QUALITATIVE EVALUATION OF BRANTFORD COMMIT

CONCEPT AND PRACTICE IN COMMUNITY MOBILIZATION FOR HEALTH: A QUALITATIVE EVALUATION OF THE BRANTFORD COMMIT SMOKING CESSATION INTERVENTION TRIAL

By

BLAKE DAVID POLAND, M.A.

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AUTHOR: Blake David Poland, B.A. (Carleton University)

M.A. (McMaster University)

SUPERVISORS: Professor J.D. Eyles
Professor S.M. Taylor

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ABSTRACT

The Community Intervention Trial for Smoking Cessation (COMMIT) was one of the largest health promotion interventions in North America. Using 11 pairs of matched intervention and control communities, the U.S. National Cancer Institute sought to establish the viability of a community-based approach to smoking cessation, with the expectation of significant impacts on cessation rates amongst heavy smokers during the four years of intervention.

The evaluation components of the COMMIT trial relied primarily on the use of surveys to document quantitative changes in attitudes, beliefs and behaviours. A complementary ancillary qualitative evaluation was conducted by the author in the only Canadian intervention site in the trial in Brantford, Ontario. Depth interviews and focus groups were conducted with 45 members of a Smokers' Network established by COMMIT. Subsequently, 35 intervention staff, researchers and community influentials were interviewed. Transcripts were coded and analysed using qualitative analysis software.

Several objectives guided the qualitative evaluation study in Brantford: 1) establish the degree to which the COMMIT met the needs of smokers for assistance in quitting; 2) identify the factors that inhibited or facilitated program success; and 3) consider the implications for community mobilization for smoking cessation. Findings in each of these areas are discussed.

This work seeks to contribute to knowledge development in health promotion at the level of theory and method, as well as substantively in terms of the design and implementation of community health promotion interventions. A critical-interpretive methodology is advanced as being consistent with the 'new' health promotion, based on a review of the literature on social theory which also argues for an explicit critical and emancipatory orientation to theory and practice in health promotion. These approaches are applied to the examination of a community-level smoking cessation intervention. Chapter 9 contains a critical sociological examination of the nature of tobaco control, drawing upon the work of Goffman.

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CHAPTER ONE

INTRODUCTION

1.1 RESEARCH CONTEXT

For several decades, medical research and morbidity/mortality statistics have demonstrated that the major causes of illness and death in North America are linked to what we eat, breathe, and drink, our levels of exercise, our use of seatbelts and our sexual practices (Lalonde 1974, Knowles 1986). The assumption was that our 'lifestyle' affects our health, and that these behaviours can be changed through education. This vision fueled many of the early developments in health promotion.

Relatively recent developments in health policy at the national (Epp 1986) and international (WHO 1986) level suggest an increase in the importance of health promotion within the public health sector, as well as a reformulation of what is included under the rubric of 'health promotion'. In *Achieving Health for All*, Jake Epp (1986) identified health promotion as the primary strategy for achieving health for all Canadians.

Yet more than a decade of attempts to frighten, cajole and entice people into adopting more 'appropriate' behavioural habits have sometimes produced only modest results (Norman 1986), perhaps because they did not sufficiently acknowledge constraints on choice beyond the individual's immediate control, for which practitioners were sometimes accused of 'blaming the victim'. These not only constitute 'physical' constraints such as lack of resources to participate in recreational sports, for example, but also 'social' constraints in the form of shared behavioural norms and values surrounding health and behaviours affecting health. This realization has resulted in a gradual metamorphosis in the rhetoric of health

promotion in two fundamental respects. First, there is a growing awareness of and sensitivity to the environmental contexts (social, cultural, political, material) through which health and behaviours affecting health are mediated, so that interventions which portray smoking or other lifestyle issues as purely individual problems are seen as no longer sufficiently balanced. Health promotion is therefore increasingly being construed in terms of multifaceted intervention programs targeting a broad range of social, political, material and behavioural factors. The second fundamental change in health promotion has been the realization that the most significant and lasting changes derive from traditional target groups being involved as full and active participants. In other words, 'ownership' is crucial to program success.

