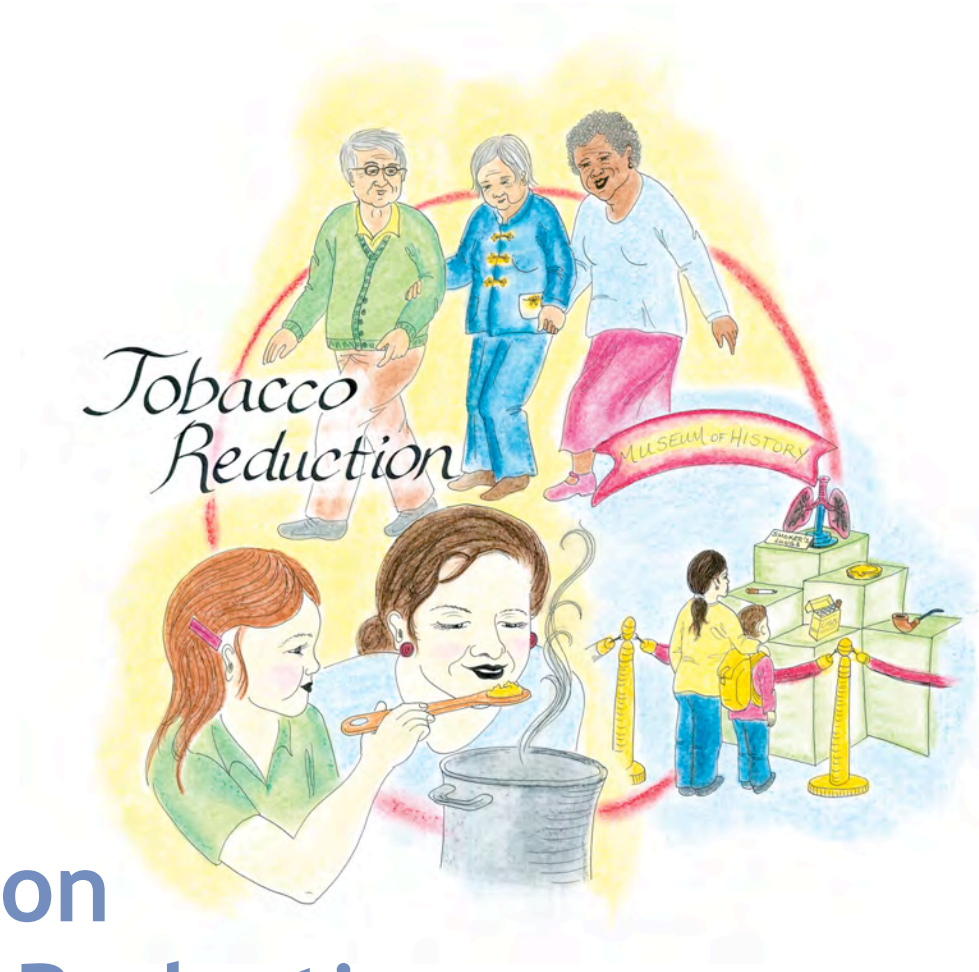

Position on Tobacco Reduction

An Integrated Population Health Approach

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northern health
the northern way of caring

"… Sometimes it feels like this. There I am standing by the shore of a swiftly flowing river, and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who is upstream pushing them all in."

McKinlay, J.; 1979

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1.0 Introduction

This report outlines the position of Northern Health regarding tobacco use. Tobacco use is the most significant contributing factor toward increased rates of "preventable" non-communicable disease and the resulting burden on the healthcare system. Using a population health approach, we will engage with communities and individuals to move toward increased health and wellness. This will be accomplished by advocating and promoting tobacco reduction initiatives which include protection, cessation, enforcement and prevention. We will work with community partners to improve the health, wellbeing and quality of life of those living, working, learning and playing in Northern BC.

