Nova Scotia Tobacco Control Strategy Evaluation

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Prepared for:

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Prepared by:

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Executive Summary

In 2001, the Tobacco Control Unit of the Nova Scotia Department of Health developed a comprehensive provincial tobacco control strategy (the Strategy) with the participation of many stakeholders from across the province. In 2006, Pyra Management Consulting Services Inc. (PMCS) was contracted to perform an evaluation of the Strategy.

The evaluation was conducted using the evaluation framework developed in 2002 for the Strategy. The purpose of the evaluation was:

- to describe the implementation to date of each component of the Strategy;
- to assess the outcomes of the Strategy;
- to identify key stakeholder perceptions of the successes, challenges, and effectiveness of the Strategy; and
- to make recommendations to support renewal of the Strategy.

Methodology

Data for the evaluation was collected through interviews and focus groups with stakeholders in the tobacco control community, as well as through a review of fifteen documents provided by Nova Scotia Health Promotion. There were a number of limitations to the data collection process, including lack of data to measure some of the planned outcomes, inconsistent data collection across the province and the unavailability of some key informants for interviews.

Conclusions

Overall, although there are areas that have been identified as opportunities for improvement, the implementation of the Strategy has been considered by most tobacco control stakeholder to be effective. Some key informants point to rising quit rates and decreasing uptake rates as an indicator of success of the Strategy. Participants responded overwhelmingly that the Strategy

has been an extremely useful mechanism for focusing efforts and attention on key areas, and welcome the opportunity to renew the Strategy.

A majority of the planned outcomes documented in the evaluation framework were achieved, as noted in the following summary. It should also be noted that a number of significant achievements were made that had not been aligned with the planned outcomes, such as the provision of Nicotine Reduction Therapy (NRTs) to treatment program participants.

The following table presents a summary of the evaluation of the Strategy.

	Number of Outcomes				
Component	**Achieved**	**Partially Achieved**	**Not Achieved**	**Data not available**	**Total**
Pricing and Taxation	1		1		2
Smoke-Free Legislation and Policy	2	1			3
Treatment and Cessation	5	1	2	1	9
Community Based Programming	5				5
Youth Smoking Prevention		1	3	2	6
Media and Public Awareness	3			2	5
Monitoring and Evaluation	1	2	1		4
Totals	**17**	**5**	**7**	**5**	**34**

Top Considerations

As part of this evaluation, participants were asked to describe their thoughts regarding the areas or components they felt should be given consideration during the renewal of the Strategy. It should be noted that the responses given were the opinions of the interview participants and do not necessarily constitute best practice.

Considerations noted by key informants are grouped below based on the number of interview sessions in which the consideration was voiced.

The following considerations were indicated during most interview sessions with key informants.

1. Introduce Point of Sale advertising legislation to remove tobacco products from within sight of customers;

2. Implement the provincial evaluation framework to collect and report data consistently for all District Health Authorities;
3. Increase funding, staff and other resources to adequately meet the current and projected demand for cessation and treatment services, which are rising and expected to continue to do so in response to the success of the Strategy;
4. Promote research to determine the most appropriate way to treat youth addicted to nicotine. If appropriate, funding of nicotine replacement therapy should be considered for youth;
5. Develop a climate within schools that places increased priority on actions to prevent smoking and reduce tobacco use; and
6. Create and sustain a tobacco industry de-normalization initiative with a focus on youth, reviewing and applying lessons from youth advocacy initiatives such as the Expose initiative in Ottawa.

Recommendations

Based on the evaluation data, evaluation findings, and the key themes noted by both the evaluation participants and the workshop results of the Tobacco Control Summit, the following recommendations are offered regarding the Strategy.

1. Renew the Strategy in light of the considerations identified by evaluation participants in the Strategy renewal process and the key themes developed and discussed at the Tobacco Control Summit. Consider the expansion of the Strategy to include new pillars or components, and connect the Strategy with other health promotion strategies without diffusing the focus of attention on tobacco control;
2. Provide funding for the renewed Strategy at levels comparable to best practice funding levels recommended by the Centers for Disease Control ($7 to $20 per capita for population less than three million)[1];
3. Promote the provincial strategy as the only Strategy, and encourage district tobacco control staff to collaboratively design one- and three-year district specific implementation

plans linked directly to the provincial strategy. This process should incorporate on-going information sharing and resource sharing where appropriate;

4. Identify a process for collecting data and support an ongoing data collection cycle. Consider developing and implementing common collection, management and reporting tools across all districts. Support DHAs in implementing consistent data collection analysis and reporting that will inform program planning;
5. Develop and implement a regular communication mechanism through which tobacco control staff and HPP meet to discuss accomplishments, planned activities, issues, and best practices:
6. Clarify the roles and expectations of tobacco control staff. Where they are not already in existence, develop role descriptions and expected tobacco control expertise for tobacco control staff. Develop a professional training and development plan to ensure that all tobacco control staff have equitable access to professional development;
7. In partnership with Nova Scotia's tobacco-vulnerable populations, identify and develop initiatives to reduce tobacco use among these groups;
8. Support pro-active and ongoing knowledge translation activities, so that all tobacco control staff across the province have easy access to current research about tobacco use and best practices related to tobacco control. This includes the identification and sharing of best practices occurring in Nova Scotia;
9. Determine from best practices and evidence the direction most appropriate across the province regarding youth possession legislation, disseminate the results to all tobacco control staff and tobacco stakeholders, and as appropriate work with legislators to ensure that legislation reflects best practice;
10. Develop an integrated, consistent approach and implementation plan in Nova Scotia for provision of brief intervention training for tobacco control for healthcare staff. A consistent approach to evaluation of this training should also be developed;
11. Explore the effect of the Smokers' Helpline on social messaging to determine if the existence, advertisement and accessibility of such a service provides impetus to a smoker's decision to take action; and

12. Improve the HPP web-page and ensure information and links are clearly labeled to promote easy navigation and access to information and services.

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Introduction

In 2001, the Tobacco Control Unit of the Nova Scotia Department of Health developed a comprehensive provincial tobacco control strategy (the Strategy) with the participation of many stakeholders from across the province. In 2002, an evaluation framework was developed to describe the process and outcome evaluation measures for the Strategy. In 2006, Pyra Management Consulting Services Inc. (PMCS) was contracted by Nova Scotia Health Promotion and Protection (HPP) to perform an evaluation of the Strategy using the framework developed in 2002. This report presents the results of this evaluation.

Background

The objectives of the evaluation of the Strategy were:

- To describe the implementation to date of each component of the Strategy;
- To assess the outcomes of the Strategy as described in the evaluation framework developed in 2002;
- To identify key stakeholder perceptions of the successes, challenges, and effectiveness of the Strategy; and
- To make recommendations for renewal of the Strategy.

This report describes the methodology used to collect and analyze data to support the evaluation objectives, and describes each of the Strategy components and the progress achieved related to each one. Key informants interviewed during the evaluation were asked to describe their thoughts regarding the next steps and items to be considered for the renewal of the Strategy. A synthesis of key informant opinions about future considerations as well as recommendations based on the evaluation results and the results of an October 2006 tobacco stakeholder conference are also included in this report. Appendix 1 – Evaluation Framework Indicators contains the specific results for each indicator from the 2002 evaluation framework.

Methodology

The Nova Scotia Tobacco Control Strategy Evaluation Framework developed by the Nova Scotia Department of Health Tobacco Control Unit in 2002 contains the process and outcome indicators used to evaluate the progress of the Strategy. The evaluation was conducted in three stages:

- Data collection, related to the indicators of the evaluation framework;
- Data analysis, involving the determination of how the collected data measures the progress of the Strategy; and
- Reporting, involving the documentation of the findings, trends, and conclusions drawn from the data analysis.

Data collection and data analysis are described in the following sections, as are the limitations encountered during the evaluation.

Data Collection

Two key methods of data collection were utilized for the evaluation; review of program documentation and other documentation collected by HPP, and interviews with key informants identified collaboratively by HPP and the evaluators. All documentation reviewed, with the exception of the HPP website on tobacco control, was collected by HPP and made available to the evaluators. The only primary data collection conducted by the contractor was qualitative interviewing.

The documents reviewed consisted of:

- Tobacco Control Strategy Renewal (Framework and Key Steps – Draft March 30 2006);
- Nicotine Addiction Treatment Program Updates from eight of the nine Nova Scotia District Health Authorities (DHAs) or Shared Service Areas (SSAs);
- Public Health Tobacco Control Strategy Progress Reports from each SSA;
- Smokers' Helpline Quarterly Report – Nova Scotia, June 2005;

- Nova Scotia's Comprehensive Tobacco Control Communications Campaign Presentation;
- The Nova Scotia Tobacco Control Communications Campaign – Phase 2 Final Report, 28 April 2006;
- Thinkwell Research – Extreme Group 2006 Smoking Cessation Focus Groups Discussion Report, 25 January 2006;
- Nextbus Report on Telephone Surveys, 23 February 2006, and 26 April 2006;
- Smoking Status Report – Quantitative, Smoke Free Around Me Campaign, February 2005;
- Tobacco Control Strategy – Progress Report, October 2001 – March 2004;
- Comparative tax rates as of September 2005 and Smoking Prevalence Rates;
- Canadian Tobacco Use Monitoring Survey (CTUMS) 2005 results for Nova Scotia – Draft;
- The HPP Tobacco Control Website (http://www.gov.ns.ca/hpp/tobaccoControl.html); and
- Thinkwell Research – Public Opinion Survey Presentation, October 12, 2005.

The following key informant interviews were conducted as group, facilitated sessions:

- HPP Manager Tobacco Control (current and former);
- Directors of Addiction Services;
- Directors of Public Health Services; and
- Health charities and non-government organizations:
    - Lung Association of Nova Scotia;
    - Canadian Cancer Society (Nova Scotia);
    - The Heart and Stroke Foundation of Nova Scotia;
    - Cancer Care Nova Scotia;
    - Doctors Nova Scotia; and
    - Smoke-Free Nova Scotia.

Telephone interviews were conducted with tobacco control and nicotine specialists. One telephone interview with the simultaneous participation of the Tobacco Coordinator and a Community Outreach Worker (Nicotine Addiction Treatment) in each DHA was planned. Prior to each interview, the key informants were provided with the interview questions to give them an opportunity to consider the questions and objectives of the interview prior to the session. Tobacco Coordinators and Addictions Staff from seven DHAs agreed to participate in the interview process. Directors of Addictions Services and all Directors of Public Health Services agreed to participate in the interview process. Since all directors agreed to participate, the perspectives of all DHAs have informed the evaluation to at least some extent.

In addition, the results of workshops held in Halifax at the October 2006 Tobacco Control Summit informed the development of recommendations for the Strategy renewal. A draft of this report was presented to the Evaluation Steering committee and feedback from Committee members was incorporated into the final report.

All interviews and facilitated group sessions were recorded with the permission of the participants and transcribed for analysis. All collected data are stored in locked cabinets at PMCS. Data will be retained for a period of five years and then destroyed.

Data Analysis and Reporting

Qualitative data analysis was conducted using the collected data. Qualitative analysis software was used to organize data sources and streamline the coding of data to map to the indicators of the evaluation framework. The coded data was then analyzed to identify themes related to the progress of the Strategy.

Thirty people participated in eleven interview sessions during the evaluation. As well, the evaluation was informed through the review of the draft report by members of the Tobacco Advisory Committee, a number of whom also participated in the interview sessions. To indicate the strength of responses by participants, the terms “a few”, “some”, “many” and “most” are

used in the evaluation report to indicate the frequency with which responses were noted in different interview sessions. The following definitions were applied:

- "A few" indicates that the response was noted in more than one interview session;
- "Some" indicates that the response was noted in at least a quarter of the interview sessions;
- "Many" indicates that the response was noted in at least half of the interview sessions; and
- "Most" indicates that the response was noted in nearly all interview sessions.

Quotes from the interview sessions are used in the evaluation report to illustrate responses noted during the evaluation. These quotes are not attributed to protect the anonymity of the interview participants, and appear in the report as indented *italicized* paragraphs.

It should be noted that the term tobacco control staff is used throughout the evaluation report to denote both Tobacco Coordinators and Addictions Services staff who deal as front-line staff directly with the public. This term is used to protect anonymity in what is a small sample set.

In some instances, only approximate values were available for inclusion in the evaluation. Where approximate values were used, they are denoted with a tilde (~).

Limitations

Lack of Data

The following data sources are indicated in the evaluation framework as required for collecting data to support assessment of the Strategy:

- Key informant interviews;
- Program records;
- Public opinion surveys;
- Addiction Services client surveys;

- Smokers' Hotline user surveys;
- Health care provider surveys;
- Canadian Tobacco Use Monitoring Survey (CTUMS);
- NS Teacher Surveys;
- NS Student Surveys; and
- Website User Surveys.

A number of these data sources did not exist or were not made available to the contractors during the course of the evaluation. Although listed in the evaluation framework as data sources necessary to measure the indicators in the evaluation framework, results of public opinion, healthcare provider, teacher, student and website user surveys were not available for the evaluation.

In particular, data was not provided to assess the following outcomes of the Strategy:

- Treatment and Cessation:
    - The percentage of smokers (ever smokers) who are preparing to take action (in the previous 12 months) will move from 7% to 15% by 2004;
- Youth Smoking Prevention:
    - 30% of youth that complete a cessation support program will not be smoking at a 1 month follow-up;
    - The percentage of smokers (ever smokers) aged 15 to 19 who are thinking about quitting will increase from 33% to 40%;
- Media and Public Awareness:
    - The percentage of smokers (ever smokers) who are preparing to take action (in the previous 12 months) will move from 7% to 15% by 2004; and
    - Increase (over time) in number of users of the 1-800 services who report that they called for assistance because of media messages.

Inconsistent Data Collection Across Province

In addition, program records maintained by the DHAs / SSAs are not consistent with each other and do not include all of the indicators from the evaluation framework. This lack of consistency makes it difficult to create a provincial picture of progress on the indicators outlined in the evaluation framework.

Unavailability for Interviews

Interviews could not be scheduled with tobacco control staff from two DHAs, possibly due to scheduled vacations during the data collection period, which took place in August and September 2006. Interviews therefore took place with public health and addictions staff of the seven districts, two Directors of Addiction Services and all Directors of Public Health Services and two staff members from HPP.

Tobacco Control Strategy Components

The provincial Strategy is organized into strategic components that evidence has determined produce the greatest effect in reducing disease, disability, and death caused by tobacco use. The components of the Strategy are:

- Pricing and Taxation;
- Smoke-free Legislation and Policy;
- Treatment and Cessation;
- Community-based Programming;
- Youth Smoking Prevention;
- Media and Public Awareness; and
- Monitoring and Evaluation.

The evaluation framework is organized in a similar manner, based on a logic model of the Strategy goals, activities, short-term, intermediate term, and long-term planned outcomes.

Evaluation findings for each of the Strategy components are presented in the following sections.

Pricing and Taxation

It was recognized in the Strategy that controlling and increasing the price of cigarettes will encourage smokers to quit and will prevent youth from starting to smoke cigarettes. In 2001, the combined federal and provincial taxes were increased to $8 per carton of cigarettes.

Planned Activities and Intended Outcomes

The following summarizes the intended outcomes and planned activities for this component of the Strategy.

Intended Outcomes Stated in Evaluation Framework	Planned Activities To Achieve the Outcomes
• The tax increase of $8 per carton of cigarettes achieved in 2001 is at minimum maintained; and • Tobacco tax rates are equal across all tobacco products by 2003.	• Consult with the federal, provincial and territorial governments to ensure continued taxation; and • Consult with the federal and provincial governments to ensure adequate funding for the Strategy.

Evaluation Results

Progress towards this component of the Strategy was mixed, with one of the two planned outcomes attained. Indicators for evaluating this component of the Strategy focused on consultation activities and resource allocation to the taxation issue. It appears from the data that activities planned in response to this component were only partially carried out. However, the activities related to this component were not well documented, so there is incomplete data available on which to evaluate the indicators for this component of the Strategy.

Consultation Activities

Key informants indicated that informal consultations were held about taxation issues before and during the beginning stages of the Strategy. Consultations were held with tobacco control stakeholders both within government and with non-government organizations, however, these consultations did not include the public.

Resource Allocation

There has not been clear accounting of the number or types of fiscal or human resources dedicated to pricing and taxation. Insufficient resources have been allocated to on-going analysis and comparison of pricing, taxation and tobacco use. The inability to analyze the cause of the recent decline in tobacco tax revenue is an example of the impact of not having the capacity to conduct analysis around this component of the Strategy. Is the decline in provincial tobacco tax revenue over the past few years caused solely by a drop in tobacco consumption or is it caused by a decline in the purchase of cigarettes and tobacco sticks and an increase in the purchase of other tobacco products that are taxed differently? Without resources to support analysis of pricing, taxation and tobacco use, this question will remain unanswered.

Outcomes Achieved for this Strategy Component

The tax increase of 2001 was maintained and increased to a level of $31.04 per carton of cigarettes by September 2005. However, different tobacco products are taxed at different rates. Cigarettes and tobacco sticks are taxed at the same rate and are the highest taxed products. Chewing tobacco and cigars are each taxed at different rates, less than that of cigarettes. A concern was stated by most evaluation participants that the differing tax rates may encourage cigarette consumers to switch to a cheaper product in order to maintain their addiction.

Table I: Pricing and Taxation Outcomes

Outcome	Status
The tax increase of $8 per carton of cigarettes achieved in 2001 is at minimum maintained.	Achieved
Tobacco tax rates are equal across all tobacco products by 2003.	Not Achieved

Smoke-Free Legislation and Policy

Legislation ensuring smoke-free public places and workplaces was considered in the Strategy as a key element given that it protects non-smokers from the effects of exposure to second-hand smoke and promotes the prevention and cessation of smoking.