The mechanisms and implementation strategies proposed in Epp's (1986) framework for health promotion reflect this newer conceptualization of health promotion: self-care, mutual aid, healthy environments, fostering public participation, strengthening community health services, and coordinating healthy public policy. But while the language is 'user friendly' and the concepts are universally appealing, the framework falls short of describing what the 'new' health promotion will look like in practice. However, there is an emerging consensus on the need for an integrated community-based approach that would draw together all these elements to address a priority health issue in a single locale, and that could be defined "from an operational standpoint as the combination of educational, organizational, economic, and environmental supports for action conducive to health" (Bracht 1990, 39). Specifically, among the multiple points of intervention that such an approach might include would be the core elements of a holistic health promotion identified by Tanguay (1988/89): health education, political lobbying, organizational change, community development, media, fiscal measures (e.g. taxation of tobacco products) and social marketing.

Despite the emerging consensus at a conceptual level, such a comprehensive integrated approach to health promotion has rarely been implemented, and remains to be adequately evaluated. To understand if this is indeed a model to be emulated, one must know something of how it works in practice. In addition to standard outcome and process measures, a thorough evaluation must indicate how the intervention is perceived by its intended beneficiaries, as well as issues surrounding

the implementation of a standardized intervention protocol. The research project described in this dissertation used this approach in its evaluation of Brantford Ontario component of the largest community-based health promotion project in North America: the Community Intervention Trial for Smoking Cessation (COMMIT). Brantford is the only Canadian intervention site in the multi-centre trial, with Peterborough as its comparison control community (there being 11 pairs of intervention and control sites trial-wide). An eight-year continent-wide randomized community trial, COMMIT utilizes a multifaceted community mobilization approach to effect an anticipated 10 percent reduction in smoking by 1993. The aim of the intervention trial is to work in partnership with the community through a community board to mobilize health care providers, worksites and organizations, cessation resources and services and public education so as to "(a) increase the priority of smoking as a public health issue, (b) improve the community's ability to modify smoking behaviour, (c) increase the influence of existing policy and economic factors that discourage smoking, and (d) increase social norms and values supporting non-smoking" (COMMIT Research Group 1988, numbering added). The rationale offered by the U.S. National Cancer Institute (sponsor of the trial) for a community-wide approach is that it will reach a wider audience on a more sustained basis than sporadic clinic-based activities, and that the impact on social norms and circumstances surrounding smoking will reinforce the efforts of the 80 percent (Glynn and Cullen 1989) of the smoking population that have already expressed a desire to quit. In view of the resistance of heavy smokers to clinic-based programs, it is hoped that a multifaceted intervention will be able to "increase the frequency of quit attempts as well as greater maintenance of cessation" among this group (Glynn and Cullen 1989).

An evaluation of the COMMIT trial in Brantford will contribute to the continued vitality of smoking cessation efforts following completion of the intervention trial in that town. It may also enhance the existing knowledge base concerning health promotion interventions at the community level, and could contribute to the design and implementation of similar efforts in the future. COMMIT is a state-of-the-art intervention targeting a well-defined public health problem, the risks of which are better documented and less controversial than for most other lifestyle-related morbidity, and most smokers already profess a desire to

quit. One would therefore expect COMMIT to have the best chances of demonstrating the utility of a community-based approach.

1.2 RESEARCH GOALS AND OBJECTIVES

The primary goal of this dissertation is to contribute to current understanding of community-based health promotion through critical appraisal of the Brantford COMMIT trial, and thereby inform subsequent research, intervention design, and health policy. For the purposes of this study, evaluation is defined as "the systematic application of social research procedures in assessing the conceptualization and design, implementation, and utility of social intervention programs" (Rossi and Freeman 1985, 19).

The objectives of this research stem from the three basic questions implied in the evaluation of any health promotion intervention. First, how does one define and measure 'success' in a health promotion intervention?. Second, how does one account for the success (or failure) of *this* intervention in *this* community?. Third, how can one apply this knowledge to practice in similar communities and interventions? Each of these has a corollary of particular relevance to an evaluation of the COMMIT trial in Brantford.

In the case of the first objective, it is assumed that judgements regarding the success of the intervention should be based on establishing the degree to which COMMIT has met the needs of smokers in Brantford. This implies interviewing smokers who have had contact with the program to learn directly about what they found useful about the program, and to discover unmet needs for assistance in quitting. There is also the opportunity to inquire about perceived changes in community social norms and changes in specific intervention channels (such as health care providers and worksites) during the course of the trial.

In the case of the second evaluation question, one accounts for the success (or failure) of a particular intervention by identifying the factors that appear to be inhibiting or facilitating programme 'success', where success in this case is defined

in terms of meeting the needs of smokers for assistance in quitting. Again, this implies speaking directly with smokers who have been involved with Brantford COMMIT. However, because most smokers are not aware of many of the day to day operations of the intervention, pinpointing barriers to (and facilitators of) success requires that the opinions of key informants both inside the project and in the community at large be solicited. In fact, the evaluation is enhanced if a variety of stakeholder groups are consulted and their claims, concerns and issues documented regarding the implementation of the COMMIT intervention in Brantford.