2.0 Background

2.1 History of Tobacco Control

Tobacco control is one of the best examples of successful public health interventions. It is well documented that tobacco use rates have decreased significantly over time. In 1965, an estimated 50% of Canadians over the age of 15 years used tobacco. This number was reduced to 24% by 2000 (a 50% reduction in the tobacco-using population over 35 years), and only 17% of the Canadian population use tobacco daily as of 2010. While tobacco control efforts continue to be successful in decreasing tobacco rates, the decline is in much smaller increments, indicating that we are now faced with a harder-to-reach population of Canadian tobacco users.

Canadian tobacco control is successful due to supportive legislation.[i] Looking at the history of tobacco control in Canada (Table 1), we see that before 1988, very little legislation was in place to support tobacco control. However, since 1988, federal and provincial governments have enacted different legislation to support tobacco control initiatives.

Table 1: Benchmarks in Canada and BC's Tobacco Control Legislation[ii,iii]

1908	• *Tobacco Restraint Act* passed (illegal to sell cigarettes to persons under age 16)
1988	• *Tobacco Sales to Young Persons Act* passed (remove tobacco vending machines; illegal to sell or give to persons under age 18) • *Non-Smokers Health Act* passed (federal work places are smoke free; prohibit smoking on aircrafts, ships, and trains) • Cigarette packages must display health warnings
1989	• *Tobacco Products Control Act* passed, replaces *Tobacco Control Act* • Manufacturers must list additives and amounts
1993	• Legal age to purchase cigarettes is increased to age 18
1994	• Cigarette packaging to display new health warning messages
1997	• *Tobacco Act* passed (replace *Tobacco Sales to Young Persons Act* and *Tobacco Products Control Act*)
1999	• Retailers must display signage of legal minimum age to purchase tobacco
2000	• New warning messages for tobacco packaging; warnings must cover ½ of the package
2005	• Supreme Court of Canada says provinces have right to limit tobacco displays • Supreme Court of Canada rules that BC can sue cigarette companies for the cost of treating smoking-related illness dating back 50 years and into the future
2007	• Child Care Licensing Regulation amendment (restricts smoking at community care facilities) • British Columbia *Tobacco Tax Act* enacted (tobacco retailers must apply for a Tobacco Retailer Authorization Certificate for each location tobacco is sold) • Occupational Health and Safety Regulation amendment (govern smoking and second-hand smoke in the workplace)

2008	• British Columbia *Tobacco Control Act* enacted (limits promotion and sale of tobacco products, bans smoking in indoor public and work places, and bans all tobacco use in schools and on school grounds)
2009	• *Community Care and Assisted Living Act* amendment (restricts smoking at community care facilities) • British Columbia *Motor Vehicle Act* amendment (smoking in motor vehicle prohibited when children under the age of 16 are present)
2010	• Kelowna bans smoking on beaches, in parks and across outdoor recreation areas • Vancouver bans smoking on beaches, in parks and across outdoor recreation areas
2011	• Supreme Court of Canada rules that the federal government cannot be liable in lawsuits directed at recovering smoking-related health costs from tobacco companies

2.2 Rates of Use

British Columbia has the lowest tobacco use rate in all of Canada at 14%. Nova Scotia, Manitoba, and Saskatchewan have the highest at 21% (Table 2). However, the tobacco use rate across the Northern Health region is 24% - a rate higher than any other province in Canada. Moreover, within the Northern Health region, the Northwest HSDA has the lowest rate at nearly 21% and the Northeast and Northern Interior HSDAs are at 28% and 23% respectively.

Tobacco use rates should also be considered in the context of regions with similar socio-economic characteristics (i.e. cultures, age, gender and living and working conditions). Following national standards, Northern Health is more comparable to the Northwest Territories, Yukon, northern Alberta, northern Ontario, northern Quebec and Labrador. These rates are presented as 'Peer Group E'[1] and 'Peer Group H'[2] (Table 2). The rates of peer groups are generally higher than the Northern Health HSDAs, except the Northeast HSDA which has use rates comparable to peer groups.