Planned Activities and Intended Outcomes

The following summarizes the intended outcomes and planned activities for this component of the Strategy.

Intended Outcomes Stated in Evaluation Framework	Planned Activities To Achieve the Outcomes
• Percentage of Nova Scotians who think second-hand smoke is a significant cause of health problems will increase from 48% to 75% by 2005; • All Nova Scotians will be covered by legislation providing 100% smoke-free places (workplaces and public places) by 2003; and • The number of smoke-free homes in Nova Scotia is increased from 55% to 75% by 2005.	• Provide education on the known health effects of second-hand smoke; • Support and encourage parents to reduce or eliminate children's exposure to second-hand smoke in the home; and • Implement province-wide smoke-free workplace legislation.

Evaluation Results

Two of the three outcomes for this component were achieved. All Nova Scotians were covered by legislation providing smoke-free workplaces and public places, and strengthened legislation will be implemented in 2006. The percentage of Nova Scotians who think that second-hand smoke is a significant cause of health problems rose to 88%.[2] In addition, the number of smoke-free homes in Nova Scotia increased to 73%[3] by 2005, almost achieving another planned outcome.

Activities to Increase Awareness About Second Hand Smoke

A number of awareness campaigns about tobacco that contained significant components regarding second-hand smoke were implemented with the largest being the *Smoke Free Around Me* campaign, developed locally in one DHA and adopted provincially. This campaign included television and radio advertisements and newspaper advertisements in both English and French. A web-site was also created that allowed families to register their homes as smoke-free (1842 families are currently registered). This has been the largest campaign dealing with second-hand smoke, although each DHA also participated in a number of other awareness activities as the opportunity arose. The use of a comprehensive strategy for reaching people through a number of different means and a single consistent message was thought by many key informants to be most effective.

> *I would say it was the media campaign . . . because it was consistent . . .I think that's very key, that we have consistent messaging.*

> *. . . we're a small province and I think we have to capitalize on that. So I don't think we need to have a bunch of little messages here and there. I think we're small enough yet large enough that we can have the same consistent message.*

Although all tobacco control staff who participated in the evaluation reported using material such as brochures obtained from the Canadian Cancer Society or Health Canada, it was clear that a comprehensive approach using a variety of materials and media were considered by many key informants to be the most effective approach.

> *I don't think it's any one activity that's most effective. I think it's a comprehensive approach that's most effective. I don't think that brochures necessarily are the most effective approach.*

Advocacy

Non-government organizations, such as Smoke-Free Nova Scotia, Smoke-Free Kings and the DHAs working together provided considerable advocacy efforts, such as organizing of petitions for stronger legislation concerning Smoke-Free Places. It was noted by many tobacco control staff that the Smoke Free Places legislation has been one of the strongest tools for creating awareness about second-hand smoke. According to many key informants, the media and stakeholder discussion about existing and proposed legislation combined with the awareness campaigns such as Smoke-Free Around Me increased awareness of the issue. As noted earlier, quantitative data about Nova Scotians' awareness about the harms of second hand smoke were not available for the evaluation.

> *What I've heard from my clients and some of the people out in the community is that the legislation that we have around smoke-free places has got them to start asking, "Why do we have that legislation?" So it's given me an opportunity to talk about second-hand smoke.*

> *Well I think the legislation [has] caused quite a stir, and the stir has made people start thinking and asking questions and following up with, "Well, why are people stopping me from smoking in public places?"*

The *Smoke-Free Around Me* campaign was used twice. Surveys conducted in February and April 2006 (Nextbus) indicated that the public has a reasonable level of unaided recall of the messages (4% in February and 1% in April). However, it is important to note that the ability to recall messages does degrade over time, so the message requires reinforcement. An approach using a variety of media, and utilizing hand-outs or "take-aways" has been used by t staff to maximize recall and retention of the message about second-hand smoke.

Outcomes Achieved for this Strategy Component

The number of smoke-free homes in Nova Scotia has almost met the intended outcome of the Strategy, with 73%[3] of Nova Scotia homes reporting that they are smoke-free. In December 2006, legislation will be implemented that prohibits smoking in all public and work places (except long-term care facilities, which may have designated smoking areas for residents only). The percentage of Nova Scotians reported as believing that second-hand smoke is a significant cause of health problems increased to 88%, which met and exceeded the planned outcome.

Table II: Smoke-Free Legislation and Policy Outcome Summary

Outcome	Status
Percentage of Nova Scotians who think second-hand smoke is a significant cause of health problems will increase from 48% to 75% by 2005.	Achieved
All Nova Scotians will be covered by legislation providing 100% smoke-free places (workplaces and public places) by 2003.	Achieved
The number of smoke-free homes in Nova Scotia is increased from 55% to 75% by 2005.	Almost Achieved

Treatment and Cessation

This component of the Strategy was developed in recognition that the cessation process is a difficult one for most smokers and that effective cessation supports are required to realize a significant and sustained reduction of smoking rates in Nova Scotia.

Planned Activities and Intended Outcomes

The following summarizes the intended outcomes and planned activities for this component of the Strategy.

Intended Outcomes Stated in Evaluation Framework	Planned Activities To Achieve the Outcomes

• Smoking cessation and treatment services are enhanced throughout the province, specifically:
  o Enhanced information on the government website related to cessation and treatment;
  o An effective 1-800 service is implemented;
  o At minimum, 9 Addiction/Drug Dependency Services staff positions dedicated throughout the province by March 2003;
• 45% of smokers who use the 1-800 service will make at least 1 quit attempt at a 1 month follow-up;
• 65% of smokers who use the 1-800 service will have cut down the amount they smoke at a 1 month follow-up;
• 45% of nicotine addicted individuals that complete a nicotine addiction treatment program will not be smoking at a 12 month follow-up;
• The percentage of smokers who made at least one quit attempt in the previous
	• Provide self-help treatment and cessation information via the government website and its links to other effective treatment and cessation sites;
	• Develop and implement a 1-800 treatment and cessation counseling service that assists Nova Scotians with accessing Nicotine Addiction Treatment Services, and to provide counseling and support with quitting smoking;
	• Dedicate Addictions Services staff within DHAs to provide and evaluate a range of nicotine treatment services;
	• Support and train health care providers in providing brief interventions; and
	• Develop an ongoing media and communication strategy to motivate and support people to stop smoking or to reduce tobacco use.

Intended Outcomes Stated in Evaluation Framework	Planned Activities To Achieve the Outcomes
12 months will increase from 45% to 55% by 2004; • The percentage of smokers (ever smokers) who are thinking about quitting (in the previous 12 months) will increase from 19% to 25% by 2004; and • The percentage of smokers (ever smokers) who are preparing to take action (in the previous 12 months) will move from 7% to 15% by 2004.	

Evaluation Results

Table III presents the outcomes of quit actions drawn from analysis of CTUMS data, the June 2005 Smokers' Helpline Quarterly Report, and reports from the DHAs. The intended outcomes documented in the evaluation framework were met with the exception of the percentage of individuals who completed a nicotine addiction treatment program and were not smoking at a 12 month follow-up. However, the expectation that 45% of individuals who completed a program would be not smoking at a 12 month follow-up may be too high. There is some evidence that suggests that 30%[4] would be more reasonable target. The percentage of smokers preparing to take action was not available at the time of evaluation. Table III provides an overview of the outcome indicators related to quit actions.

Table III: Quit Action Outcomes

Quit Action	Outcome
Smokers who used the 1-800 service and had made at least 1 quit attempt at a 6 month follow-up.	90% took some action ~57% quit for at least 24 hours ~11.5% quit for a period greater than 30 days
Smokers who used the 1-800 service and had cut down the amount they smoke at a 6 month follow-up.	~70%
Nicotine addicted individuals who completed a nicotine addiction treatment program and were not smoking at a 12 month follow-up.	18.75% to 32% (depending on DHA) from April 2004 to March 2005

Quit Action	Outcome
	19.04% to 35.9% (depending on DHA) from April 2005 to March 2006
Smokers who made at least one quit attempt in the previous 12 months surveyed in 2005.	56%
Smokers (ever smokers) who were thinking about quitting (in the previous 12 months) surveyed in 2005.	65%
Smokers (ever smokers) who were preparing to take action (in the previous 12 months) surveyed in 2005.	Not Available

Web-Page

The HPP web-page concerning tobacco control (http://www.gov.ns.ca/hpp/tobaccoControl.html) contains information regarding the Smoke-Free Places Act and indicates that the Strategy was developed to focus efforts on the reduction of tobacco use within the province. There is no information or links on this page specifically related to treatment or cessation services. However, there are a number of links from the page that either contain information on treatment and cessation or provide further specifically labeled links that support navigation to information.

Smokers' Helpline

The Smokers' Helpline June 2005 report indicates that between November 2002 and February 2005, 1,485 first-time callers made use of the service. The total call volume during this period was 4,573 calls, indicating that the service is being utilized. The volumes experienced in Nova Scotia are aligned with and slightly higher than national averages. Collected demographic information reported by the Helpline indicates that youth are not accessing this resource in numbers comparable to the adult population.

This seems to be a popular service based on the satisfaction survey results reported by the Helpline, and the outcome monitoring performed by the Helpline indicates that nearly 90% of users take some action toward quitting during the next six months after use. As well, some DHA tobacco control staff members encounter people who have been referred to them through the

Helpline and these people report a general satisfaction with the service. However, evidence about satisfaction with the Helpline is anecdotal.

> *As part of the group that I do, everybody gets the Smokers' Helpline number and I explain what they do and what they have to offer. People do access it. The people that have that I've talked to, have found it really helpful.*

Tobacco control staff from DHAs across the province expressed some desire for more detailed statistics regarding the use and effectiveness of the Smokers' Helpline, such as a breakdown of use by DHA.

> *And people like the idea … when I talk about it… of the Smokers' Helpline. But I never really hear back how many people are actually using it and if it's helping them or not.*

> *I have also heard folks in the community talk about having used it. And again, I don't have any reasonable sense of how effective that is. You know, they get referred … locally here if they call the Smokers' Helpline.*

> *And it would be nice to get really good, concrete stats on that from the district like how many people from my district actually do contact them.*

Some of the questions tobacco control practitioners had regarding the effectiveness of the Helpline appeared to stem from a lack of known indicators of success for the Helpline as one of a series of tools and services in cessation and treatment.

> *We need a range of options but we do need to understand the best model for a helpline. For example, it could be a national line that every province buys into for the number of calls that we get. And then we need to get a better understanding of how do you*

effectively engage people to call the line. What is it that encourages people to actually call?

As a few key informants noted, there may be intangible benefits associated with the Smokers' Helpline. For example, does having the number displayed at the end of an anti-smoking advertisement prompt people to call or to consider controlling their use of tobacco? Only further research can determine the effectiveness of the Smokers' Helpline.

Addiction Treatment Programs

Nicotine addiction treatment programs have been created in each DHA, and generally follow similar formats. The core programs consist of group sessions held once a week for a five to six week period. These sessions combine group support with the provision of nicotine replacement therapies. All DHAs reported holding sessions of this type, although in the districts with a predominately rural population, the sessions were held in various communities throughout the district. Although holding the sessions in different communities was viewed as the best way to ensure adequate coverage across the districts, this approach does stretch tobacco control staff resources in part due to the geographic distances of the communities.

I think one of the strengths of our program is that we've been to all communities within our district.

Right now I'm offering groups in five communities - seven groups in five communities. And they're ongoing, open groups that people can attend at any point in time and come for as long as they want.

Nicotine Replacement Therapy

Although not formally included in the Strategy or identified in any of the planned Strategy outcomes, the use of nicotine replacement therapy (NRT) has played a significant role in

achieving the smoking cessation rates reported. Free NRT options were introduced in 2003 and resulted in the dramatic increase in participation in group therapy programs. When budgets for NRTs were exhausted, participation figures dropped again.

> *We do fund the patch and the gum and the Zyban. This has been really an incentive for people to come to the groups. They enjoy the support but they also like the idea that they can get their funding for the NRT. The groups have been very successful.*

At the time of evaluation, there were a number of different models in use for handling and administering NRTs as a part of an overall treatment program. Many key informants felt that research should be conducted to determine best practices regarding the application of NRTs, and subsequent adoption of those practices.

> *The opportunity may lie there to … look at the programming, … training people to continue to do that programming and to establish standards in terms of delivery but also in terms of use of NRTs.*

Some key informants considered funding for NRTs within treatment programs to be one of the significant budget pressures that they encounter. This sentiment is an indication that they consider the use of NRTs to be effective, both as an incentive to participate in a group and as a cessation aid.

Other Programs

In addition to these core programs, all DHAs reported having specialized programs that they used to provide counselling services for specific groups. Areas of interest in programming have been to provide services within or with schools for youth and with healthcare facilities for pregnant women and new mothers. Another growing area reported is the provision of workplace services supported by employers and providing cessation and treatment services to employees.

Demand in this area in some districts has outstripped the capacity of tobacco control staff to provide such services while maintaining core programming.

> *Initially, we got a lot of requests from people to deliver programs at their workplace. This year, we have done a couple of workplace programs … and it's really effective. We've had a couple of employers give time during the workday to let people come to the program.*

Resource Allocation

Most districts in the province have dedicated staff providing tobacco treatment and cessation services. Often, there was at least one full time equivalent (FTE) reported per district. However, in at least one SSA, the allocation of human resources has been reduced to one FTE for the SSA rather than the DHA.

In general, in all DHAs participating in this evaluation, the pace of requests for Addiction Services programs has strained the capacity of staff to provide those services.

> *…the treatment component (staffing and NRT) cannot be expanded without additional funding and most other strategy components when effective generate a demand for treatment.*

> *…the treatment and cessation program has been offered by the nicotine specialist or whatever, who has been one full-time employee for the shared service area. And therein lies the problem. We have a lot of mileage between points. … we were all not getting what we needed because of the person being on the road all the time. And there was only one person. Since that [then], that person went to another position well over a year ago. And our person was just hired maybe a couple of months ago and has since left the position so there's still no one.*

As noted above, a successful Strategy will increase short-term demand for cessation and treatment services in all DHAs. It is unlikely that DHAs, at their current staffing levels, will be able to accommodate such an increase in demand.

Professional Development

One aspect of maintaining staff dedicated to the provision of treatment and cessation services is professional development. Professional development opportunities related to tobacco control were not tracked adequately to evaluate their effectiveness. Tracking was not consistent among districts or SSAs, and evaluations were not performed on the effectiveness of the professional development opportunities. For those DHAs that did track professional development, the typical venue for that development was by seminar or training courses.

Training for Health Care Professionals

The training of health care providers in brief interventions related to tobacco use was inconsistent across the province. The greatest effort appears to have been expended in Cape Breton, where training happened as part of the implementation of policy developed by the DHA.

> *…the Cape Breton District Health Authority has adopted a policy … that all patients be given a brief intervention around tobacco use when they come to one of the nine sites. [It] involved … a pilot training program for primarily nurses, but [also] some respiratory therapists and dieticians who are going to be doing this with patients. And we decided that it was really difficult to train people at that level so we developed a self-directed learning package for healthcare professionals.*

In other DHAs, brief intervention training was provided, but seemed to have been initiated by tobacco control staff rather than by implementation of DHA policy. Overall, training seemed to have resulted in a greater number of referrals to Addiction Services, but this assessment is only based on anecdotal evidence from key informants. Evaluation of these training sessions, where

present, consisted of immediate post-training surveys and indicated a level of knowledge transfer acceptable to the tobacco control staff who conducted the evaluation. Little follow-up has been done to determine intermediate or long-term effectiveness of training on the delivery of brief interventions by healthcare providers, with the exception of the training provided in some DHAs where an eight-week learning log was used as a follow-up device. In most cases, there was little documentation of the characteristics or the numbers of healthcare providers trained.

> *So I think if anything, it was effective in that we raised the bar and raised the awareness of it and, you know, to watch out for things. So I think it increased knowledge and that can only help. But that was just immediate comments afterwards. So long term, not sure.*

Training provided to healthcare providers has been conducted at different times in different DHAs, with some having been completed two years ago, and others ongoing at the time of the evaluation.

Media and Public Awareness

All DHAs had at the time of this evaluation a web-presence that included information and links to Addictions Services. Most DHAs included tobacco cessation and treatment services on these sites and a number included program schedules.

The larger DHAs that have a greater presence of radio and television broadcasting located in the communities had more exposure to Nova Scotians. In most of these cases, the tobacco control staff reported that their programs were the subjects of news or community features performed by local broadcasters such as CBC radio or ATV television. In the areas where radio and television exposure was not prevalent, print media was used to promote Addictions Services programs regarding tobacco. Some districts reported that this is declining due to re-allocation of funds from advertising.

> *Money was an issue to advertise so* [informal advertising methods] *was the way that I felt that it could be done. And because of that, I find word of mouth has been very successful as well, from what I'm hearing from the clients coming to the groups.*

A reduction of advertising may also have been prompted by a desire to control the number of program participants to levels that are within the capacity of the DHA tobacco control staff to provide services.

> *Initially we put quite a bit of money into advertising our program, both in the newspaper and on radio. But we don't very often put an ad in the paper anymore. We occasionally do. But we've had enough people without needing to and we were a little afraid if we advertised, we wouldn't be able to meet the needs.*

Communication Strategies

DHAs had communication strategies regarding tobacco cessation and treatment programs, but the ability to implement these strategies seemed to be inconsistent across the province. The main means of promoting services, other than through formal media, were noted to be through the use of community presentations, posters, brochures, and face-to-face meetings with healthcare providers to encourage referrals to Addictions Services. Hospitals, clinics and doctors' offices were noted to be used to place posters and brochures, as well as community bulletin boards.

