

Benita_Cohen@umanitoba.ca

<http://umanitoba.ca/faculties/nursing/aboutus/academic-staff/cohen.html>

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