In the case of the third generic evaluation question, the emergence of themes arising from this research on the COMMIT trial in Brantford has implications for other communities, including the application of a community-based approach of this sort to other health problems or lifestyle behaviours. These themes arise from a comparative analysis of the experiences and opinions of smokers and key informants. The importance of community context, the reluctance of intervention volunteers to be controversial, and socio-economic biases in the design and implementation of some health promotion interventions are some of the enduring themes arising from this research with clear implications for the way similar interventions might be designed and conducted in the future. They are also among the lessons learned which contribute to knowledge development in health promotion.

1.3 RESEARCH DESIGN

This research comprised a multi-stage design in keeping with the major study objectives (Table 1.1). There were four stages in the data collection process (Table 1.2). First, depth interviews were conducted with 45 smokers enrolled in a local cessation Network established by Brantford COMMIT. There was little in the existing COMMIT evaluation protocol that allowed respondents to indicate what it was about cessation resources or services (or other program activities) that they found useful in quitting. Although a qualitative evaluation component was drafted (Corbett et al 1989), it was never incorporated into the final trial-wide evaluation protocol. For the interviews with smokers in Brantford, respondents were roughly split between heavy versus light or moderate tobacco consumption at the time they

signed on to the Smokers' Network, with somewhat more women (26) than men (19), and covering a spectrum of age groups and social classes. After receiving a summary of the interview material, a subset of interviewees participated in focus groups designed to refine and extend the analysis by exploring key themes emerging from the interview stage. Third, depth interviews were conducted with key informants from a variety of stakeholder groups, including researchers, intervention staff and volunteers, and members of the community-at-large. A fourth stage involved a focus group with some of the key participants in the Brantford COMMIT intervention: the chairpersons of the local channel-specific Task Forces, as well as members of the Community Board. In addition, data analysis was supplemented by consulting project documentation in the form of Quarterly Reports and by consulting the relevant academic literature (Table 1.2)

The common thread uniting each approach across all objectives was a reliance on qualitative and critical interpretive research methods. The rationale for this approach in the context of a community-based health promotion intervention was threefold (Corbett et al 1989). First, health promotion messages are not interpreted uniformly by all individuals and groups within a single community. Yet these interpretations are crucial to the impact of the intervention. This variability of interpretation cannot be adequately understood using formal survey techniques and quantitative measures. Second, insofar as community-based health promotion seeks to influence the dynamics of how a community functions and interacts to support smoking cessation, contextual information is fundamental to a thorough evaluation. Third, understanding people's interpretations and community dynamics is fundamental to understanding why things have turned out as they have. The formal quantitative evaluation conducted by NCI for the COMMIT trial may reveal program effects in terms of primary impact objectives, but fail to recognize other strong community impacts that could be uncovered through qualitative analysis. This might include, for example, profound organizational changes that have not had time to be reflected in elevated cessation rates amongst 'clients'. Even if the trial does achieve a ten percent increase in cessation rates, it is important to know how and why this occurred in order that the experiences of the trial can be synthesized and applied to other communities. The addition of an explicitly critical component to qualitative research strategies helps to (a) avoid some of the victim blaming that

could accompany such an approach, by focussing attention on social and systemic roots of ill-health and health-related behaviour as well as personal responsibility (and ultimately, the interconnectedness and cultural embededness of the two); (b) explicate the social and behavioural contexts of smoking behaviour and cessation efforts that are often taken for granted in daily lived experience and therefore do not often get discussed in qualitative interviews; and (c) situate health promotion, tobacco control and the intervention itself in a larger social context.

1.4 SCHOLARLY AND PRACTICAL SIGNIFICANCE

The rationale for conducting an evaluation of Brantford COMMIT included (a) the considerable public health implications of tobacco consumption, (b) an emerging consensus on the need for a community-based approach to smoking cessation research (Lichtenstein, Wallack and Pechacek 1990-91; Schwartz 1987; Bracht 1990), (c) the scale and multifaceted nature of the trial, and therefore (d) the need to evaluate COMMIT not only for the future of smoking cessation elsewhere (i.e. broader *geographic* application) in terms of its potential implications for the conceptualization and practice of health promotion in general (broader *disciplinary* application).