Table 2: Rates of Use in Selected Regions, 2010

Region	% of Population, Current Tobacco Users	
Canada[iv]	**17**	**Province**
Lowest Provincial Rate	**14**	British Columbia
Highest Provincial Rate	**21**	Nova Scotia, Manitoba, Saskatchewan
Northern Health	**24**	
Northeast HSDA[v]	**28**	
Northern Interior HSDA[vi]	**23**	
Northwest HSDA[vii]	**21**	
Other Northern Regions		
Peer Group E[viii]	**29**	
Peer Group H[ix]	**27**	

Note: Canadian and Provincial rates are for the population over the age of 15 years. HSDA and Peer Group rates are for the population over the age of 12 years.

[1] Peer Group E is comprised of the following health regions: Central Zone (AB), North Zone (AB), Northeast HSDA (BC), Northwest Territories, South Eastman Regional Health Authority (MB) and the Yukon.

[2] Peer Group H is comprised of the following health regions: Labrador-Grenfell Regional Integrated Health (NFLD and Labrador), Nor-Man Regional Health Authority (MB), Northern Interior HSDA (BC), Northwest HSDA (BC), Northwestern Health Unit (ON), Parkland Regional Health Authority (MB), Prairie North Regional Health Authority (SK), Prince Albert Parkland Regional Health Authority (SK), Région de la Côte-Nord (QC), and Région du Nord-du-Québec (QC).

Each year, more than 6,000 British Columbians die from tobacco use.[x] Tobacco is not used homogenously in the population. Specific populations tend to have higher rates of tobacco use. In Canada, such groups include Aboriginal populations, those with mental health and addiction diagnoses, blue collar workers and individuals with lower incomes and lower educational attainment.[xi]

Across Northern Health, it could be expected that the high proportion of First Nation communities and other populations that fall into the noted categories contribute to the higher rates across the North. Of particular concern is the availability of lower-cost tobacco on-reserve and the distinction between tobacco misuse and its use for traditional and ceremonial purposes in some First Nation cultures. Tobacco is available at a lower cost as a result of federal legislation exempting First Nation people from tobacco tax. This is a challenge for reducing tobacco use on-reserve; the Canadian average tobacco use rate on-reserve is 59%.[xii]

2.3 Harm and Benefits of Tobacco

2.3.1 Tobacco Users

Tobacco use extends beyond smoking cigarettes to include chewing tobacco, cigars/cigarillos, pipes as well as other types of tobacco (i.e. hookah). Tobacco products contain many carcinogens and irritants, yet the addictive chemical is nicotine.[xiii] Nicotine is a stimulant to the central nervous system and is classified as a drug. Nicotine does not cause cancer. Moreover, nicotine has two benefits. It is an effective antidepressant and appetite suppressant. However, the harm of tobacco use far outweighs the benefits of nicotine.

Tobacco use is the single leading preventable cause of death, disease and disability. [xiv, xv] This year, more than 37,000 Canadians will die prematurely related to tobacco use.[xvi] Evidence suggests that all tobacco users are at increased risk of:

Aortic aneurysm	Asthma	Cancer	Cataracts
Chronic bowel disease (Crohn's Disease)	Chronic bronchitis	Chronic obtrusive pulmonary disease (COPD)	Common cold
Coronary heart disease (heart attacks)	Emphysema	Fertility challenges	Gum disease
High blood pressure	High cholesterol (LDL)	Impotence	Influenza
Peptic ulcers	Peripheral vascular disease (circulatory problems)	Pneumonia	Sleep problems
Thyroid disease (Grave's Disease)	Tooth decay (cavities)	Osteoporosis	

Of particular note, tobacco use is correlated with 15 types of cancer, including: lung, larynx, oral cavity and pharynx, paranasal sinuses, esophagus, stomach, pancreas, liver, kidney, ureter, bladder, uterine cervix, bone marrow, colon and rectum, and mucinous tumours of the ovary.[xvii] Moreover, smoking can negatively impact appearance by causing the skin to wrinkle and cause premature aging as well as reduce the sense of smell and taste.[xviii]

The prevention of tobacco addiction in youth is of particular importance. Evidence suggests that only one or two cigarettes can cause brain changes that induce cravings in youth.[xix] Most youth do not intend to use tobacco into their adult years yet find it

difficult to quit when they attempt. Youth may be setting themselves up for a lifetime of tobacco addiction and withdrawal discomfort.