> *For the smoking cessation programs, what I've done is I've literally knocked on doors and went face-to-face with the doctors and the dentists in my areas, explaining to them what the program was about, how to refer and the fact that we provide the NRT to the clients. And it's been, I would say very, very successful. Referrals are clearly coming from these areas. I've literally wallpapered* [major communities] *with my posters.*

Advertising of treatment and cessation programs has been performed primarily at the DHA level, with few campaigns targeting cessation programs at the provincial level. Most of the provincial efforts at HPP have been directed to date at the Smokers' Helpline, which provides referrals to Addictions Services. Overall, although the outcomes and high-level activities are similar, there have been differences in the detailed planning and implementation of communication strategies from DHA to DHA.

Outcomes Achieved for this Strategy Component

Five of the nine intended outcomes were clearly achieved and involve the establishment of a 1-800 service and the provision of nicotine treatment services. The effectiveness of the 1-800 service is not known, but the service was established and is used. The government website does not appear to have been enhanced as navigation labels for treatment and cessation services are not clear. It should be noted that the expectation that 45% of individuals who participate in a cessation program will not be smoking at the time of a 12 month follow-up may be unrealistic. As previously mentioned, there is some evidence that suggests that 30%[4] would represent a significant accomplishment. During the evaluation, the percentage of smokers preparing to take action was not available, and the outcome was not measured.

Table IV: Treatment and Cessation Outcome Summary

Outcome	Status
Enhanced information on the government website related to cessation and treatment.	Not Achieved
An effective 1-800 service is implemented.	Partially Achieved; data regarding effectiveness is inconclusive
At minimum, 9 Addiction/Drug Dependency Services staff positions dedicated throughout the province by March 2003.	Achieved
45% of smokers who use the 1-800 service will make at least 1 quit attempt at a 1 month follow-up.	Achieved
65% of smokers who use the 1-800 service will have cut down the amount they smoke at a 1 month follow-up.	Achieved

Outcome	Status
45% of nicotine addicted individuals that complete a nicotine addiction treatment program will not be smoking at a 12 month follow-up.	Not Achieved; expectation may be too high
The percentage of smokers who made at least one quit attempt in the previous 12 months will increase from 45% to 55% by 2004.	Achieved
The percentage of smokers (ever smokers) who are thinking about quitting (in the previous 12 months) will increase from 19% to 25% by 2004.	Achieved
The percentage of smokers (ever smokers) who are preparing to take action (in the previous 12 months) will move from 7% to 15% by 2004.	Unknown; data not available

Community-Based Programming

The Tobacco Strategy recognizes the key role played by the community in tobacco cessation and reduction and that an effective strategy must encompass actions taken at the community level as well as at the provincial and district levels.

Planned Activities and Intended Outcomes

The following summarizes the intended outcomes and planned activities for this component of the Strategy.

Intended Outcomes Stated in Evaluation Framework	Planned Activities To Achieve the Outcomes
• New and strengthened community-based initiatives for tobacco control; • New and strengthened partnerships/coalitions for tobacco control; • New and strengthened partnerships for tobacco control within ethno-cultural networks; • New and strengthened community leadership for tobacco control; and • DHA tobacco strategies developed and implemented to support provincial strategy.	• Coordinate a provincial skill development and motivation conference in partnership with key stakeholder groups. • Hire district tobacco coordinators to support community-based tobacco initiatives. • Support Nova Scotia's ethnically diverse communities in addressing their tobacco control issues by: o Review existing data on smoking behaviours by ethnicity and identifying both issues specific to Nova Scotia and gaps in information; and o Identify partners from existing ethno-cultural networks and organizations to work with to address smoking issues. • Provide ongoing technical assistance to community organizations and community tobacco coordinators.

Evaluation Results

Community groups have played a strong role in the implementation of the Strategy, and although not all planned activities could be assessed during the evaluation, all outcomes were shown to have been achieved. Key informants have identified areas that may be built upon for further improvement.

Motivational Conferences

Conferences were held in 2001 and 2005 to provide motivation and skills for community groups. Documentation of these sessions was not maintained, and it is difficult to determine whether these sessions resulted in motivated activity within community groups.

Tobacco Coordinators

Tobacco Coordinators were hired for each of the province's nine DHAs, although there have been discontinuities in position knowledge due to staff changes in some districts.

Community Group Involvement

A number of community groups have stepped forward to work toward goals aligned with the Strategy's intended outcomes, most notably in the area of youth sport associations, First Nations groups, the health care sector, and individual municipalities. Each of these groups have either engaged or been engaged by tobacco control staff. Typically, tobacco control staff have assisted these groups by helping groups to become organized, through capacity building and through the development or refinement of tools to support community-based programs. The most successful groups have formed strong partnerships with tobacco control staff and other tobacco control stakeholders.

> *So where we're providing the capacity and the training, they're taking the lead in their community to work with their tobacco control strategy coordinators to work with the politicians to address those issues.*

> *[Group] has been very active looking at tobacco control in that comprehensive model. So for instance, they did an evaluation on youth possession legislation as a piece of looking at how is this impacting schools...*

Key informants noted that some community groups have become heavily involved in integrated approaches that address the main components of the Strategy.

> *[Community Groups] span a variety of areas, I think there are a lot that were developed to deal with the smoke free public places, and consequently some municipal by-law work that we did. So whether its [organization], or [organization], or the work [of organization], that seems to be one thread. The other kind of thread seems to be around working with youth.*

There appeared to be a growing number of businesses collaborating with tobacco control staff and with other community groups to begin tobacco reduction / cessation programs with their employees.

> *And so they've had this strategy to become 100% smoke-free, which has involved sending materials to the families of their workers. So they've been doing some work around if your partner smokes, how do you work with that, and some other pieces like that.*

Action in your Community against Tobacco Program

Many of the key informants indicated that Action in your Community against Tobacco (ACT) program played a key role in developing and supporting networks of community groups working to promote tobacco control. ACT coach training has been provided to tobacco control staff in each of the nine DHAs, and the ACT toolkit has been used by a number of community groups to begin tobacco control programs such as Tobacco Free Sport and Recreation. The toolkit and training have also been modified to tailor it for the needs of communities such as within First Nations.

> *The [ACT] partnership has been very strong … and coming out of that, we have a Tobacco-Free Sport and Recreation committee formed under the ACT steering committee.*
>
> *[A province-wide initiative] was really a partnership with Smoke-Free Nova Scotia working with the DHAs and the community health coordinators and the ACT network to engage individuals to distribute and sign all the petitions.*
>
> *We've been building a relationship with First Nations communities, working with … the ACT network to build relationships there …we oriented a number of people from the community to the ACT approach.*

Some key informants indicated that one of the strengths of ACT has been the presence of the ACT network throughout the province. This provincial presence has provided consistent messages and tools for community groups. Many key informants considered this to be a clear strength.

Ethno-Cultural Partnerships

Partnerships and coalitions with ethno-cultural groups have concentrated almost exclusively with First Nations. These partnerships, which took place in most of the DHAs interviewed that include First Nations' communities, were reported as collaborations in which tobacco control staff provided organizational assistance, capacity-building, tool refinement, or elements of all three.

> *So for the last two years we've been building a relationship with First Nations communities, working with the tobacco control coordinators and the ACT network to build relationships there. And we oriented a number of people from the community to the ACT [approach]. So when we met with First Nations representatives, they said, "You*

don't need to create something that is solely for us in First Nations. But you need to help us understand how we can adapt your tools to work within our cultural reality."

We've worked in the Aboriginal community, it's been pretty minimal in terms of actual programming … We have done some training with aboriginal people in the workplace on one reserve at least. We've partnered with the Aboriginal Agency and delivering some programs.

In April 2005, the Tui'kn Initiative sponsored a planning session 'Planning for Collaborative Action: Tackling Non-Traditional Tobacco Use' and several priorities emerged from that meeting. Several members from the First Nations communities suggested the First Nations/Public Health Services Tobacco Reduction Committee was the appropriate committee to take action on the priorities identified.

One of the reasons for the close association with First Nations rather than other ethno-cultural groups may be the fact that First Nations have their own government structures and staff assigned to work on tobacco issues. This structure makes it easier to build partnerships than in ethno-cultural communities that do not have such structures. First Nations are challenged by the three levels of government jurisdiction for issues related to health. This multi-jurisdictional responsibility is a challenge as well for DHAs who are partnering with First Nations.

Part of the dilemma with First Nations is kind of where they fall. In some cases they … embrace the federal legislation, in others they're embracing a provincial legislation and others are somewhere in between. So generally speaking it has been really quite positive. The dilemma has been for us in terms of capacity, just having people in place … to be able to move the agenda and implement in a comprehensive way.

Generally, reaching ethno-cultural groups other than First Nations was an acknowledged gap by most DHAs interviewed. There has been work done with community groups, such as Boys' and

Girls' Clubs, in some predominately African-Nova Scotian communities, but few other collaborations were identified specifically targeting cultural groups.

DHA Tobacco Control Strategies

Each of the DHAs has developed a tobacco control strategy, as intended in the provincial Strategy. However, during the evaluation it was difficult to assess the effect these district strategies have had on developing or strengthening community-based programming. In most cases, it was reported that the district-level strategies were developed early after the development of the provincial strategy (in 2001 to 2003), but have not been reviewed or revised since development. In at least one case, a strategy was developed in 2001 and remained in draft form at the time of evaluation, thus raising questions regarding how well known it is and whether it has been implemented in any way.

> *But I think part of the background, too was that I think it was made known that there would be money for each of the district health authorities for tobacco control. And one way of getting the funding was to develop a strategy.*

Outcomes Achieved for this Strategy Component

All planned outcomes for this component were achieved, however further work is required in the areas of ethno-cultural networks, and strategy implementation at the DHA level. The lack of work done with few ethno-cultural groups other than First Nations was acknowledged as a gap by most key informants. Additionally, although DHA strategies were developed it is unclear to what extent these strategies have been used or have supported the provincial strategy.

Table V: Community Based Programming Outcome Summary

Outcome	Status
New and strengthened community-based initiatives for tobacco control.	Achieved
New and strengthened partnerships/coalitions	Achieved

Outcome	Status
for tobacco control.	
New and strengthened partnerships for tobacco control within ethno-cultural networks.	Achieved
New and strengthened community leadership for tobacco control.	Achieved
DHA tobacco strategies developed and implemented to support provincial strategy.	Achieved

Youth Smoking Prevention

The Strategy recognized that the reduction of youth smoking rates would require action in all Strategy components identified.

Planned Activities and Intended Outcomes

The following summarizes the intended outcomes and planned activities for this component of the Strategy.

Intended Outcomes Stated in Evaluation Framework	Planned Activities To Achieve the Outcomes
• Enhanced prevention services for youth (e.g. curriculum supplement implemented; information on the website); • Enhanced nicotine treatment/cessation services for youth; • 30% of youth that complete a cessation support program will not be smoking at a 1 month follow-up; • The percentage of smokers (ever smokers) aged 15 to 19 who are thinking about quitting will increase from 33% to 40%; • All schools in Nova Scotia implement and enforce 100% smoke-free schools and school ground policy by 2005; and • Sales to minors compliance rate is increased from 67% to 80% by 2004.	• Continue to support the Provincial Youth Tobacco Advisory Committee; • Develop a school smoking prevention program consisting of: o Smoking prevention curriculum supplement (grades p-12); o Guidelines for effective school tobacco policy; o Youth cessation support; o School/community-based prevention programs; • Develop a youth site as part of the government website on tobacco control; • Continue the enforcement program concerning the ban on sale of tobacco to minors under the N.S. Tobacco Access Act; and • Develop a public awareness campaign to educate the public about the law (ban on sale of tobacco to minors under the N.S. Tobacco Access Act) and to increase compliance.

Evaluation Results

Although youth smoking rates were reported by some key informants to be declining, the Strategy did not achieve the planned outcomes associated with this component. However, it must be noted that most key informants, while recognizing the many challenges that exist also strongly indicated that the Strategy has had a strong overall impact on youth smoking.

Provincial Youth Tobacco Advisory Committee

The Provincial Youth Tobacco Advisory Committee was found by key informants to be an ineffective means for engaging youth. Meaningful engagement of youth on the committee was revealed to be a labour intensive organizational task that severely strained resources. As well, it was suggested by some key informants that youth can provide greatest impact on tobacco use rates when working with other youth.

> *Tobacco Action Teams use youth to work with youth. That model's incredibly powerful. And continuing to use that model and taking that leadership in the high school and looking at what those students could do with the younger students, would be very interesting as well.*

Overall, it was felt by key informants that youth should continue to be engaged at the community level as many DHAs have done.

Curricula Development and Training

Nova Scotia teachers have been in-serviced on curricula such as the *No More Butts* program, *Smoke Free for Life, Teens Tackle Tobacco, Kids Against Tobacco Smoke (KATS)* and the *You Choose* program. However, there have been inconsistencies in uptake of offered in-service training. For example, in one district there were no English teachers who took advantage of training offered in the language arts program *You Choose*. Most in-servicing has been supplemental to the Personal Development and Relationships (PDR) curricula. In-servicing was

reported as most effective where the tobacco control staff performing the training have developed strong working relationships with the PDR teachers, and where the PDR teachers have a strong personal interest in the subject.

> *…and sometimes PDR teachers in junior high will certainly call and contact me for information. And sometimes I'll, you know, talk to them over the phone about it or just meet them at their school.*

> *I would say every once in a while you have a PDR teacher who really has a passion for some of this work. And because of that passion, they make the time and devote some of the time to be able to do it. But unfortunately, PDR teachers generally - or a lot of times, it's not a subject that they choose to do. They're given it. And so their comfort level in doing some of this work is not there.*

As well, the availability of teachers for in-servicing and delivery of curricula was noted by most key informants as an impact on the success of the programs. Most key informants pointed out that schools, principals and teachers have a number of valid issues competing with tobacco use for their attention.

> *… would be time and comfort level -- teachers saying that there's no time within their school day to do some of what needs to be done.*

Curricula Implementation

In general, there were mixed feelings amongst key informants regarding the implementation of curricula. Although in-servicing has occurred, it has been inconsistent throughout the province. There are a number of views that the curricula may be considered to be 'add-on' pieces that are not considered required curricula and therefore not applied consistently, or only applied at the discretion of principals and teachers. Although some possible barriers to effective curricula implementation have been identified, such as teacher availability and competing issues requiring

curricula time, discussions with the Department of Education (DoE) or with teachers have not taken place to fully explore this issue.

> *How do we look at how we really can talk with teachers to find out, for them, what the barriers are? I mean we have some understanding from our perspective what the barriers appear to be. But what truly are the barriers for the teachers and how can we make these curricula easy for them to access in their classrooms? And, whether it's a five-minute snippet or an hour-long class, how can we engage that?*

Materials from the main curricula, *No More Butts,* and *You Choose* are available to the public via links on the HPP website, as is *Sick of Smoke* which is packaged to appeal to youth and *Gotta Quit* which has also been designed for youth. Hit tracking against these pages has not been performed, so the reach of these pages cannot be ascertained.

School Policies

As well as curricula, school policies regarding tobacco use play a role in the prevention of youth smoking. School policy guidelines were developed provincially when the Smoke-Free Places Act was implemented. The guidelines were disseminated through the school boards to assist in the development of policy at individual schools. Many key informants noted that use of these guidelines and implementation of school policy has been uneven across the province. It seems that in many cases, implementation has been dependent on the level of interest within individual schools, with decisions on school policy made by principals who do not usually consult the guidelines.

> *But our [understanding] is that they're still very concerned that school policies, as they're implemented at the local level where decisions seem to be made by principals more than by following regulation or direction, are very inadequate. And very uneven.*

We may have had guidelines but I'm not sure how much discussion really there was to get the school boards to buy in, to implement this. And I think there's a lot of feeling from the school boards that this was imposed on them for health reasons. And so there's variable buy-in because of that.

Policy Enforcement

As indicated previously, the development of school policy was spurred by enactment of the Smoke-Free Places Act. Enforcement of this legislation on schools appears to be mixed across the province, possibly in part due to limited resources for inspectors as noted by a few key informants. Most schools within the province are 100% smoke-free, but there are a number of exceptions. In fact, in some DHAs, the majority of schools are not. Key informants report a number of reasons for the lack of 100% compliance with the legislation, including concerns regarding student safety when leaving school property to smoke, the difficulty to enforce the legislation, the lack of resources to perform outdoor monitoring, and an allocation of effort and resources to issues with a greater perceived impact. As well, it should be noted that schools have traditionally not experienced repercussions for not enforcing smoke-free policies.

Some of the arguments used … was that … moving people off property was linked in with increasing drug use, sexual activity -- all this kind of stuff. So we need to try to work and address those kinds of issues as well.

I think some of the other difficulties that we ran into is the school boards were getting funding for health promoting schools, physical activity, eating, but they were in violation of provincial legislation. Even though we all sit at the table, there was no kind of discussion about gosh you can't be a health promoting school because you're in violation of provincial legislation.

It's hard to enforce. It's hard to control the students because they're leaving property to smoke. They have concerns about what they're doing when they're off property besides

smoking. The other thing that I've heard a lot about is that they feel the tobacco possession piece of the legislation is very weak and that they want that strengthened to help them kind of enforce the whole smoke-free policy.