Population attributable risk fractions, as a measure of the proportion of deaths attributable to smoking, can be calculated for specific causes of death (Peron and Strohmenger 1985), and in this manner it has been estimated that 30 percent of all cancers, 85 percent of chronic obstructive lung disease and 30 percent of coronary heart disease can be attributed to tobacco consumption (Semenciw 1987). Smoking has also been associated with risk of mortality from peptic ulcer, stroke, atheroscierosis and other circulatory diseases, as well as from fires (Wigle, Mao and Davies 1987; USDHHS 1983), for which reliable attributable risk ratios are not available (Collishaw 1982). Goodyear (1990) has recently estimated that "tobacco is responsible for the death of 50,000 people in Canada annually (about 40% of all deaths), nearly 10 times as much major disability, and a net loss to the Canadian economy of approximately $12 billion per annum (about $1,000 per taxpayer)". Global impact figures range between one and 2.5 million premature deaths per year

worldwide due to smoking (WHO 1983; Chandler 1986). In the light of the evidence, cigarette smoking has been identified as "the most important avoidable cause of death in Canada" (Wong and Arraiz 1990).

Based on import and export data, total cigarette consumption in Canada is estimated to be in the order of 56 billion pieces, representing an annual per capita consumption of 2000 cigarettes in 1989 (Kaiserman and Allen 1990), or nearly 8,000 per smoker per year. That put Canadians, until very recently, among the top ten per capita consumers of tobacco products in the world (Garcia, d'Avernas and Best 1988; Kaiserman and Allen 1990). Prevalence rates are nearly 50 percent within some age groups, such as those 20-29 years old (Collishaw 1985). And while the overall proportion of daily cigarette smokers in the population 15 years of age and older has declined from 45 percent in 1965 (Collishaw 1981) to 34 percent in 1985 (Rootman *et al.* 1988) and 29 percent in 1990 (Pederson 1993), the average tobacco consumption among those who continue to smoke has steadily increased (Collishaw 1981; COMMIT Research Group 1988). This could be attributed in part to (a) smokers subconsciously compensating for lower nicotine cigarettes by increasing the number smoked, (b) lighter smokers spontaneously quitting in greater numbers than heavy smokers, and (c) lighter smokers more successfully maintaining abstinence following the decision to quit. All three are manifestations of the addictive nature of smoking. Furthermore, it should be noted that "tobacco has been an economic staple of a large region of the country for more than 250 years [and]... cigarettes have acquired firm cultural associations, at times with social sophistication, individuality, or maturity, and such associations remain attractive to many people" (Gerstein and Levison 1982, 2). Heavy smokers experience great difficulty in maintaining abstinence following the decision to quit (Hughes *et al.* 1981). In fact, of the 17 million smokers in North America who try to quit each year, fewer than one in ten succeed (Lichenstein, Wallack and Pechacek 1990-91).

Considerable research has been conducted to refine modes of intervention for encouraging smoking cessation among the general public, but relatively little attention has been directed specifically at heavy smokers, particularly outside of the clinical context (COMMIT Research Group 1988). The literature on health promotion and on smoking cessation both point to the advisability of designing

comprehensive community-wide cessation programmes, given the effect of social norms and social supports on human behaviour, as well as the potential for community-based interventions to reach a wider segment of the population on a more sustained basis. But consensus regarding the conceptual merits of a multifaceted community-based approach to health promotion is no substitute for the thorough evaluation of such interventions: indeed it suggests that evaluation is all the more urgently required. In his closing address to the 1993 Health Promotion Research conference in Vancouver, Dr. Larry Green suggested that health professionals have another five to ten years to develop conceptual clarity and standards of rigour for the field and to demonstrate the effectiveness of health promotion if the field is to avoid receding in importance from the public health arena. While traditional approaches to outcome and process evaluation will be helpful, a clear articulation and explanation of the mechanisms by which health promotion 'succeeds' will necessitate the use of qualitative and consensus building methods capable of elucidating the meanings ascribed by stakeholders situated in a particular context vis a vis the evaluand.

Judging from what has been written about the 'new' health promotion, its distinguishing features would appear to include an awareness of and sensitivity to the *environmental contexts* (social, cultural, political, material) through which health and behaviours affecting health are mediated. In fact this is part of the impetus for community-based approaches in health promotion. The concept of *empowerment* in health promotion is coming to be understood in terms of "enabling people to increase control over and to improve their health" (WHO 1986, iii) in terms of both individual and social action (c.f. Kar 1989) in keeping with the *self-perceived needs* of affected groups. A parallel methodological shift in research for health promotion has placed increased emphasis on basing health promotion interventions on a thorough *qualitative* understanding of the subjective 'lifeworlds' of 'target' populations. The new vision is thus of a broad-based and multifaceted participatory approach to community-based action for health promotion (Bracht 1990). The challenge presented by such a vision is how to successfully integrate these four components of the new health promotion in the process of needs assessment and evaluation in health promotion.