2.3.2 Environmental Tobacco Smoke

Even those who do not use tobacco products directly can be at risk for the negative health impacts of tobacco through exposure to tobacco smoke in the environment. There is no safe level of exposure. Exposure to environmental tobacco smoke places individuals at an increased risk for some of the same negative health impacts of tobacco use as tobacco users. Pregnant women who are exposed to environmental tobacco smoke are at risk to deliver low birth weight babies and infants exposed are at risk for sudden infant death syndrome.[xx] Children are especially vulnerable to environmental tobacco smoke as a result of an increased breathing rate, a less developed immune system and inability to impact their environment.[xxi]

2.3.3 System Costs

Tobacco use increases the cost of providing health care. Across Canada, tobacco use costs more than $17 billion annually, including $4.4 billion in direct healthcare costs. The indirect costs of tobacco use to the provincial health care system are approximately $2.3 billion annually, including $605 million in direct costs.[xxii]

2.4 Health Benefits of Quitting Tobacco Use

Unless tobacco users quit, nearly half of them will die prematurely as a result of tobacco use. Even while vital, tobacco users commonly have a reduced quality of life as a result of early health impacts. Fortunately, most negative health impacts of tobacco can be minimized and potentially reversed by quitting tobacco use.[xxiii] The effect of quitting has immediate and long term implications for health, such as:

- Within eight hours, carbon monoxide levels in the body decrease and oxygen levels increase.
- After two days, the risk of heart attack decreases and the sense of smell and taste improve.
- After three days, lung capacity increases.
- After the first year, risk of heart attack is cut in half.
- Within 10 years, the risk of dying from lung cancer is cut in half.
- Within 15 years, the risk of dying from a heart attack is equal to that of a person who has never used tobacco.
- Overall, former tobacco users live longer than active tobacco users.

2.5 Tobacco Management

> *Of all possible interventions to reduce illness and death in society from any cause, smoking cessation is among the most cost effective.*
>
> *- Health Canada, 2004*

Tobacco cessation treatments are available. The benefits of tobacco cessation are clear for both individual health and health system costs. Moreover, research shows that the majority of tobacco users would like to quit. However, tobacco use is commonly not a lifestyle choice; it is an addiction.[xxiv] Managing tobacco addiction is complex. It involves a rigorous and systematic approach to support the necessary behaviour change required to overcome tobacco addiction. Tobacco addiction is a chronic, relapsing disease; a biopsychosocial addiction that while complex, is highly treatable.

Comprehensive tobacco cessation programs work to overcome the various elements of addiction and symptoms of withdrawal, including physical, mental, emotional, chemical, and habitual conditions.[xxv] Comprehensive approaches to tobacco cessation, such as the use of counselling and medication, can more than double the opportunity for a tobacco user to quit tobacco.[xxvi] In terms of interventions, there are brief interventions and pharmaceutical interventions. Both will be introduced below. Without intervention (counselling or pharmacotherapy), success is reported at a rate of 10% or less.[xxvii]

2.5.1 Brief Interventions

Brief interventions are defined as a when a clinician addresses a client's tobacco addiction during a direct service interaction. Interactions are typically less than 5 minutes.[xxviii] One of the most cited examples of a brief intervention is the 5A's Approach. When a tobacco user is in the care of a clinician, it is an ideal time to intervene.

The U.S. Public Health Service developed a set of standard guidelines for clinical intervention, including intervention with tobacco users. The **5A's Approach** has been adopted by many organizations across North America as a systematic and longitudinal approach: [xxix]

- **Ask**: identify tobacco users.
- **Advise:** in a clear, strong, and personalized manner and advise every tobacco user to quit.
- **Assess:** is the user ready to try to quit using tobacco? Discuss motivation: what is the relevance of quitting? What are the risks of continuing to use tobacco? What are the rewards of quitting? What are potential solutions to roadblocks? Repeat each visit.
- **Assist:** help the user make plans. Recommend and offer supports, including: pharmacotherapies, programs offering counselling, quit lines and other supportive resources and materials.
- **Arrange Follow-Up**: schedule follow-up, either in-person or on the phone. Provide prevention intervention, including discussing benefits, rewards, congratulations and encouragement to remain abstinent.