Youth Possession Legislation

During the evaluation, a dichotomy regarding legislation on youth possession of tobacco products became evident. There were some key informants who considered existing legislation in this area to be somewhat weak and felt that strengthening it would lead to improvements in tobacco use among youth.

… that whole possession issue … where you might not be able to smoke in school, but you have ability to possess [cigarettes] and as a result of that there is no prosecution or any kind of punitive action.

The possession issue, if that can be strengthened, the odds are we would have more success.

The tobacco possession piece of the legislation is very weak and that … [should be] strengthened to help enforce the whole smoke-free [school] policy.

However, there were also a few key informants who considered youth possession legislation of little or no benefit in the reduction of tobacco use among youth.

We need to think about … the possession legislation … [and] is it making a difference? No, it's more of a problem and causing more harm than it is good; so [we should] get rid of it.

[Youth possession legislation] passed but it did not come from evidence or consultation. It was not based on the research and there was not a lot of support for this.

Similar to the views expressed by those who did not support the youth possession legislation, a recent study sponsored by Smoke Free Kings on the effectiveness of the youth possession legislation has suggested that tightening legislation would be unenforceable and counter-productive.[5] Given the difference in opinion demonstrated by key informants during the Strategy evaluation, careful examination of the evidence around youth possession legislation should inform the process of renewing the tobacco strategy so that evidence and best practice inform future directions.

Stakeholder Relationships

As indicated by many key informants, it is believed that a closer dialogue is required between tobacco control stakeholders, including HPP, the DoE and the school boards to promote greater alignment of outcomes and a more complete understanding of the issues faced by each in implementing and enforcing smoke-free policies.

> *We really need to connect better with the schools so that we can build the schools' capacity to do this in a way that makes sense for them. We need to know what they need, what would help them do this. Perhaps we should be advocating for a broader health promotion strategy that encompasses tobacco, such as health-promoting schools.*

Youth Smoking Prevention

Overall, it was felt by most key informants that youth tobacco use prevention has been enhanced through implementation of the Strategy, particularly in the areas of social marketing, legislation, the introduction of Tobacco Coordinators to work closely with schools, and the use of Youth Tobacco Action Teams.

> *A comment about the results: I think the proof is in the pudding,. The smoking rate for youths or those even starting to use or tried cigarette smoking has decreased in the last 4 years tremendously.*

Teen health centres have been crucial in terms of looking at the tobacco issue both on a prevention school policy basis, and also the treatment … The other thing that teen health centres have been involved in are initiatives that go on in the schools.

Youth Smoking Cessation

Many key informants felt that the Strategy has had little impact on youth smoking cessation other than by providing encouragement through media campaigns. A number of key informants indicated that the use of NRTs for the treatment of nicotine addicted youth was inconsistent. It was noted that the reason that Addiction Services programs do not provide NRTs for youth is that evidence indicated that these products should not be used under the age of 19. A number of Youth Health Centres, however, do provide NRTs to clients under that age. Key informants report that there is a need for further research regarding youth cessation, behaviours and treatment techniques in order to consistently implement effective youth cessation programs.

Outcomes Achieved for this Strategy Component

Of the six planned outcomes for this component, the required data to assess two were not available during the evaluation. The outcomes related to prevention and cessation services targeted specifically at youth have not been achieved due to several factors, including lack of implementation of curricula and lack a consistent cessation approach based on best practices. Not all schools in the province are fully implementing and enforcing smoke-free policies. However, it must be noted that most key informants, while recognizing the many challenges that exist also strongly indicated that the Strategy has had a strong overall impact on youth smoking.

Table VI: Youth Smoking Prevention Outcome Summary

Outcome	Status
Enhanced prevention services for youth (e.g. curriculum supplement implemented; information on the website).	Not Achieved
Enhanced nicotine treatment/cessation services for youth.	Not Achieved

Outcome	Status
30% of youth that complete a cessation support program will not be smoking at a 1 month follow-up.	Unknown; data not available
The percentage of smokers (ever smokers) aged 15 to 19 who are thinking about quitting will increase from 33% to 40%.	Unknown; data not available
All schools in Nova Scotia implement and enforce 100% smoke-free schools and school ground policy by 2005.	Not Achieved
Sales to minors compliance rate is increased from 67% to 80% by 2004.	Almost Achieved; (77.1% in 2004, 79.1% in 2005 – Tobacco Inspection Reports)

Media and Public Awareness

The Strategy recognized the importance of supporting other strategic components through increasing public awareness about dangers of smoking and the options available to control tobacco use.

Planned Activities and Intended Outcomes

The following summarizes the intended outcomes and planned activities for this component of the Strategy.

Intended Outcomes Stated in Evaluation Framework	Planned Activities To Achieve the Outcomes
• Percentage of Nova Scotians who think second-hand is a significant cause of health problems will increase from 48% to 75% by 2005; • The percentage of smokers who make at least one quit attempt in the previous 12 months will increase from 45% to 55% by 2004; • The percentage of smokers (ever smokers) who are thinking about quitting (in the previous 12 months) will increase from 19% to 25% by 2004; • The percentage of smokers (ever smokers) who are preparing to take action (in the previous 12 months) will move from 7% to 15% by 2004; and • Increase (over time) in number of users of the 1-800 services who report that they called for assistance because of media messages.	• Develop and implement television and print ads; • Create and distribute promotional resources; and • Make enhancements to the government website.

Evaluation Results

Overall, as indicated by the documents reviewed and key informant interviews, the media and public awareness activities and campaigns have been successful in reaching target Nova Scotian audiences, in promoting relatively high recall rates, and raising awareness of second-hand smoke and other tobacco issues.

Table III on page 17 presents the outcomes of quit actions drawn from analysis of CTUMS data, the June 2005 Smokers' Helpline Quarterly Report, and reports from the DHAs. The percentage of Nova Scotians who thought second-hand smoke is a significant cause of health problems was not available at the time of the evaluation. Similarly, the increase or decrease in the number of 1-800 service users was not available for the evaluation. The number of clients who reported accessing the 1-800 service as a result of media exposure is reported in the Smokers' Helpline Quarterly Report during a four year period, but was not broken down by year.

Advertising Campaigns

Although a complete list of all advertisements produced for television, radio and print throughout the province is not available, certain media campaigns were conducted and evaluated in the course of implementing Nova Scotia's Comprehensive Tobacco Control Communications Campaign. These advertisements included the *Great Reasons to Smoke* campaign which utilized television, print, posters, and the web, and the *Smoke Free Around Me* campaign which used primarily television and print. Both of these campaigns utilized an approach that took advantage of a variety of media, and were designed based on best practices and evidence from media campaigns conducted in other jurisdictions.

Message Recall

Recall surveys conducted as part of the evaluation of the *Great Reasons to Smoke* campaign indicated a relatively high rate of aided recall, and youth focus groups held in 2005 indicated an

extremely high rate of recall among youth. Successive recall surveys indicated a decline in unaided recall over time.

Promotional Material

To supplement media campaigns, additional promotional material has been developed, such as the *Smoke Free Around Me* window-clings, posters, and brochures. Numbers and distribution of these items have not been tracked, so although demand is still seen for items such as window-clings, there is no clear measure of distribution.

Web-Page

At the time of the evaluation, the HPP web-page contained links to the media campaign *Sick of Smoke*, which provided access to the messages designed primarily for youth and to tobacco control options and services. Other links from the HPP page provided access to community and non-government organizations, such as Smoke-Free Nova Scotia, which provided information regarding tobacco control and cessation services. The HPP page did not contain specific information other than information about the Strategy, and links are not specifically labeled to indicate content other than the linked site or organization.

Outcomes Achieved for this Strategy Component

Although two of the five planned outcomes for this Strategy component could not be assessed as the relevant data were not available to the evaluation, the message recall rates and the interviews with key informants indicate that this has overall been a successfully implemented component.

Table VII: Media and Public Awareness Outcome Summary

Outcome	Status
Percentage of Nova Scotians who think second-hand smoke is a significant cause of health problems will increase from 48% to 75% by 2005.	Achieved

Outcome	Status
The percentage of smokers who make at least one quit attempt in the previous 12 months will increase from 45% to 55% by 2004.	Achieved
The percentage of smokers (ever smokers) who are thinking about quitting (in the previous 12 months) will increase from 19% to 25% by 2004.	Achieved
The percentage of smokers (ever smokers) who are preparing to take action (in the previous 12 months) will move from 7% to 15% by 2004.	Unknown – data not available
Increase (over time) in number of users of the 1-800 services who report that they called for assistance because of media messages.	Unknown – data not available

Monitoring and Evaluation

The Strategy recognized the importance of the ongoing use of monitoring and evaluation to gauge progress and to generate recommendations for improvements and revisions to the Strategy.

Planned Activities and Intended Outcomes

The following summarizes the intended outcomes and planned activities for this component of the Strategy.

Intended Outcomes Stated in Evaluation Framework	Planned Activities To Achieve the Outcomes
• Baseline data is collected; • Development and utilization of databases; • Continuous update and improvement of the Strategy; and • Evaluation report produced every two years.	• Establish a provincial monitoring and evaluation group to develop an evaluation strategy and long-term targets; • Conduct an independent annual evaluation of the provincial Strategy and produce annual reports; and • Revise the Strategy whenever needed based on evaluation results.

Evaluation Results

Monitoring and evaluation was recognized by many key informants as an area that may be improved. Most key informants indicated that the information provided by monitoring and evaluation thus far, particularly evaluation of specific initiatives and reports on progress made toward the Strategy outcomes has been invaluable to implementation of the Strategy.

Evaluation Framework

Although an Evaluation Advisory Committee was created to develop an evaluation framework, there is no indication that a more permanent working group was developed for monitoring and

evaluation of the Strategy. An evaluation framework for the Strategy was developed in 2002 and was used to inform this current evaluation. However, the framework either was not widely disseminated within the province, or was not adopted by the DHAs or SSAs.

> *So I think our hopes initially were that there would be a provincial framework and when we realized that wasn't going to happen then we kind of started to look at how are we going to measure the progress of the overall [SSA] strategy.*

> *From the province there's been - I've seen very little as far as evaluation. There is an evaluation strategy for the tobacco strategy but to my knowledge there's been very little that has been implemented from that.*

Data Collection

There are a number of indicators in the evaluation framework for which there is no data collection mechanism in place (see Appendix 1 – Evaluation Framework Indicators), which shows that further work must be done to support the implementation of this or future evaluation frameworks.

Evaluation Activities

At the time of evaluation, three general types of monitoring and evaluation were performed across the province: outcome monitoring, specific program evaluation, and program reporting. Outcome monitoring of Addictions Services programs was performed in all areas and ideally consisted of follow-up monitoring at 3-, 6- and 12-month intervals. In practice, this was inconsistently applied across the province, with some DHAs performing only 12-month monitoring due to resource allocation.

> *So we had hoped initially to do evaluations or contact people at three months, six months and one year, but we really only had funding to contact them at one year.*

Individual tobacco control initiatives or specific programs that had a separate specific budget for evaluation allocated up to 25% of the budget for evaluation activities. Most respondents reported that these evaluations were typically performed as planned, usually by a third party and the results were distributed through the province.

> *An evaluation campaign, things like that, was to be included in any project that you gather any monies for. The evaluation component would be included in that budget, not something that the district would come up with…*

The third type of evaluation performed was at the SSA level and consisted of reporting on the activities DHA tobacco strategies. Since many of the local tobacco control strategies were developed five years ago and may exist only in draft form, these progress reports may not have accurately reflected the current outcomes and objectives of the SSAs. In many cases, logic models were developed based on local strategies tied, to the provincial Strategy through the strategic components. Outcomes identified in the logic models were used as a basis for reporting. Without common evaluation and reporting tools across all SSAs and DHAs, these progress reports often contained somewhat different information. The inconsistent information in progress reports increased the difficulty of performing comparative analysis and potentially obscured best practices or lessons-learned developed by individual districts. A number of the participants of this evaluation considered this to be an area that could be strengthened.

> *One of the things that was really clarified as we went through the work of the progress report was that we needed more consistent and clear tracking mechanisms than have been implemented now.*

> *I find evaluation something that, and I'm generalizing here, we don't do well. And I find that the [provincial] tobacco strategy is weak on that and I think if it was strengthened … then it would cause districts and tobacco coordinators to strengthen theirs as well.*

Evaluation Effort

Key informants reported that the effort allocated to evaluation of local strategies in most DHAs was planned at 10% of the annual budget of the district. In practice, this has been applied inconsistently.

> *In terms of dollars and staff time I would tell you that 10% of the budget you receive should be around evaluation. … That's something that we kind of use as principle, because it's actually more intense in terms of the follow up around evaluation then it is at the actual treatment.*

> *So in my knowledge, there isn't any money for evaluation. If anything, it's for purchasing of resources.*

> *[Evaluation is] just what I decide to do. And if I didn't decide to do it, it probably wouldn't get done.*

Information Distribution

Data from the Outcome Monitoring System, from individual project evaluations, and from other relevant sources have been distributed within the province and were applied at the DHA and SSA level to inform program development and approaches. This is considered a valuable tool, but it is clear that there is not a strong dissemination structure or provincial group in place to review, tailor and disseminate best practices in an efficient manner.

Outcomes Achieved for this Strategy Component

The planned outcomes regarding the collection of baseline data and the development of databases were partially achieved as the Outcome Monitoring System used across the province consistently measures the success of treatment programs, but progress toward the Strategy and local strategies is not collected or measured consistently throughout the province. There is at

best a rudimentary dissemination network for the results of monitoring and evaluation. This is an area acknowledged by many key informants as one requiring additional work.

Table VIII: Monitoring and Evaluation Outcome Summary

Outcome	Status
Baseline data is collected	Partially Achieved
Development and utilization of databases	Partially Achieved
Continuous update and improvement of the Strategy	Not Achieved
Evaluation report produced every two years	Achieved

Summary and Conclusions

Overall, although there are areas that have been identified as opportunities for improvement, the implementation of the Strategy has been considered by most tobacco control stakeholders to be effective. Some key informants point to rising quit rates and decreasing uptake rates as an indicator of success of the Strategy. Participants responded overwhelmingly that the Strategy has been an extremely useful mechanism for focusing efforts and attention on key areas, and welcome the opportunity to renew the Strategy.

A majority of the planned outcomes documented in the evaluation framework were achieved, as noted in the following summary. It should also be noted that a number of significant achievements were made that had not been aligned with planned outcomes, such as the provision of NRTs to treatment program participants.

Table IX: Summary of Planned Outcome Status

	Number of Outcomes				
Component	**Achieved**	**Partially Achieved**	**Not Achieved**	**Unknown (data not available)**	**Total**
Pricing and Taxation	1		1		2
Smoke-Free Legislation and Policy	2	1			3
Treatment and Cessation	5	1	2	1	9
Community Based Programming	5				5
Youth Smoking Prevention		1	3	2	6
Media and Public Awareness	3			2	5
Monitoring and Evaluation	1	2	1		4
Totals	**17**	**5**	**7**	**5**	**34**

The Strategy has been acknowledged by many key informants as a foundation for the tobacco control community in Nova Scotia. Most key informants noted that there is still work to be done, and there is a need to ensure that tobacco control efforts are linked to other health promotion efforts. Most importantly, there is a need to ensure that the success of the Strategy thus far does not lead to complacency. The process to renew the Strategy can build as the successes to date, and re-energize the tobacco control stakeholder community to continue collaborative efforts for more successes in the future.

> *I know that there has been concern that some of the commitment of some partners seems to wane a bit as the tobacco strategy has kind of moved forward and had a sense of success. You know unless we keep it linked into the chronic disease prevention agenda and the work in primary health care, you know there is a possibility that some of our partners may move on to other issues, which I would hate to see happen.*

Considerations for Strategy Renewal

As part of this evaluation, participants were asked to describe their thoughts regarding the areas or components they felt should be given consideration during the renewal of the Strategy. It should be noted that the responses given were the opinions of the interview participants and do not necessarily constitute best practice.

Considerations noted by key informants are grouped below based on the number of interview sessions in which the consideration was voiced.

Top Considerations

The following considerations were indicated during most interview sessions with key informants.

1. Introduce Point of Sale advertising legislation to remove tobacco products from within sight of customers;
2. Implement the provincial evaluation framework to collect and report data consistently for all District Health Authorities;
3. Increase funding, staff and other resources to adequately meet the current and projected demand for cessation and treatment services, which are rising and expected to continue to do so in response to the success of the Strategy;
4. Promote research to determine the most appropriate way to treat youth addicted to nicotine. If appropriate, funding of nicotine replacement therapy should be considered for youth;
5. Develop a climate within schools that places increased priority on actions to prevent smoking and reduce tobacco use; and
6. Create and sustain a tobacco industry de-normalization initiative with a focus on youth, reviewing and applying lessons from youth advocacy initiatives such as the Expose initiative in Ottawa.

Important Considerations

The following considerations were indicated during some interview sessions with key informants.

1. Equalize taxation rates such that all tobacco products are equally expensive as a deterrent for smokers considering a switch to an alternative tobacco product;
2. Concentrate greater resources into enforcement of legislation to support enactment of stronger legislation in December 2006; with tougher provincial legislation, municipalities may repeal strict municipal by-laws in order to move the costs of enforcement to the province;
3. Develop a regular mechanism for coordinated planning involving a variety of stakeholders at the local and provincial level, including common communication messages, strengths, opportunities, and ways to help keep stakeholders aligned in their tobacco control activities;
4. Concentrate on identifying and developing strategies for specific groups that are at high risk from tobacco use, such as:
    a. The mental health community;
    b. Call-centre employees;
    c. Remote communities;
    d. Young adults not in school;
    e. Community assistance clients;
    f. Recent immigrants;
5. Strengthen the youth possession legislation;
6. Increase collaboration between HPP and DoE to increase effectiveness of youth smoking prevention;
7. Integrate the tobacco strategy with other HPP work in the areas of chronic disease prevention, injury prevention and primary health care to strengthen plans and reduce the 'silos' between health promotion activities with similar goals; and
8. Provide more accountable funding from provincial tobacco taxes to increase capacity to meet projected rising demand for treatment and cessation services.