2.5.2 Pharmaceutical Interventions

Another proven cessation strategy is the use of pharmacotherapies. Pharmacotherapies may significantly increase the probability of cessation. There are various types available, including nicotine replacement therapies and medications. The success rates are increased with different medications ranging from 19% to 33% (Table 3).

Table 3: Success Rates of Pharmaceutical Interventions[xxx]

Medication	Estimated Abstinence Rates (%)
Placebo	14
Nicotine Patch (6-14 weeks)	23
Nicotine Gum 6-14 weeks)	19
Nicotine Inhaler	25
Bupropion SR	24
Varenicline (1 mg. per day)	25
Varenicline (2 mg. per day)	33

2.5.3 Combined Interventions

The Ottawa Model for Smoking Cessation is a model that has contributed to cessation success. The Model is comprehensive in its approach and integrates brief interventions with pharmacotherapy and support. This model has demonstrated a 15% increase in long-term quit rates at the University of Ottawa Heart Institute (from 29% to 44% at 6 months).[xxxi]

2.5.4 Tobacco Reduction Strategy at Northern Health

Northern Health's existing Tobacco Program utilizes a comprehensive approach to address tobacco use. The strategy applies educational, clinical and regulatory elements organized into four areas: prevention of tobacco initiation, protection from exposure to environmental tobacco smoke, cessation of tobacco use and enforcement of tobacco legislation.[xxxii]. As part of this program, Northern Health has staff in place to deliver this program, including tobacco reduction coordinators, tobacco enforcement officers and nicotine intervention counselling centre staff.[xxxiii] As part of this strategy, Northern Health implemented a Smoke Free Grounds Policy in 2008. This Policy is consistent with Provincial and Municipal legislation that establishes smoke-free public spaces.[xxxiv]

2.5.5 BC Smoking Cessation Program

In September 2011, the Provincial Government initiated the BC Smoking Cessation Program to support people to quit tobacco use by assisting with the costs of smoking cessation medications and providing nicotine replacement therapy (nicotine patch and nicotine gum) at no cost. In addition, the program endorses client use of the QuitNow website for ongoing follow-up and counselling support. There is no planned end date for this program.[xxxv]

2.5.6 Stop Smoking Before Surgery

A program of the BC Cancer Agency, the Stop Smoking Before Surgery initiative encourages partnership between public health initiatives and surgical services. The initiative supports clients to quit tobacco eight weeks prior to surgical procedure. By quitting before surgery, it is documented that clients will likely heal faster, have a reduced risk for infection and potentially require a shorter inpatient stay.[xxxvi] Northern Health Board has endorsed the initiative for planning and implementation across the Northern Region as of December 2011.

2.5.7 Managing Tobacco Legislation Exemptions

Legislation is a key tool in reducing tobacco use. However, legislation can have exemptions which may inhibit its overall effectiveness. For example, BC's *Tobacco Control Act* provides an exemption to persons in care or residents whereby space may be designated for smoking in community care facilities, assisted living residences, and hospitals.[xxxv] Exemptions can pose care and enforcement challenges to health professionals. In some cases, restrictions are only in place for a certain amount of time before compliance is mandatory.[xxxvi] Health authorities can play a key role in managing such exemptions, particularly where they have authority over the space where the exemption is provided. For example, in Mackenzie smoking is not permitted for long term care residents at the hospital. In this case, the Health Authority has the ability to manage the exemption for tighter tobacco control. In addition, health authorities have a responsibility to advocate with partners for stronger and healthier legislation for all residents.

In other cases, there must be consideration for social and cultural norms that may change over time as a result of legislation. For example, as tobacco use is denormalized through legislation, extending the restriction to exempted areas will be more readily accepted (i.e. Long-term care facilities, assisted living residences, multi-family dwellings, and recreational parks). In the future, if fewer people are using tobacco products, those that still use may have increased

motivation to quit. Across Northern Health, our smoking rates are high without effective reduction and prevention strategies and policies for our population.

2.5.8 Targeting Specific Populations

It is important to tailor prevention, cessation, protection and enforcement messages to the target audience. Not all populations are motivated by the same reasons to change. For example, youth are enticed to quit with strong negative emotions that produce a sense of loss, disgust or fear. They are also impacted by personal testimony and graphic descriptions.[xxxvii] There are also gender differences regarding tobacco use, motivations and perceptions of risk.[xxxviii] To effectively promote reduction and cessation, these differences need to be taken into consideration.

3.0 Northern Health Position

Northern Health wants to increase health and wellness and improve quality of life by promoting tobacco reduction and prevention. This will be achieved by working with individuals and community partners to promote the following messages:

- Prevent children and youth from starting to use tobacco.
- Brief interventions should be used by all health professionals during every clinic visit; use the 5A's Approach to identify tobacco users and support them to quit.
- Promote Stop Smoking Before Surgery.
- The health sector will take responsibility to train staff to manage nicotine withdrawal; everyone needs to be involved.
- Protection from second hand smoke; there is no safe level of exposure.
- To reduce tobacco use through prevention, protection cessation and enforcement and focus on comprehensive approaches such as the Ottawa Charter approach.

4.0 Strategies to Achieve this Position

The Ottawa Charter for Health Promotion is an international resolution of the World Health Organization. Signed in Ottawa, Canada in 1986, this global agreement calls for action towards health promotion through five areas of strategic action. In concert, these strategies can create a comprehensive approach to addressing risk factors, such as tobacco use.

This section presents examples that support the five strategic action areas of the Ottawa Charter to achieve the same goals outlined in this position paper. Examples are evidence-based and come from an environmental scan of strategies proven effective in other places.

4.1 Build Healthy Public Policy

A broad range of local, regional, provincial, and federal organizations have a role in building healthy public policies that promote tobacco reduction through prevention, protection, cessation and enforcement. Some examples include:

- Increased cost of tobacco products (i.e. tax or real price increases)
- Smoke-free legislation /bylaws (i.e. Health Canada's Smoke Free Public Spaces)
- Advertising bans and other legislative controls on the tobacco industry
- Funding for mass-media campaigns (i.e. World Lung Foundation's Tobacco Control Mass Media Resources).
- Development of large-scale, comprehensive strategic directions (e.g. Saskatchewan's Strategy for Tobacco Control)

4.2 Create Supportive Environments

People interact with a variety of settings through daily life – settings where they live, work, learn, and play. These settings should be carefully considered when seeking to create supportive environments. Within each of these environments, there is opportunity to support tobacco reduction using examples such as:

4.2.1 Home

- Denormalize tobacco use (i.e. City of Hamilton's Tobacco-Free Living)
- Magnify the personal costs of tobacco use (financial and otherwise, i.e. Cost of Smoking Calculator)
- Intervene with parents/families who smoke in homes with children (i.e. Stop Tobacco Outreach Program)

4.2.2 Work

- Smoke-Free work places (i.e. US Smoke-Free Indoor Air Fact Sheet; Northern Health's Smoke Free Grounds policy)
- Offer programs, supports and activities at the workplace including on-site, during work hours, etc. (i.e. Health Canada's Smoking Cessation in the Workplace)
- Work with community agencies to deliver programs, supports and activities off-site and providing self-help materials (i.e. American Cancer Society's FreshStart)

4.2.3 School

- Youth-focused materials (i.e. Ontario's Ministry of Health Smoke-FX website)
- Partner with educational providers to deliver tobacco prevention and cessation programming (i.e. Washington State's Educational Service District 123's Tobacco Prevention and Cessation Program; Vermont State's NOT on Tobacco, Quit Smoking education for youth)
- Integrate tobacco prevention and cessation within school-based curriculum (i.e. Maryland, USA, Department of Health and Mental Hygiene's Students Against Starting Smoking)

4.2.4 Leisure

- Promote activity and exercise to aid quitting smoking (i.e. Quit and Keep Fit)
- "Train the Trainer" – educate coaches, volunteers, and facility employees regarding tobacco addiction and the importance of cessation
- Seek out examples of communities that have extended smoke-free areas to include parks, outdoor public places and events (i.e. Smoke-Free Calgary).