Other Considerations

The following considerations were indicated during a few interview sessions with key informants.

1. Keep focus and pressure on government to retain tobacco as a priority at both district and provincial levels;
2. When developing actions and plans for Strategy implementation, consider all aspects of the various components, the linkages and interdependencies between the components as they tend to support each other strongly in an effective initiative or program;
3. Although the price of cigarettes is shown to be an effective deterrent, manufacturers and vendors have made available smaller packages that are more affordable. Consider options for eliminating the sale of smaller packages, or for varying price or tax rates to reduce the attraction of this option;
4. Introduce legislation banning the misleading use of terms such as 'Light' or 'Mild' in reference to packaging of tobacco products;
5. Place pressure on federal agencies to take over the tobacco industry in Canada to remove the effort currently spent against that industry; resources can then be re-allocated to prevention and treatment;
6. Re-frame prenatal/postpartum messaging and intervention to be woman-focused vs. fetus centered;
7. Concentrate on working with the 11 to 12-year-old (grade 6) age group where staff are seeing a lot of increase in smokers and complement that with research regarding how quickly youth can become addicted;
8. Education / social marketing to increase awareness of risks of smokeless tobacco use;
9. Target smoke-less tobacco products to combat a growing trend in the use of chewing tobacco as a cigarette replacement;
10. Drill into greater detail with CTUMS data to determine differences in districts, in urban vs. rural, and along ethno-cultural groups;

11. Develop a framework for the evaluation not just of the Strategy, but also for programs and initiatives such that there is a common understanding of success criteria, the impact of actions, and a common access to best practices;
12. Increase communications and encourage non-profit organizations to decrease the number of charitable donations accepted from the tobacco industry to remove any 'good-news' stories from that industry;
13. Determine the alignment of current research programs to the Strategy, and develop infrastructure within HPP to ensure that future research is clearly aligned with the Strategy;
14. Strengthen HPP infrastructure to better support the collection and distribution of best practices and lessons learned from across the province.

Recommendations

Based on the evaluation data, evaluation findings, and the key themes noted by both the evaluation participants and the workshop results of the Tobacco Control Summit, the following recommendations are offered regarding the Strategy.

1. Renew the Strategy in light of the considerations identified by evaluation participants in the Strategy renewal process and the key themes developed and discussed at the Tobacco Control Summit. Consider the expansion of the Strategy to include new pillars or components, and connect the Strategy with other health promotion strategies without diffusing the focus of attention on tobacco control;
2. Provide funding for the renewed Strategy at a level comparable to best practice funding levels recommended by the Centers for Disease Control ($7 to $20 per capita for populations less than three million)[1];
3. Promote the provincial strategy as the only Strategy, and encourage district tobacco control staff to collaboratively design one- and three-year district specific implementation plans linked directly to the provincial strategy. This process should incorporate on-going information sharing and resource sharing where appropriate;
4. Identify a process for collecting data and support an ongoing data collection cycle. Consider developing and implementing common collection, management and reporting tools across all districts. Support DHAs in implementing consistent data collection analysis and reporting that will inform program planning;
5. Develop and implement a regular communication mechanism through which tobacco control staff and HPP meet to discuss accomplishments, planned activities, issues, and best practices;
6. Clarify the roles and expectations of tobacco control staff. Where they are not already in existence, develop role descriptions and expected tobacco control expertise for tobacco control staff. Develop a professional training and development plan to ensure that all tobacco control staff have equitable access to professional development;

7. In partnership with Nova Scotia's tobacco-vulnerable populations, identify and develop initiatives to reduce tobacco use among these groups;
8. Support pro-active and ongoing knowledge translation activities, so that all tobacco control staff across the province have easy access to current research about tobacco use and best practices related to tobacco control. This includes the identification and sharing of best practices occurring within Nova Scotia;
9. Determine from best practices and evidence the direction most appropriate across the province regarding youth possession legislation, disseminate the results to all tobacco control staff and tobacco stakeholders, and as appropriate work with legislators to ensure that legislation reflects best practice;
10. Develop an integrated, consistent approach and implementation plan in Nova Scotia for provision of brief intervention training for tobacco control for healthcare staff. A consistent approach to evaluation of this training should also be developed;
11. Explore the effect of the Smokers' Helpline on social messaging to determine if the existence, advertisement and accessibility of such a service provides impetus to a smoker's decision to take action; and
12. Improve the HPP web-page and ensure information and links are clearly labeled to promote easy navigation and access to information and services.

End Notes

(1) Centers for Disease Control. Best practices for comprehensive tobacco control programs: Executive Summary. August 1999. Available at: http://www.sen.parl.gc.ca/ckenny/cdc_executive_summary.htm. Accessed October 26, 2006.

(2) Thinkwell Research. Thinkwell public opinion survey presentation. October 12, 2005.

(3) Xu MA. Canadian tobacco use monitoring survey (CTUMS) 2005 results for Nova Scotia - draft. 2005.

(4) US Department of Health and Human Services. *Clinical Practice Guideline Treating Tobacco Use and Dependence*. June 2000.

(5) Pyra Management Consulting Services Inc, Research Power Incorporated. Is it making a difference? An evaluation of Nova Scotia's youth tobacco possession law. June 2005.

Appendices

Appendix 1 – Evaluation Framework Indicators

Table X: Pricing and Taxation Indicators

Indicator	Data Collection Method	Findings
Process Measures		
What type of awareness and consultation activities was carried out?		
1.1 Number and type of consultation activities	Interview: HPP Staff	- Consultation activities were not documented. - No formal public awareness activities conducted around pricing and taxation. - Tobacco control stakeholders provided input through various meetings since 2000.
Were resources allocated to the tobacco control strategy?		
1.2 Amount and type of resources (financial and staff) allocated to the comprehensive tobacco control strategy	Interview: HPP Staff	- There is no clear accounting of the number or type of fiscal or human resources that have been dedicated to pricing or taxation. - Staff feels that there have not been sufficient resources dedicated to this. - A lack of analysis between tobacco revenues and tobacco use has been identified. For example, there has been no analysis of why there's been a decline in revenue from tobacco.
Planned Outcome		
1.3 The tax increase of $8 per carton of cigarettes achieved in 2001 is at minimum maintained	Interview: HPP Staff Comparative Tax rates as of September 2005	- Tax increase was maintained and in fact, Nova Scotia went beyond what was stated in the Strategy. - The tax per carton of cigarettes as of Sept 2005 was $31.04.
1.4 Tobacco tax rates are equal across all tobacco products by 2003	Interview: HPP Staff	- Tobacco tax rates are not equal across all tobacco products. - Cigarettes are higher than roll-your-own cigarettes, cigars are taxed differently, chewing tobacco is again taxed in a different way.

Table XI: Smoke-Free Legislation and Policy Indicators

Indicator	Data Collection Method	Findings
Process Measures		
Did knowledge about the health effects of second-hand smoke improve?		
2.1 Type and extent of social marketing activities	Interview: HPP Staff Document Review: - NS Comprehensive Tobacco Control Communications Campaign PowerPoint Presentation - NS Tobacco Control Communications Campaign – Phase 2 Contribution Agreement Final Report - Smoking Status Report – Quantitative, Smoke Free Around Me Campaign	- Smoke Free Around Me promotion, window-clings, posters and a website. - Smoke Free Around Me campaign re-aired in fall 2005 in preparation for the public places legislation. - Status Report: Smoke-Free Around Me. - Media ads generated discussion of SSH issues.
2.2 Reach of social marketing activities	Survey	- Not available
2.3 Recall of social marketing messages	Survey Nextbus Telephone Survey:	- Anecdotal evidence (requests for window-clings) indicate good recall of message. - 4% surveyed Nova Scotians recalled unaided ads regarding dangers of second-hand smoke (Feb 2006). - 1% surveyed Nova Scotians recalled unaided ads regarding dangers of second-hand smoke (Apr 2006). - Appears this message degrades over time without re-inforcement.
2.4 Number and type of materials developed and distributed	Document Review: • Data from DHAs	DHA 7,8: - Brochure distributed by CBDHA & GASHA on Stop-Smoking programs includes

Indicator	Data Collection Method	Findings
	Interview: HPP Staff Interviews: DHA staff	panel on Second Hand Smoke. DHA 1,2,3: - [to public health staff]... individual, family or group discussions; printed material, videos and "teachable moments" through pre-natal classes, home visits to clients and presentations. - Kids Against Tobacco Smoke (KATS) program in elementary schools. DHA 9: - Created proprietor and public education campaign in collaboration with HRM staff. - Development (solely or in collaboration) of the Tobacco Industry Tactics in Nova Scotia Communities report and presentation, used as an education aid. DHAs 7,8: - Smoke Free Around Me Media campaign. - Be a Hero media campaign. - Window Clings. - Canadian Cancer Society secondhand smoke and the new Health Canada documents. DHA 9: - Fact sheets (SFP Act) Halifax by-law. - Smoke Free mail out. - Second hand smoke and your child. - Student Action Teams. - Post Secondary institutions (smoke-free residences). - Post-natal interview with new mothers. - Individual messages to tobacco users. DHA 4: - Community Presentations. - 1 page handouts. - Teens Tackle Tobacco (school program). DHA 5: - Media releases. - School visits. - Pre-natal with HCWs. - Materials to “Maggie’s Place” – family resource centre. DHA 1: - SFAM literature/brochures and Window - clings successful.

Indicator	Data Collection Method	Findings
		- HC brochures. - Take it Outside posters, etc. - KATS (elementary schools). - Display materials. - Treatments handout. DHA 2: - SFAM literature / brochures. - Prenatal program. - Community presentations. - KATS. - Approved resources from Public Health that might come from the Canadian Cancer Society or the Heart and Stroke Foundation. HPP: - TV spots, posters, print materials, direct mail campaign and a Web site, which is still active, implemented as part of the Smoke-Free Around Me campaign. They were unable to provide specific numbers for that. There were also TV ads conducted as part of the broader social marketing campaign that had two ads with a secondhand smoke focus. The Smoke-Free Around Me program was evaluated and shown to be effective.
2.5 Usefulness and/or effectiveness of materials developed	Program material survey	- Not available - Anecdotally, the DHA tobacco control staff generally feel that promotional materials are effective when used in the context of a comprehensive program. Consistency of message considered to be one of the greatest assets.
Was public demand for legislation and policy created?		
2.6 Number and type of awareness and consultation activities (e.g. community forums)	Interview: HPP Staff	- Consultations not performed. - Awareness campaigns as per recorded in indicator 2.4.
2.7 Type and extent of social marketing activities to garner public support	Interview: HPP Staff Document Review: (Tab 6 in binder) - NS Comprehensive Tobacco Control Communications Campaign PowerPoint	- High school media literacy program (You Choose). - Work place programs. - SFAM media campaigns. - SickOfSmoke website. - “Open Casting Call" traveling booths to collect and display youth discussing smoking. - Ambient Ads and distribution targeting youth. - 97 advocates mobilized to lobby councilors and attend public hearings in one

Indicator	Data Collection Method	Findings
	Presentation	DHA. - Monitored casino. - Provided information supporting HRM staff & council. - Provided by-law compliance & enforcement support. - Coordination of a petition (11,000 signatures) re smoke-free legislation. - 26 presentations to gather support for 100% smoke-free legislation in 3 DHAs. HPP: - Not the role of the province to implement advocacy campaigns that garner public support for legislation. Smoke-Free Nova Scotia, some of the DHAs and Smoke-Free Kings have been involved in work trying to gain public support for legislation.
2.8 Reach of social marketing activities	Survey	- Not available
2.9 Recall of social marketing messages	Survey	- Not available
2.10 Type and extent of media accounts highlighting the need for legislative/ regulatory measures	Document review	- Not available
Was smoke-free workplace and public places legislation developed?		
2.11 Province-wide smoke-free legislation is developed and passed to provide 100% smoke-free workplaces and public places	Interview: HPP Staff	- All Nova Scotians will be covered by legislation providing 100% smoke-free places by December 1, 2006. It covers pretty much everything except long-term care facilities, which will be able to have a designated smoking room. Even patios on bars and restaurants outside will be covered by this legislation.
Was the legislation enforced?		
2.12 Number and type of monitoring and enforcement activities	Interview: HPP Staff	- The provincial legislation is being enforced. It is enforced through a team of different types of inspectors throughout government. For example, workplaces are covered by occupational health and safety monitors. In places with a liquor license it's monitored by the Alcohol and Gaming Authority, in food licensed establishments it would be the food inspectors from Agriculture and Fisheries, and in retail sales outlets it would be the tobacco inspectors from the Department of Health Promotion and Protection. -

Indicator	Data Collection Method	Findings
Planned Outcomes		
2.13 Percentage of Nova Scotians who think second-hand is a significant cause of health problems will increase from 48% to 75% by 2005	Public opinion poll (Thinkwell Research)	- 88%
2.14 All Nova Scotians will be covered by legislation providing 100% smoke-free places (workplaces and public places) by 2003	Interview: HPP Staff	- See 2.12
2.15 The number of smoke-free homes in Nova Scotia is increased from 55% to 75% by 2005	CTUMS Summary	- 73% - *Note: there is a website available through which homes may be registered as smoke-free, but the majority of registered homes are located in Cape Breton as this was an initiative of DHA 8.*

Table XII: Treatment and Cessation Indicators

Indicator	Data Collection Method	Findings
Process Measures		
Was treatment and cessation information developed and posted on the government website?		
3.1 Number and type of information on government website	Document Review: • Review of web site	- Sick of Smoke site has information on Smokers' Hotline and CDHA Addiction Services. Includes how to find addiction services in other parts of the province. - Canadian Council for Tobacco Control has some self-help material on cessation. - Canadian Lung Association has a detailed description of a cessation process and links to CLA support groups. - Heart and Stroke Foundation has cessation initiation encouragement, some cessation planning information, but little support information. - Medical Society of NS (DoctorsNS) has information about how they promote smoke cessation (under health and wellness) and links to brochures and an

Indicator	Data Collection Method	Findings
		information card. The brochure gives some information about encouragement, cessation planning, and treatment options. - Smoke-Free Nova Scotia has information on the smokers' hotline, directions to contact CDHA addiction services and the Lung Association Quit4Good program.
3.2 Number and type of links	Document Review: • Review of web site	Links include: From Sick of Smoke: - You Choose – youth directed tobacco-control media ads and english program curricula. - Quitting Help, Health Canada – Cessation initiation and management information. - Canadian Cancer Society – Cessation encouragement, information re Smokers Hotline, cessation information for pregnant and new mothers. - Physicians for a Smoke Free Canada – information for doctors, propaganda, and some links to other organizations for cessation information. - Gotta Quit – NY site used to have access to ex-smoking quit coaches (cancelled due to lack of funding) Offers links to cessation plans, tips, non-personalized encouragement. - Quit Net – Online cessation support network run from Boston. Contains information re treatment 'medication', and provides an online shop to purchase. Offers a premium, paid membership as well as free membership. Smoke-Free Nova Scotia has links to: - http://www.gov.ns.ca/health/tcu.htm - Broken Link to Tobacco Control Unit. - quitsmoking.about.com Resources, encouragement and paid advertisements on About.com. - Sick of Smoke Web site - And a number of links to Canadian and American (mostly Canadian) sites, resources and information.
Was a 1-800 treatment and cessation counseling service created?		
3.3 Number and type of counselors hired	Document review	- Not available
3.4 Number of users	Document Review: - Smokers HelpLine Quarterly Report June 2005 (Tab 5 in binder)	- 1485 first-time callers called for themselves between November 2002 and June 2005.
3.5 Topics of contacts	Document review	- Not available.

Indicator	Data Collection Method	Findings
3.6 Characteristics of participants	Document Review: - Smokers HelpLine Quarterly Report June 2005 (Tab 5 in binder	- Majority of users (59.2%) were female. - Most common age ranges were 40-49 (24.8%) and 50-59 (26.1%). - Education seems not to be a great factor in people's use of the SHL (34% less than high school, 37% high school, 28.8% post-secondary). - 18.9% identified themselves as quitters, 67.5% of users were in the 'preparation' stage of cessation. Nationally, only 16.4% identified themselves as quitters, and 55.6% were in the preparation stage. - The majority (46.5% have Medium HSI) (national is 45.5%).
3.7 Participant satisfaction (timeliness, helpful, etc.)	Document Review: - Smokers HelpLine Quarterly Report June 2005 (Tab 5 in binder	- Larson score, mean satisfaction 9 (SD 2.4), median score 9 & max score 12. - Anecdotal information from tobacco control staff discussion with clients indicate a general satisfaction with results, but many staff members do not hear or receive any information.
3.8 Effectiveness of service (i.e. reducing or stopping smoking) – see outcomes	Document Review: - Smokers HelpLine Quarterly Report June 2005 (Tab 5 in binder	- Almost 90% take some action within 6-months toward quitting (70% cut down, ~58% stop for 24 hrs, ~53% set a quit date). - Determination of effectiveness could be improved through a more detailed reporting of outcomes. Reporting by district, by postal code, and / or by community / ethnic group would provide greater information regarding the uptake of the service within targeted specific at-risk groups.
Were nicotine addiction treatment programs created?		
3.9 Number and characteristics of participants	Document review: - Data provided by DHAs	DHA 9 reported: - 3295 participants (communication services). - 158 4-week Keeping it Going support groups (communication services). DHAs 4,5,6 reported: - 5389 Adults over 5 services. DHAs 7,8 reported: - DHA 7: 809. - DHA 8: 1191. - Characteristics (DHA 8) of sample of 182 people attending between Apr'05 - Mar'06: Demographic characteristics average, with high-points: High / V High dependence 68.3% (Fagerstrom), 2-5 prev quit attempts 49%. DHAs 1, 2, 3 reported: - 1956 participants (Apr '04 - Mar '06) all services - *Note: the reporting of program and participant data was inconsistent between Shared Service Areas, with better data collection, management, and reporting*

Indicator	Data Collection Method	Findings
		dependent on resources allocated to quality management.
3.10 Participant satisfaction	Document review: - Data provided by DHAs	DHAs 1,2,3 reported: - Overall satisfaction Good: 3.5%, V Good: 29.6%, Excellent: 62.6% (Apr'04-Mar'05). - Overall satisfaction Good: 27.3%, V Good: 31.8%, Excellent: 37.9% (Apr'05-Mar'06). DHAs 7,8 reported: - 2004 OMD: Ex: 43%, VG: 47%, G: 9%, F: 1%. - 2005 OMD: Ex: 31%, VG: 64%, G: 5%, F: 0%. DHAs 4,5,6 reported: - 98% - *Note: Again, data collection, management and reporting is inconsistent between the Shared Service Areas.*
3.11 Effectiveness of service (i.e. reducing or stopping smoking) – see outcomes	Document review: - Data provided by DHAs	CDHA reported: - 34.7% cessation rate; 40.8% reduced. DHAs 4,5,6 reported. - Unable to report. DHAs 7,8 reported: - 2004 OMD 12-Month follow-up: 26.7% cessation, 36.7% reduced. - 2005 OMD 12-Month follow-up: 35.9% cessation, 28.6% reduced. DHAs 1,2,3 reported: - 20.9% cessation rate, 39.1% reduction rate (Apr '04 - Mar '05) 12 month post treatment. - 24.2% cessation rate, 47% reduction rate (Apr'05 - Mar'06) 12 month post treatment.
3.12 Percent of clients reporting 'no difficulty' accessing service	Document review: - Data provided by DHAs	DHAs 1,2,3 reported: - 93% Apr'04-Mar'05; 97% Apr'05-Mar'06. DHAs 7,8 reported: - 2004 OMD: 96.7%. - 2005 OMD: 98.7%. DHAs 4,5,6 reported: - 92%
Were Addiction Services staff dedicated to provide nicotine addiction treatment services for smoking cessation?		
3.13 Number and types of activities to increase staff support	Document review: - Data provided by	DHAs 1,2,3,4,5,6,9: - Not tracked / reported.

Indicator	Data Collection Method	Findings
	DHAs	DHAs 7,8: - Community Outreach Worker (COW) and PAO assigned a part-time support person. Proposal has been submitted to hire another part-time position to (in part) collect and analyze 3- and 6-month follow-up data.
3.14 Extent of resources to secure staff	Document review: - Data provided by DHAs	- Not tracked.
3.15 Number and characteristics of staff dedicated	Document review: - Data provided by DHAs	DHAs 1,2,3: - 3 Nicotine Addiction Councellors, one based in each district. - Qualifications: 1 or 2 year intensive addictions counselling skills training program. DHAs 7,8: - COW for tobacco hired in each district in Oct 2002. - DHA 8 COW characteristics: first one: masters of education & experience with community development. Second one: Bachelors of Science and Social Work, experience with Children's Aid and Community Services. - DHA 7 COW characteristics: Registered Nurse, Bachelor of Social Work. - Each district expected to have a Program Administration Officer, but DHA 7 position has been vacant for past year. DHA 9: - 2 - COW & POA (Masters of Education). DHAs 4,5,6: - 1 person initially with others filling in as terms ended and positions changed. - Currently, each DHA has 0.5 FTE allocated to the role. (since June '06).
3.16 Number and type of training 'events for staff	Document review: - Data provided by DHAs	DHAs 1,2,3: - A number of professional development initiatives have been made available, but not tracked or evaluated. - Attendance at various addictions-related workshops. - Reading current publications. - Informal and Formal networking with provincial counterparts. DHAs 7,8: - 8 events; 4 professional conferences, 4 training programs (1 - 5 day sessions). DHAs 4,5,6: - Not tracked. - *Note: this follows a trend of poor and inconsistent monitoring of internal activities not directly associated with program delivery. Support activities seem typically to*

Indicator	Data Collection Method	Findings
		be done ad-hoc and neither planned for nor evaluated.
3.17 Number and type of services provided	Document review: - Data provided by DHAs	- Not tracked.
Were health care providers trained to provide brief interventions for smoking cessation?		
3.18 Number and type of recruitment activities for health care providers	Document review: - Data provided by DHAs	- Not tracked.
3.19 Number and type of training "events" (for health care providers)	Document review: - Data provided by DHAs	- Numbers are not tracked consistently across DHAs / SSAs. DHAs 4,5,6: - Not tracked. DHAs 7,8: - DHA 8 attended planning session for CBDHA policy adoption around brief interventions. - Training pilot program developed. - Self-study brochures and videos developed. - Presentations to nurses and nurse managers. DHA 9: - 18 to date, employing train-the-trainer model. Tracking of intervention training performed after that not tracked. DHA 3: - Not performed within last 2.5 years.
3.20 Number and type (characteristics of participants) of health care providers attending	Document review: - Data provided by DHAs	DHAs 4,5,6,9: - Not tracked. DHAs 7,8: - 53 evaluations completed on presentation. - 182 evaluations completed on self-learning package. - (Note: no record of the characteristics of the participants is available). DHA 1: - To date: 50 people, including "train the trainer" and 15 physicians. DHA 2: - Dental hygienists and dentists (20 people). - Pregnancy and tobacco project.
3.21 Participant (health care providers) satisfaction with	Document review: - Data provided by	DHAs 4,5,6: - Not tracked.

Indicator	Data Collection Method	Findings
training events	DHAs	DHAs 7,8: - Presentations: 85% self-evaluated at highest level. - Self-study material: 54% self-evaluated at highest level, 36% at next highest. DHA 9: - "Highly effective" based on immediate post-training surveys indicative of generally satisfied.
3.22 Number and type of health care providers trained	Document review: - Data provided by DHAs	DHAs 4,5,6,7,8,9: - Not tracked, anecdotal reporting of numbers based on memory, typically in the 40 – 50 person range for each SSA. DHA 3: - Information is given to health care providers regarding cessation programs, but not directly regarding brief interventions. - Intervention with pregnant and nursing mothers is provided. - Plans underway to provide specific training for doctors.
3.23 Participants report increased knowledge and skills	Document review: - Data provided by DHAs	- Evaluation of training programs not performed consistently across districts / SSAs. - Where evaluations have been done, they consist entirely of immediate post-training surveys; no longer-term evaluation is performed.
3.24 Participants apply knowledge and skills from training events in providing brief interventions	Document review: - Data provided by DHAs	- Not tracked other than anecdotally.
Was a media/communication strategy developed and implemented for nicotine treatment/ smoking cessation?		
3.25 Number and type of media and communication activities	Document review: - Data provided by DHAs Interviews: HPP staff Interviews: DHA staff	- Every district has a web presence that includes Addictions Services, although the Addictions Services pages of DHAs 5 & 6 do not mention tobacco control / nicotine addiction. DHA 3: - District newsletter. - Posters, letters, packages to community doctors. - Community presentations. - Communications strategy. - Radio ads a couple of times each year. DHA 8: - Newspaper articles. - Radio ads. - Television and radio news and community features. - Posters and brochures in doctors' offices, clinics, hospitals.

Indicator	Data Collection Method	Findings
		- Media strategy exists and a review is planned. DHA 9: - Radio features (call-ins re cessation, etc). - Wallet cards distributed. DHA 5: - Cessation program calendars distributed among businesses. DHA 1: - Newspaper ads. - Community presentations. - Discussions with health providers. DHA 2: - Door-to-door discussions with health providers. - Posters in doctors' offices and community areas. - Funding has prevented large-scale use of media over past couple of years. - One Clare MLA provided advertising.
3.26 Reach of media and communication activities	Survey	- Not available.
3.27 Recall of media and communication messages	Survey	- Not available.
Planned Outcome		
3.28 Smoking cessation and treatment services are enhanced throughout the province, specifically:		
3.29 Enhanced information on the government website related to cessation and treatment;	Document review: - Review of web site	- HPP Website contains links to cessation information, but are not labeled as such. Districts have sites with information and program services, but are inconsistent with each other.
3.30 An effective 1-800 service is implemented;	Interviews: HPP staff Interviews: DHA staff	- 1-800 service implemented. - Smokers' help line report indicates service has been established, but DHAs have difficulty commenting as the data is not broken down into statistics reflecting their populations.
3.31 At minimum, 9 Addiction/Drug Dependency Services staff	Document review: - Data provided by	- Full-time positions were created in each district by 2003, with one exception. - Staffing difficulties in DHAs 4, 5, 6 resulted in establishment of positions at 0.5

Indicator	Data Collection Method	Findings
positions dedicated throughout the province by March 2003	DHAs	FTE /DHA. - Position not staffed for CEHHA at time of evaluation.
3.32 45% of smokers who use the 1-800 service will make at least 1 quit attempt at a 1 month follow-up	1-800 follow-up survey	- Not available – only have data for 6 month follow up. - (6-month evaluation). - 90% took some action. - 57% quit for at least 24 hours. - 11.5% quit for a period greater than 30 days.
3.33 65% of smokers who use the 1-800 service will have cut down the amount they smoke at a 1 month follow-up	1-800 follow-up survey	- Not available – only have data for 6 month follow up. - (6 month evaluation). - 70%
3.34 45% of nicotine addicted individuals that complete a nicotine addiction treatment program will not be smoking at a 12 month follow-up	Document review: - Data provided by DHAs	DHAs 1,2,3: - 20.9% Apr'04 - Mar'05. - 24.2% Apr'05 - Mar'06. DHA 8, 7 - 26.7% (2004 OMD). - 35.9% (2005 OMD). DHA 9 - 32 - 35% DHA 4,5,6 - 18.75% (Jan '03 - Dec '03). - 19.04% (Jan'04 - Dec'04).
3.35 The percentage of smokers who made at least one quit attempt in the previous 12 months will increase from 45% to 55% by 2004	Document review: - CTUMS summary	- 56%
3.36 The percentage of smokers (ever smokers) who are thinking about quitting (in the previous 12 months) will increase from 19% to 25% by 2004	Document review: - CTUMS summary	- 65%
3.37 The percentage of smokers (ever smokers) who are preparing to	Document review: - CTUMS summary	- Not available.

Indicator	Data Collection Method	Findings
take action (in the previous 12 months) will move from 7% to 15% by 2004		

Table XIII: Community-Base Programming Indicators

Indicator	Data Collection Method	Findings
Process Measures		
Was a motivational conference successfully planned and delivered?		
4.1 Type of motivational conference	Interview: HPP staff	- 2001 in Cornwallis. - 2005 at Saint Francis Xavier University.
4.2 Number and type of participants at conference	Interview: HPP staff	- Not available.
4.3 Satisfaction with conference	Interview: HPP staff	- Not available.
Were tobacco coordinators hired?		
4.4 At minimum, 9 tobacco coordinators hired throughout the province by March 2003	Interview: HPP staff	- Tobacco Coordinators were hired for each of the districts. There has been some discontinuity in position knowledge due to staff changes in some districts.
Was technical assistance provided through the Department of Health		
4.5 Number and type of technical assistance provided	Interviews: HPP staff	- Not available.
Were capacity building opportunities delivered to support effective tobacco control?		
4.6 Number and type of capacity building opportunities	Document review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA staff	DHA 8: - First Nations / Public Health Services Tobacco Reduction Committee - meets regularly since May 2003. DHA 3: - Kings County Smoke-free bylaw. - Acadia University Smoke-free policy. - Valley ACT group. - Smoke-Free Around Me. - Pregnancy and tobacco project.

Indicator	Data Collection Method	Findings
		- Eastern Kings Foundation. - Community Health Board Wellness Fair. DHA 4: - Community Nurses at Agricultural College (5). DHA 5: (150) - Schools. - Springhill Penitentiary. - Pregnant women. DHA 9: - Cole Harbour Soccer Club. - ACT. - Prenatal/Postpartum Tobacco use work group. - MIME training (18). - SFNS advocacy training (~30). - AUSSO (~70). - All CDHA institutions. - NSCC across the province. - Acadia. - Hampton High Smoke Free School Policy experience for all staff SJA and YHCC, students, admin from 8 other high schools (50). - Student Action Team members (284). DHA 2: - Youth centre in Shelburne. - Barrington Soccer Association.
4.7 Number attending capacity building opportunities	Document review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA staff	- Numbers of participants are not tracked consistently. See 4.6.
4.8 Characteristics of participants of capacity building opportunities	Document review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA staff	- Not available.
4.9 Participant satisfaction of	Document review:	DHA 3:

Indicator	Data Collection Method	Findings
capacity building opportunities	• Data provided by DHAs Interviews: HPP staff Interviews: DHA staff	- Evaluation not performed. DHA 9: - Post event surveys are taken, and generally show satisfaction, but not every event is evaluated. DHA 4: - Evaluation not performed. DHA 5: - Post event surveys indicate satisfaction. DHA 1: - Post event surveys indicate satisfaction. - Participant satisfaction is not evaluated consistently; tobacco control staff typically rely on anecdotal information immediately post-session. DHA 8: - First Nations' workgroup session feedback indicate general satisfaction with workshops held.
4.10 Participants of capacity building opportunities apply knowledge & skills gained	Document review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA staff	- Denormalization of tobacco use in Wolfville a result. - Kings; close results of by-law vote indicate use of skills. - Use of an 8-week working log demonstrates skill building achieved. - Community Nurses continue to train others, demonstrating use of skills acquired. - No formal follow-up but anecdotal reporting that these have been used. - Inconsistent representation from some bands, but noticeable progress made.
Was tobacco control within ethnic groups addressed?		
4.11 Collection & summary of smoking data by ethnic groups	Document review: • Data provided by DHAs	- Not collected.
4.12 Identification of partners from existing ethno-cultural networks	Document review: • Data provided by DHAs	- Collaborated with a working group formed by First Nations' representatives. - Preston / North Dartmouth African-Canadian populations.
4.13 Number & type of meetings with partners from ethno-cultural networks	Document review: • Data provided by DHAs	- Regular meetings of First Nations / Public Health Services Tobacco Reduction Committee since 2003. - *Note: Frequency and types of meetings not available from other DHAs.*
Planned Outcome		
4.14 New & strengthened community-based initiatives for	Document review: • Data provided by	- Tobacco-Free Sport and Recreation (New). - ACT (Strengthened from learning from evaluations).

Indicator	Data Collection Method	Findings
tobacco control	DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health Focus Group: NGOs	- "You're the Target" youth and leader guide derived from ACT (New). - Smoke-Free Around Me (Strengthened & rolled out across province). - Physician Involvement in development of NRT programs. - School Teen Action groups. - Mental Health Care Community. - Coalitions for municipal bylaws (Kings, Lunenburg). - Youth programs. - School Sport Federation. - Smoke-Free Kings. - Sick of Smoke communications program. - UCB. - North Preston Community Centre. - DHA capacity building. - Post-Partum Tobacco use. - HRM Advocacy. - Smoke free Grounds. - High school programs. - Nationally with Tobacco sponsoring. - Smoke Free Mental Health. - Smoke Free Addiction services. - Tobacco – Free Lunenburg – Queens (Coalition). - Management group of tobacco co-coordinators. - Pregnancy and Smoking Project (Resulted in sharing networks).
4.15 New and strengthened partnerships/coalitions for tobacco control	Document review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health Focus Group: NGOs	- ACT remains a strong coalition. - Tobacco-Free Sport and Recreation (derived from ACT). - Tobacco control staff, and Smoke-Free Nova Scotia have formed a strong partnership, particularly around legislation. - Psychology dept of Dal (for MIMI). - Dept of Transportation. - Individual businesses. - Education. - Community Services. - Cancer Society. - Prenatal educators. - Health care community in general.

Indicator	Data Collection Method	Findings
		- Acadia University. - Smoke-Free Kings. - Michelin. - Greater partnership between addictions services and public health. - Cape Breton University. - Tobacco-User Hotline. - NS Schizophrenic Society. - Mental Health. - YWCA (Pre-natal/Post-partum). - U of Vermont Psychology department. - Indigo program. - Partnership with the First Nations strengthens each time work is done together. - School Quit programs. - Teen Health Centres. - Shared-service partnership. - Doctors and health care workers. - Telehealth Advisory Committee.
4.16 New and strengthened partnerships for tobacco control within ethno-cultural networks	Document review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health Focus Group: NGOs	- ACT materials being refined for use with First Nations. - Work with ethno-cultural groups is considered a gap area. - Preston / North Dartmouth African-Canadian populations. - GLBTI Groups. - Indirectly, through work with Acadia University, which has a culturally diverse population. - Strong work with First Nations' communities through the First Nations / Public Health Services Tobacco Reduction Committee and individually through most DHAs / SSAs.
4.17 New and strengthened community leadership for tobacco control	Document review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public	- Mayor of Wolfville. - Tobacco Free Sport. - Canadian Cancer Society. - Capital Health lead by example with their own staff. - Specific municipalities have been taking the lead in developing smoke-free policies and bylaws, such as New Glasgow, Berwick as well as Wolfville. - Smoke-Free Kings. - Industry and businesses, such as Michelin with it's plans to go smoke-free in 2007

Indicator	Data Collection Method	Findings
	Health Focus Group: NGOs	- Community College. - Tri-County Women's Centre.
4.18 DHA tobacco strategies developed and implemented to support provincial strategy	Document review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health Focus Group: NGOs	- All districts report developing a strategy. - In each case, the district strategy is linked to the provincial strategy through use of the same components. - A number of district strategies have been developed in 2001 to 2003 but never revised since. At least one is still in draft form. - There has been some indication that development of a strategy, at least in one case, was done mostly for access to funding.