4.3 Strengthen Community Action

Successful actions to reduce current tobacco use and prevent future tobacco use are planned and implemented through partnerships and collaborations. Often public, private, and non-governmental organizations may be involved at local, regional, provincial, and federal levels. Examples of partnerships that foster community capacity and support tobacco reduction and prevention include:

- Engage with local business and organizations to adopt a coordinated and collaborative approach to the prevention and cessation of tobacco use (i.e. Bennington County's Tobacco-Free Community Partners; US Center for Disease Control, Guide to Building Coalitions for Tobacco Control)

- Unite community partners and target at-risk groups such as youth or First Nations, in an integrated and community-based setting (i.e. National Indian & Inuit Community Health Representatives Organization, Helping Pregnant Women and New Mothers Quit Smoking; Alberta Health Service's Teaming Up for Tobacco-Free Kids)

4.4 Develop Personal Skills

A variety of resources and systems are available to support individuals and families to improve health outcomes through awareness, engagement, education and capacity building. Stakeholders should focus on the various levels of behaviour change and construct programs accordingly. Examples of programs and campaigns that may encourage the development of personal skills towards reducing and preventing tobacco use include:

- Supportive telephone quit lines (i.e. QuitNow)
- Supportive materials and websites that offer evidence-based information (i.e. Canadian Lung Association's How to Quit Smoking)
- Warning labels on packaging (i.e. Southeast Asia Tobacco Control Alliance)

4.5 Reorient Health Services

A broad range of people are available to assist with a reorientation of health services. For example, health professionals, local government, community planners, sport and recreation professionals, general practitioners, allied health professionals and volunteer groups can influence population levels of tobacco use. Some examples of where this has been effective include:

- Evidence-based cessation services (i.e. BC Smoking Cessation Program)
- Cessation services offered in all health facilities (i.e. brief interventions using 5A's Approach).
- Enlist general practitioners and other health care professionals to assess and assist smokers (i.e. Public Health Service Clinical Practice Guidelines, Treating Tobacco Use and Dependence)
- Promote smoking cessation in conjunction with other medical services (i.e. BC Cancer Agency's Stop Smoking Before Surgery program)
- Ensure that all health professionals who use tobacco products observe the Smoke Free Grounds Policy during a paid work day; this prevents exposing clients to toxins as a result of third-hand smoke exposure on employee clothing or uniform (i.e. proposed third-hand smoke free ban at the Christus St. Frances Cabrini Hospital in Louisiana).

5.0 Conclusion

In conclusion, Northern Health aims to adopt a position on tobacco reduction as a primary modifiable behavioural risk factor for the development and progression of a wide variety of chronic disease states. Preventable disease significantly burdens our health care system and the overall health of our Northern population. The regional message is consistent with provincial and national messages, strategies and initiatives. This paper presents evidence-based strategies that have been implemented and have been proven to support tobacco reduction initiatives through protection, cessation, enforcement and prevention. These strategies support the comprehensive framework presented by the Ottawa Charter and support Northern Health's position.

6.0 Other Resources

British Columbian

Health Canada, *The Cost of Smoking in British Columbia and the Economics of Tobacco Control*

Canadian

Canadian Cancer Society, Evidence-Based Information Package on Tobacco Els, C. 2008. Tobacco Addiction: What do we know, and where do we go? Available online: http://www.lung.ca/crc/pdf/CEls3of3.pdf.

Health Canada Tobacco Control

Ontario Tobacco Research Unit. 2010. The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks. Available online: http://www.cpha.ca/uploads/progs/substance/tobacco/cpha_litreview.pdf.

Public Health Agency of Canada, Canadian Best Practices Portal – a database of interventions and resources

Non-Governmental Organizations

Canadian Council on Tobacco Control
Physicians for a Smoke-Free Canada

International

US Centers for Disease Control and Prevention, Smoking & Tobacco Use

World Health Organization,Report on Tobacco Use 2011

Cancer Council of Victoria, *Tobacco in Australia: A Comprehensive Review of Major Issues*

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