Table XIV: Youth Smoking Prevention Indicators

Indicator	Data Collection Method	Findings
Process Measures		
How did the Provincial Youth Tobacco Advisory Committee support smoking prevention and cessation among youth?		
5.1 Number and type of activities of the Provincial Youth Tobacco Advisory Committee	Interview: HPP staff	- There was an application process for youth to come and put their names forward to be on this committee but it was extremely labour intensive to organize and there was insufficient resources to sustain it. - Youth who come to a provincial committee can't represent the province and where real action happens is at the community level. - Overall, it was not an effective means for youth engagement. Youth should be engaged at the community level and in fact, many district health authorities have done that.
Was school smoking prevention curriculum supplement implemented?		
5.2 Number of teachers in-serviced on youth smoking prevention (curriculum supplement and effective prevention strategies)	Document Review: • Data provided by DHAs Interviews: HPP staff	- Training on 'No More Butts' program. - Information sessions on 'You Choose' program and 'Smoke Free for Life' held with teachers. - Not all districts were able to in-service English teachers, although offers were

Indicator	Data Collection Method	Findings
	Interviews: DHA staff	made. - Currently engaged with PDR leads, training on tobacco control has been provided - Training provided to teachers involved with 'Teens Tackle Tobacco'. - Elementary Health Curriculum Implementation Team Leaders from all school boards in Nova Scotia re Smoke Free for Life. - KATS training (teacher advisors – 19).
5.3 Extent of implementation of curriculum supplement as planned	Document Review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA staff	- They are considered add-ons, they're not a requirement to the regular curriculum and they're not consistently used across the province. - There is some question whether updating current curricula would be cost-effective in the light of the legislation that has since been introduced.
5.4 Barriers and facilitators to curriculum supplement implementation	Document Review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA staff	Barriers: - Safety issues in eliminating smoking areas resulting in students moving off school grounds to smoke. - Concerns of increased drug use, sex or violence when students move off school grounds to smoke. - Parents do not always buy-in to school-based attempts at tobacco control. - Schools do not always appreciate the link between tobacco use and the Health Promoting Schools Initiative. - Not always clear who in a particular school board has responsibilities for smoking-related issues. - Curricula do not always reach the most appropriate teachers. - Teachers have conflicting curricula demands for their time. - A lack of understanding of what barriers the teachers experience. - Possible barrier with 'You Choose' program was uneasiness of English (Language Arts) teachers to take on this curricula. - Uncertainty with whether teachers are using curricula or how they are using it. - When teachers move on, there is questions about whether they take the curricula material with them. - A lack of evaluation information regarding the curricula and supporting material - The use of 'one-of' sessions. - Curricula may be considered add-ons in many cases and not implemented well. Facilitators: - Good relationships between schools and tobacco control staff, in at least a couple of instances, community committees including both tobacco control staff and

Indicator	Data Collection Method	Findings
		school board members provide a common voice regarding a number of issues, including tobacco control. - A mature communications network between school boards and the schools. - At least one school board has developed a Health Promotion Facilitator role. - When the curricula meets national curricula standards. - Experience of teachers, particularly PDR teachers in applying curricula. - Direct backing of the school board for delivery of the curricula. - School sports policies regarding tobacco use.
5.5 Teacher satisfaction with curriculum supplement	Curriculum supplement survey/interviews	- Not available.
5.6 Student satisfaction with curriculum supplement	Curriculum supplement survey/interviews	- Not available.
Were school smoking cessation programs developed (adapted) and implemented?		
5.7 Number and type of youth tobacco cessation programs	Document Review: • Data provided by DHAs Interviews: HPP staff	- 'No More Butts' in high-schools. - Some, not all, schools have other cessation programs administered by DHAs (e.g., Teen Health Centres).
5.8 Number and characteristics of youth participating in cessation "support"	Document Review: • Data provided by DHAs Interviews: HPP staff	- Not available.
5.9 Participant satisfaction (in youth cessation)	Document Review: • Data provided by DHAs Interviews: HPP staff	- Not available.
5.10 Program effectiveness (reduction or cessation – see outcomes)	Cessation program survey	- See outcomes. - 'No More Butts' considered unsuccessful, perhaps due to inconsistent expectations regarding 'success'. - Treatment using Nicotine Replacement Therapy is sporadic and inconsistent due to a lack of research regarding it's use with youth. Many manufacturers do not recommend use by youth under 19.
Was information for youth (re: smoking) developed and posted on the government website?		
5.11 Number and type of information on government website	Document review: Review of web site	- No More Butts! Implementation information is available from the HPP page, although generic information about the program is not.

Indicator	Data Collection Method	Findings
		- Sick of Smoke Web site has material designed for youth (including the look & feel of the site) but nothing that specifically indicates that it is youth oriented. - You Choose – youth directed tobacco-control media ads and english program curricula. - Gotta Quit – Designed / Targeted for youth.
5.12 Number and type of links (e.g. to schools sites and curriculum)	Document review: Review of web site	- - You Choose – youth directed tobacco-control media ads and English program curricula. - *(Note: There is very little information available re curricula, no links to NS schools, and little evidence of any partnership between HPP and DoE)*
5.13 Participant satisfaction with the information including usefulness of the information	Website survey	- Not available.
Were school-based tobacco policy guidelines developed and used?		
5.14 Development of school-based tobacco policy guidelines	Document Review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health Focus Group: NGOs	- School policy guidelines developed at time of first implementation of Smoke-Free Places Act. - Implementation of guidelines has been uneven with decisions regarding individual schools made by principals. - Implementation has been and continues to be dependent on the level of interest within individual schools.
5.15 Extent of dissemination of school-based tobacco policy guidelines	Document Review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health Focus Group: NGOs	- Guidelines were disseminated to all school boards, which provided guidelines to individual schools.
5.16 Extent of use of guidelines by schools in policy development	Policy survey/interviews with	- Not available.

Indicator	Data Collection Method	Findings
and support	School Administration	
Was public awareness and support for legislation (N.S. Tobacco Access Act) created?		
5.17 Type and extent of campaigns to increase awareness and garner support for legislation	Interviews: HPP staff	- No campaigns were conducted regarding youth possession legislation.
5.18 Reach of awareness campaign	Survey	- Not available.
5.19 Recall about awareness campaign	Survey	- Not available.
Was the legislation enforced?		
5.20 Number and type of monitoring and enforcement activities	Interviews: HHP staff	- Limited resources for tobacco control among peace officers who are responsible for enforcement have hampered enforcement of youth possession legislation.
Planned Outcome		
5.21 Enhanced prevention services for youth (e.g. curriculum supplement implemented; information on the website)	Document Review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health Focus Group: NGOs	- Social marketing for youth has been enhanced. - Preventative messaging from tobacco control staff in schools has enhanced marketing as well. - Youth groups in schools have been supported. - Smoke-free places legislation is considered one of the greater enhancements to prevention services. - Youth Tobacco Action Teams have been a very positive force for prevention. - Teen Health Centres have been strengthened and are promoting and performing social messaging. - Some Jr High prevention programs as well, although not consistent across province. - However, some districts have expressed a concern that funding and other resources may not be present to sustain youth prevention opportunities.
5.22 Enhanced nicotine treatment/cessation services for youth	Document Review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health	- Insufficient research has been conducted on youth cessation or treatment programs - Although smoking rates have dropped it is uncertain whether that is due to cessation or to prevention. - Some school-based programs offering funding for NRTs have shown success. - Majority of Youth programs are school-based and are not reaching youth not in school, which is a high-risk group in terms of tobacco use. - Treatment for youth has not been the priority that prevention has been.

Indicator	Data Collection Method	Findings
	Focus Group: NGOs	
5.23 30% of youth that complete a cessation support program will not be smoking at a 1 month follow-up	Document Review: Data provided by DHAs	- Not available.
5.24 The percentage of smokers (ever smokers) aged 15 to 19 who are thinking about quitting will increase from 33% to 40%	Document Review: CTUMS summary	- 70%
5.25 All schools in Nova Scotia implement and enforce 100% smoke-free schools & schoolground policy by 2005	Document Review: • Data provided by DHAs Interviews: HPP staff Interviews: DHA Staff Focus Groups: Directors Addiction Services and Public Health Focus Group: NGOs	- Majority of schools are enforcing 100% smoke-free schools policy. - Safety concerns remain a large issue hampering enforcement. - Schools also have other concerns that they consider a greater priority than enforcing smoke-free policy. - Teachers felt not to be responsible for enforcement. - Enforcement seems easier, or at least more complete, in urban settings. - Schools have traditionally not had repercussions for not enforcing smoke-free policies.
5.26 Sales to minors compliance rate is increased from 67% to 80% by 2004	Document Review: HPP data (Tobacco Inspection Reports)	- 77.1% in 2004. - 79.1% in 2005.

Table XV: Media and Public Awareness Indicators

Indicator	Data Collection Method	Findings
Process Measures		
Was a comprehensive media strategy developed?		
6.1 Number and type of television and print ads developed and implemented for tobacco control	Document review	- Specific lists are not available. - Smoke Free Around Me media campaign was conducted twice. - Comprehensive media strategy was developed and included a variety of tactics based on research: - Television, print, radio ads.

Indicator	Data Collection Method	Findings
		- Posters, transit shelter ads. - SickOfSmoke website.
6.2 Reach of media activities	Survey	- Not available.
6.3 Message recall by public related to the media activities	Nova Scotia Comprehensive Tobacco Control Campaign Report (Presentation)	- Television: 73% in year 1, 83% in year 2. - Print: 16% in year 1. - Focus groups with youth indicated high degree of recall in 2005.
6.4 Number and type of promotional materials produced	Document review	- Brochures. - Window Clings. - Posters. - Numbers unknown.
6.5 Number and type of promotional materials distributed, characteristics of recipients, recipient satisfaction	Document review	- Not .vailable.
6.6 Number and type of information on government website for tobacco control	Document review: • Review of web site	- The only specific information on the web page is about the Tobacco Control Strategy itself, with little information about tobacco control actions, opportunities or services.
6.7 Number and type of links related to tobacco control	Document review: • Review of web site	- The community groups (CNS, LANS, HSF, Smokefree NS) have information on tobacco control. Beyond links to the Strategy, a progress report, the links indicated above, and vague links to one curriculum, the HPP site does not contain much in the way of tobacco control. Smokefree NS is the site that contains the majority of tobacco control information.
6.8 Number and type of media coverage for the Strategy	Document review	- Not .available.
Planned Outcome		
THE FIRST FIVE OUTCOMES ARE OUTCOMES RELATED TO OTHER SECTIONS		
6.9 Percentage of Nova Scotians who think second-hand is a significant cause of health problems will increase from 48% to 75% by 2005	Public opinion poll	- Not available.

Indicator	Data Collection Method	Findings
6.10 The percentage of smokers who make at least one quit attempt in the previous 12 months will increase from 45% to 55% by 2004	Document review: - CTUMS summary	- 56%
6.11 The percentage of smokers (ever smokers) who are thinking about quitting (in the previous 12 months) will increase from 19% to 25% by 2004	Document review: - CTUMS summary	- 65%
6.12 The percentage of smokers (ever smokers) who are preparing to take action (in the previous 12 months) will move from 7% to 15% by 2004	Document review: - CTUMS summary	- Not available.
6.13 Increase (over time) in number of users of the 1-800 services who report that they called for assistance because of media messages (baseline is not currently available as 1-800 is not yet implemented)	Document Review: Smokers HelpLine Quarterly Report June 2005 (Tab 5 in binder	- Increase difficult to determine due to lack of a baseline – reported figures represent several years of data. - ~30% contacted SHL because of a television ad. - ~12% contacted SHL because of a print ad.

Table XVI: Monitoring and Evaluation Indicators

Indicator	Data Collection Method	Findings
Process Measures		
Was an evaluation working group created and were process and outcome indicators developed?		
7.1 Creation of evaluation working group	Document review: 2002 evaluation	- An advisory committee was created. There is no indication that a more permanent working group was developed.

Indicator	Data Collection Method	Findings
	framework	
7.2 Evaluation framework developed by March 2002	Document review: 2002 evaluation framework	- This evaluation is using indicators from this evaluation framework. There are a number of indicators for which there are no data available.
Were quantitative and qualitative databases and a monitoring system for process and outcome evaluation developed and maintained?		
7.3 Type and amount of resources allocated to the evaluation – e.g. $$, staff, etc.	Interviews: HPP staff Interviews: DHA staff Focus groups: Directors of Addiction Services and Public Health	- Three types of monitoring and evaluation are performed; outcome monitoring of Addictions Services clients, evaluation of specific initiatives, and progress reporting by coordinators at the district level. These three types are tied together through the individual efforts of personnel and are not typically united in an evaluation framework. - Most DHAs / SSAs have constructed a logic model based on the local strategies, which are in turn based on the provincial strategy in terms of components. Outcomes are then reported regarding these components. Although similarities exist due to the common origins of strategies, these logic models and the resulting reports have not been consolidated and contain inconsistencies. - Generally, 10% of resources are intended to be allocated to evaluation, but typically, unless part of a specific funded initiative, evaluation receives very little effort as program delivery is considered the higher priority. - Effective follow-up of cessation program clients can and often does require greater than 10% effort and may actually cost more than the treatment. - Some specific initiatives are intended to have 25% of budget allocated for evaluation. - There are districts where the Community Outreach Workers are supported by administrative staff who perform treatment follow-up surveys. - In many cases, the amount of actual effort dedicated to monitoring and evaluation of tobacco control is not documented separately from other quality or research efforts.
7.4 Number, type and description of databases	Interviews: HPP staff	- Addiction Services Outcome Monitoring Systems are used almost exclusively for cessation rates; follow-up at 3, 6, and 12 months. - Smokers' Helpline evaluation reports are developed based on follow-up surveys. - Data collected within a district is kept locally. - CTUMS is used, but does not provide sufficient granularity to inform district staff.
7.5 Description of data methods and sources	Interviews: HPP staff	- Despite an evaluation framework for the Strategy, there does not appear to be an overall plan for the collection and analysis of data to support day-to-day evaluation of actions in a consistent manner across the province. Each SSA does this separately.

Indicator	Data Collection Method	Findings
Were data results, reports disseminated?		
7.6 Number and type of reports, briefings, scientific publications produced from the database	Interviews: HPP staff Interviews: DHA staff	- Yearly reports from Outcome Monitoring System. - CTUMS reports are made available, but reflect the entire province rather than districts. - Provincial evaluations (e.g., No More Butts evaluation report) are distributed, but are often considered limited. - Canadian Health Survey results has been distributed. - Tobacco inspection reports. - Reports / Evaluations from other districts are typically shared.
7.7 Number and type of materials (e.g. reports, briefings, etc.) disseminated and target groups (e.g. decision-makers, professionals, public, media)	Interviews: HPP staff Interviews: DHA staff	- Not available.
Were data translated into practical information?		
7.8 Number and type of publications prepared	Interviews: HPP staff Interviews: DHA staff	- Not fully available. - It appears that there is no standard format for reporting to HPP, and it is somewhat difficult to perform an accurate comparative analysis on the data reported.
7.9 Number and type of information provided to media	Interviews: HPP staff Interviews: DHA staff	- Not available.
7.10 Number and type of presentations, seminars to public, health professionals, policy-makers, etc.	Interviews: HPP staff Interviews: DHA staff	- See Community-Based programming.
Planned Outcome		
7.11 Baseline data is collected	Interviews: HPP staff	- Although data is collected, there is little consolidation of it to form baselines. - Evaluations of initiatives often do not collect baseline data prior to initiative implementation.
7.12 Development and utilization of databases	Interviews: HPP staff	- Databases are developed at the local level, but there is little evidence of consolidation other than the Outcome Monitoring System.
7.13 Continuous update and improvement of the Strategy	Interviews: HPP staff	- Anecdotal evidence suggests that the evaluation program is not sufficiently mature to accurate reflect lessons learned and best practices required for the informed improvement of strategies either at the provincial or the district levels.

Indicator	Data Collection Method	Findings
7.14 Evaluation report produced every two years	Interviews: HPP staff	- Progress reports have been developed.

Appendix 2 – Data Collection Tools

Nova Scotia Tobacco Strategy Evaluation
Interview Questions for District Health Authority Staff
Directly Associated with Tobacco Issues

Thank you very much for taking the time to participate in an interview to support the 2006 evaluation of the provincial Tobacco Strategy. Pyra Management Consulting Services Inc. is conducting the evaluation on behalf of the Department of Health Promotion and Protection. The information from the interviews that we are conducting with many stakeholders will form part of the data that we will analyze in support of the evaluation.

For the purpose of the interview, we are specifically focusing on the time period from January 2004 to June 2006.
We are also using this opportunity to ask people for their thoughts about priorities for the renewal of the provincial Tobacco Strategy.

Participation in the interview is voluntary and all information that you provide will be kept confidential. Your answers will not be associated with your name in any written reports. The responses that you provide will only be reported together with all other responses, and although individual responses may be used as quotations, you will not be identified.

For your information, the questions that you will be asked during the interview are listed below. If you have any questions about the interview, please do not hesitate to contact John or Karen at (902) 633-2929.

INTERVIEW QUESTIONS

1. **Has your District or Shared Service Area developed a tobacco strategy? If so, when was it developed? Is it linked to the provincial Strategy? If so, how?**

<u>Second Hand Smoke</u>

2. **Over the past 2.5 years, what activities took place in your District or Shared Service Area to**

increase knowledge about the effects of second hand smoke?

3. **What type and how many informational materials about second hand smoke have been distributed within your District or Shared Service Area?**

4. **What do believe was the most effective approach or activity implemented as part of the tobacco strategy to increase knowledge about the effects of second hand smoke?**

Treatment and Cessation

5. **What types of activities are offered in your District or Shared Service Area to support nicotine treatment and smoking cessation? How effective were these activities? How did you measure effectiveness?**

6. **Thinking particularly about youth now, overall, would you agree that the Tobacco Strategy has resulted in enhanced nicotine treatment/cessation services for youth? If so, please give examples of ways in which youth treatment and cessation services have been enhanced. If not, what could have been done differently to better enhance youth treatment and cessation services?**

7. **Did your District or Shared Service Area provide training to health care providers about brief interventions for smoking cessation? If yes, about how many people were trained? How effective were the training sessions? How was effectiveness measured?**

8. **What type of media and communication activities about nicotine treatment and/or smoking cessation have been undertaken in your District or Shared Service Area?**

9. **In your experience, how effective has the smokers help line been? Please explain your answer.**

Youth Smoking Prevention

10. **Has your district provided any in-service training for teachers on the youth smoking prevention curriculum? If so, how many teachers participated?**

11. **What would you say are the major barriers and facilitators to the implementation of youth smoking prevention curricula in schools?**

12. **To your knowledge, were guidelines for developing school-based tobacco policies developed as part of the Tobacco Strategy? If so, how were these guidelines disseminated within your District or Shared Service Area?**

13. **To your knowledge, are all of the schools located within your District or Shared Service Area implementing and enforcing 100% smoke-free schools and school ground policies? If NOT, what do you believe are the major reasons why some schools have not implemented or enforced 100% smoke free policies?**

14. **Overall, would you agree that the Tobacco Strategy has resulted in enhanced tobacco <u>prevention</u> services for youth? If so, please give examples of ways in which youth prevention services have been enhanced. If not, what could have been done differently to better enhance youth prevention services?**

<u>Community-Based Programming</u>

15. **When you think about the last 2.5 years, have there been any new or strengthened community-based initiatives for tobacco control in your district? If, so, please briefly describe them**.

16. **When you think about the last 2.5 years, have there been any new or strengthened partnerships or coalitions for tobacco control in your district? If, so, please briefly describe them.**
    If YES:
    - **Do any of these new partnerships or coalitions involve ethno-cultural organizations? If so, please describe the partnership and the organizations involved.**

17. **When you think about the last 2.5 years, would you say that any new or strengthened community leadership related to tobacco control has emerged in your in your District or Shared Service Area? If, so, please briefly describe.**

18. **Did your District or Shared Service Area offer any community-capacity-building opportunities related to tobacco control over the past two and a half years?**
    If YES:
    - **Please describe these activities.**
    - **How many people participated in the activities?**
    - **What type of people attended these activities? For example, were they representatives of non-government organizations, members of the general public, or health professionals? How would you characterize the participants?**
    - **How satisfied were people with the activities? How did you measure satisfaction?**
    - **Have participants applied the knowledge and skills they gained by participating in the activity? If so, how? How do you know?**

Evaluation and Future Directions of the Tobacco Strategy

19. **What type of evaluation activities related to the tobacco strategy have been undertaken in your District or Shared Service Area over the past 2.5 years?**

20. **What would you estimate to be the resources allocated to Tobacco Strategy evaluation activities in your District or Shared Service Area, both in terms of dollars and staff time**?

21. **Have you received reports or other results of evaluation or monitoring activities? If so, were these of use to you?**

22. **Finally, as you know, the provincial Tobacco Strategy is undergoing a renewal process. From your perspective, what you believe are the most important priorities for tobacco control in Nova Scotia over the next three to five years? When you think about priorities, you may wish to refer to the components of the current Tobacco Control Strategy, which are:**
    - **Pricing and taxation**
    - **Smoke-free legislation and policy**
    - **Treatment and cessation**
    - **Community-based programming**
    - **Youth smoking prevention**
    - **Media and public awareness**
    - **Monitoring and evaluation**

Nova Scotia Tobacco Strategy Evaluation

Interview Guide for Health Promotion and Protection Staff

Directly Associated with Tobacco Issues

Thank you very much for taking the time to participate in an interview to support the 2006 evaluation of the provincial Tobacco Strategy. Pyra Management Consulting Services Inc. is conducting the evaluation on behalf of the Department of Health Promotion and Protection. The information from the interviews that we are conducting with many stakeholders will form part of the data that we will analyze in support of the evaluation.

For the purpose of the interview, we are specifically focusing on the time period from January 2004 to June 2006.

We are also using this opportunity to ask people for their thoughts about priorities for the renewal of the provincial Tobacco Strategy.

Participation in the interview is voluntary and all information that you provide will be kept confidential. Your answers will not be associated with your name in any written reports. The responses that you provide will only be reported together with all other responses, and although individual responses may be used as quotations, you will not be identified.

For your information, the questions that you will be asked during the interview are listed below. If you have any questions about the interview, please do not hesitate to contact John or Karen at (902) 633-2929.

INTERVIEW QUESTIONS

1. **Have all Districts or Shared Service Areas developed a tobacco strategy? If so, were they developed in a timely manner? Are all such strategies linked to the provincial strategy? If so, how?**

Pricing and Taxation

2. **Has there been consultative awareness activities related to pricing and taxation? If so, please describe them.**

3. **What kind of resources have been dedicated to pricing and taxation?**

4. **Has the tax increase of $8 per carton of cigarettes that was achieved in 2001 been maintained?**

5. **Are tobacco tax rates equal across all tobacco products?**

Second Hand Smoke

6. **Over the past 2.5 years, what activities took place in your District or Shared Service Area to increase knowledge about the effects of second hand smoke?**

7. **What type and how many informational materials about second hand smoke have been distributed?**

8. **What type and how many other awareness activities of a consultative nature have been completed? Please describe them. How effective have these activities been? How was effectiveness determined?**

9. **What types of social marketing activities have been implemented to garner public support? Please describe them. How effective have these activities been? How was effectiveness determined?**

10. **What do believe was the most effective approach or activity implemented as part of the tobacco strategy to increase knowledge about the effects of second hand smoke?**

Smoke-free workplaces and public places legislation

11. **Were all Nova Scotians covered by legislation providing 100% smoke-free places (workplaces and public places) by 2003?**

12. **Has legislation been enforced? If so, what types of monitoring and enforcement activities are performed? If not, what barriers are there to enforcement?**

Treatment and Cessation

13. **What type of media and communication activities about nicotine treatment and/or smoking cessation have been undertaken?**

14. **In your experience, how effective has the smokers help line been? Please explain your answer.**

15. **What kinds and how many youth smoking cessation programs have been implemented? How many youth are participating in these programs? What groups do they come from? How satisfied are the participants with the programs? How is that satisfaction measured?**

16. **Would you agree that the Tobacco Strategy has resulted in enhanced nicotine treatment/cessation services for youth? If so, please give examples of ways in which youth treatment and cessation services have been enhanced. If not, what could have been done differently to better enhance youth treatment and cessation services?**

Youth Smoking Prevention

17. **How did the Provincial Youth Tobacco Advisory Committee support smoking prevention and cessation among youth? What kind of activities has the advisory committee undertaken?**

18. **Have districts provided any in-service training for teachers on the youth smoking prevention curriculum? If so, how many teachers participated?**

19. **To what extent has the curricula been implemented? What would you say are the major barriers and facilitators to the implementation of youth smoking prevention curricula in schools?**

20. **To your knowledge, were guidelines for developing school-based tobacco policies developed as part of the Tobacco Strategy? If so, how were these guidelines disseminated?**

21. **What kind and how many public awareness campaigns for youth possession legislation were created? How effective were these campaigns? How was effectiveness measured?**

22. **Has the youth possession legislation been enforced? What means have been used for enforcement? How effective has enforcement been? How has effectiveness been measured?**

23. **To your knowledge, are all of the schools located within your District or Shared Service Area implementing and enforcing 100% smoke-free schools and school ground policies? If NOT, what do you believe are the major reasons why some schools have not implemented or enforced 100% smoke free policies?**

24. **Overall, would you agree that the Tobacco Strategy has resulted in enhanced tobacco prevention services for youth? If so, please give examples of ways in which youth prevention services have been enhanced. If not, what could have been done differently to better enhance youth prevention services?**

Community-Based Programming

25. **Was a motivational conference successfully planned and delivered? Can you describe it? How many and what kinds of participants took part in the conference? How satisfied were they with the conference? How was that measured?**

26. **How many tobacco coordinators were hired throughout the province? When were they hired and in place?**

27. **What sort of assistance, if any, was provided through the Department of Health?**

28. **When you think about the last 2.5 years, have there been any new or strengthened community-based initiatives for tobacco control in your district? If, so, please briefly describe them**.

29. **When you think about the last 2.5 years, have there been any new or strengthened partnerships or coalitions for tobacco control in your district? If, so, please briefly describe**

them.

If YES:

- **Do any of these new partnerships or coalitions involve ethno-cultural organizations? If so, please describe the partnership and the organizations involved.**

30. **When you think about the last 2.5 years, would you say that any new or strengthened community leadership related to tobacco control has emerged? If, so, please briefly describe.**

31. **Have the Districts or Shared Service Areas offered any community-capacity-building opportunities related to tobacco control over the past two and a half years?**

    If YES:

    - **Please describe these activities.**
    - **How many people participated in the activities?**
    - **What type of people attended these activities? For example, were they representatives of non-government organizations, members of the general public, or health professionals? How would you characterize the participants**?
    - **How satisfied were people with the activities? How did you measure satisfaction?**
    - **Have participants applied the knowledge and skills they gained by participating in the activity? If so, how? How do you know?**

Evaluation and Future Directions of the Tobacco Strategy

32. **Were quantitative and qualitative databases and a monitoring system for process and outcome evaluation developed and maintained? If so, please describe them, the data methods, and data sources**

33. **What type of evaluation activities related to the tobacco strategy have been undertaken in your District or Shared Service Area over the past 2.5 years?**

34. **What would you estimate to be the resources allocated to Tobacco Strategy evaluation activities in your District or Shared Service Area, both in terms of dollars and staff time**?

35. **Have you received reports or other results of evaluation or monitoring activities? If so, were these of use to you?**

36. **Were databases developed with baseline data included? Are databases being maintained and used?**

37. **Finally, as you know, the provincial Tobacco Strategy is undergoing a renewal process. From your perspective, what you believe are the most important priorities for tobacco control in Nova Scotia over the next three to five years?**

    - Pricing and taxation
    - Smoke-free legislation and policy
    - Treatment and cessation

- Community-based programming
- Youth smoking prevention
- Media and public awareness
- Monitoring and evaluation

Nova Scotia Tobacco Strategy Evaluation

Focus Group Questions for Directors of Addiction Services and Directors of Public Health

Thank you very much for taking the time to participate in a focus group to support the 2006 evaluation of the provincial Tobacco Strategy. Pyra Management Consulting Services Inc. is conducting the evaluation on behalf of the Department of Health Promotion and Protection. The information from the focus groups that we are conducting will form part of the data that we will analyze in support of the evaluation.

For the purpose of the focus group, we are specifically focusing on the time period from January 2004 to June 2006.
We are also using this opportunity to ask people for their thoughts about priorities for the renewal of the provincial Tobacco Strategy.

Participation in the focus group is voluntary and all information that you provide will be kept confidential. Your answers will not be associated with your name in any written reports. The responses that you provide will only be reported together with all other responses, and although individual responses may be used as quotations, you will not be identified.

For your information, the questions that you will be asked during the focus group are listed below. If you have any questions about the interview, please do not hesitate to contact John or Karen at (902) 633-2929.

FOCUS GROUP QUESTIONS

Community Based Programming

1. **When you think about the last 2.5 years, have there been any new or strengthened community-based initiatives for tobacco control implemented? If, so, please briefly describe them.**

2. **When you think about the last 2.5 years, have there been any new or strengthened partnerships or coalitions for tobacco control developed? If, so, please briefly describe them.**

If YES:

- **Do any of these new partnerships or coalitions involve ethno-cultural organizations? If so, please describe the partnership and the organizations involved.**

3. **When you think about the last 2.5 years, would you say that any new or strengthened community leadership related to tobacco control has emerged? If so, please briefly describe.**

Youth Smoking

4. **To your knowledge, were guidelines for developing school-based tobacco policies developed as part of the Tobacco Strategy? If so, how were these guidelines disseminated?**

5. **Overall, would you agree that the Provincial Tobacco Strategy has resulted in enhanced tobacco prevention services for youth? If so, please give examples of ways in which youth prevention services have been enhanced. If not, what could have been done differently to better enhance youth prevention services?**

6. **To your knowledge, are all schools implementing and enforcing 100% smoke-free schools and school ground policies? If NOT, what do you believe are the major reasons why some schools have not implemented or enforced 100% smoke free policies?**

7. **Overall, would you agree that the Provincial Tobacco Strategy has resulted in enhanced nicotine treatment/cessation services for youth? If so, please give examples of ways in which youth treatment and cessation services have been enhanced. If not, what could have been done differently to better enhance youth treatment and cessation services?**

Evalutions and Future Directions of Provincial Strategy

8. **What type of evaluation activities related to the tobacco strategy have been undertaken over the past 2.5 years?**

9. **What would you estimate to be the resources allocated to Tobacco Strategy evaluation activities, both in terms of dollars and staff time?**

10. **How is your District or Shared Service Area Tobacco Strategy linked to the provincial strategy?**

11. **Finally, as you know, the provincial Tobacco Strategy is undergoing a renewal process. From your perspective, what do you believe are the most important priorities for tobacco**

control in Nova Scotia over the next three to five years? When you think about priorities, you may wish to refer to the components of the current Tobacco Control Strategy, which are:

- **Pricing and taxation**
- **Smoke-free legislation and policy**
- **Treatment and cessation**
- **Community-based programming**
- **Youth smoking prevention**
- **Media and public awareness**
- **Monitoring and evaluation**

Nova Scotia Tobacco Strategy Evaluation
Focus Group Questions for Non-Government Organizations Directly Associated with Tobacco Issues

Thank you very much for taking the time to participate in a focus group to support the 2006 evaluation of the provincial Tobacco Strategy. Pyra Management Consulting Services Inc. is conducting the evaluation on behalf of the Department of Health Promotion and Protection. The information from the focus groups that we are conducting will form part of the data that we will analyze in support of the evaluation.

For the purpose of the focus group, we are specifically focusing on the time period from January 2004 to June 2006.
We are also using this opportunity to ask people for their thoughts about priorities for the renewal of the provincial Tobacco Strategy.

Participation in the focus group is voluntary and all information that you provide will be kept confidential. Your answers will not be associated with your name in any written reports. The responses that you provide will only be reported together with all other responses, and although individual responses may be used as quotations, you will not be identified.

For your information, the questions that you will be asked during the focus group are listed below. If you have any questions about the interview, please do not hesitate to contact John or Karen at (902) 633-2929.

FOCUS GROUP QUESTIONS

Community Based Programming

1. **When you think about the last 2.5 years, have there been any new or strengthened community-based initiatives for tobacco control implemented? If, so, please briefly describe them.**

2. **When you think about the last 2.5 years, have there been any new or strengthened partnerships or coalitions for tobacco control developed? If, so, please briefly describe them.**

If YES:

- **Do any of these new partnerships or coalitions involve ethno-cultural organizations? If so, please describe the partnership and the organizations involved.**

3. **When you think about the last 2.5 years, would you say that any new or strengthened community leadership related to tobacco control has emerged? If so, please briefly describe.**

Youth Smoking

4. **To your knowledge, were guidelines for developing school-based tobacco policies developed as part of the Tobacco Strategy? If so, how were these guidelines disseminated?**

5. **Overall, would you agree that the Provincial Tobacco Strategy has resulted in enhanced tobacco prevention services for youth? If so, please give examples of ways in which youth prevention services have been enhanced. If not, what could have been done differently to better enhance youth prevention services?**

6. **To your knowledge, are all schools implementing and enforcing 100% smoke-free schools and school ground policies? If NOT, what do you believe are the major reasons why some schools have not implemented or enforced 100% smoke free policies?**

7. **Overall, would you agree that the Provincial Tobacco Strategy has resulted in enhanced nicotine treatment/cessation services for youth? If so, please give examples of ways in which youth treatment and cessation services have been enhanced. If not, what could have been done differently to better enhance youth treatment and cessation services?**

DHA Strategies and Future Directions of Provincial Strategy

8. **How is your District or Shared Service Area Tobacco Strategy linked to the provincial strategy?**

9. **Finally, as you know, the provincial Tobacco Strategy is undergoing a renewal process. From your perspective, what do you believe are the most important priorities for tobacco control in Nova Scotia over the next three to five years? When you think about priorities, you may wish to refer to the components of the current Tobacco Control Strategy, which are:**
   - **Pricing and taxation**
   - **Smoke-free legislation and policy**
   - **Treatment and cessation**

- **Community-based programming**
- **Youth smoking prevention**
- **Media and public awareness**
- **Monitoring and evaluation**