Substantively, this research aimed to contribute to both the smoking cessation and health promotion literatures through a critical appraisal of a community-based approach to smoking cessation. Methodologically, this study was innovative in its application of a modified fourth generation approach (Guba and Lincoln 1989) to evaluation in a health promotion setting. The use of focus groups as well as depth interviews enhanced validity through triangulation, and involved study participants in the initial analysis of interview material gleaned from themselves and their peers. The application of critical-interpretive methods of data collection and analysis is not widespread in health promotion.

1.5 CHAPTER OUTLINES

This dissertation contains eleven chapters. Chapter 2 is premised on the observation that despite evidence of a paradigm shift in health promotion at a conceptual level, this has not been accompanied by the articulation of a 'new' research methodology to accompany the 'new' health promotion. The chapter has three main sections. First, some of the limitations and contradictions that separate the rhetoric of health promotion from its current operationalization in research practice are discussed. In asserting the inherent links between theory, methodology and method, the need for a new research paradigm is demonstrated. In the second section, seven key issues derived from the literature on sociological theory are identified and discussed in terms of their implications for choosing a new research methodology for health promotion. In the third section it is suggested that using these issue areas as a 'decision map' leads to the selection of a preferred strategy which brings together both interpretive and critical perspectives to bear on our understanding of social reality as it affects health. Elements of both of these approaches and the nature of their potential complementarity are considered. Throughout these deliberations consideration is given to the potentially conservative or activist orientations that alternate methodologies imply, and to a critical evaluation of how these mesh with the emerging rhetoric of fostering empowerment that is the cornerstone of the 'new' health promotion. Chapter 2 is a reworked version of Poland (1992).

The issues discussed in Chapter 2 are pursued in Chapter 3, where it is suggested that the recent surge in interest among health professionals in the use of qualitative methods in the design and evaluation of health promotion interventions raises a number of issues concerning the appropriate role for lay perceptions in intervention design and evaluation. It is suggested that at present the promises have received more attention in the literature than the potential pitfalls in using a primarily qualitative approach to health promotion research. The 'promise' of taking lay perception seriously is twofold and somewhat contradictory: (a) on the one hand, it is consistent with the literature on the 'new' health promotion, which stresses the need for a more participatory process that is empowering of disadvantaged groups who are traditionally the target of many lifestyle behaviour modification interventions, yet (b) it also provides the knowledge necessary to fine-tune sometimes manipulatory social marketing interventions so as to increase their effectiveness (when measured against traditional attitudinal and behavioural outcome measures). Some of the potential pitfalls in stressing lay perception in health promotion research inhere whenever a dominant social group (e.g. health professionals) invoke new concepts, methods or jargon more for their "political correctness" than out of a genuine understanding of the need for redressing power imbalances in the research process. It is suggested that while lay perceptions must be taken into consideration in both the design and evaluation stages, an appropriate framework for doing so must be developed that guards against some of the potential pitfalls identified.

Chapter 4 contains a review of the conceptualization and design of the U.S. N.C.I.-sponsored Community Intervention Trial for Smoking Cessation (COMMIT) as a community-level randomized control trial. In particular, the goals and objectives of the trial and of each intervention channel (Task Force) are reviewed. The chapter concludes with an overview of the trial-wide evaluation protocol, which includes outcome and process measures in all 11 intervention sites as well as comparison measures in control communities.

The methodology employed in the qualitative evaluation research conducted for this dissertation is presented in Chapter 5. It comprises three main sections. First, an overview of the general methodological approach is provided. More detailed

information is provided in the next section concerning each stage in the collection and analysis of data for the study. Third, relevant biographical details of the author as researcher and research instrument are discussed.

In order to gain a balanced picture of BC from the smokers' perspective, several approaches have been taken. In Chapter 6, smokers' direct experiences with Brantford COMMIT (primarily through their membership in the Smokers' Network) are examined. First, smokers' self-articulated reasons for joining the BC Smoker's Network and their expectations of the program are examined. Second, their experience of specific activities and resources such as the Quit and Win contests, cessation package, newsletter and hotline are discussed. Third, the overall level of support perceived by smokers to have been available is advanced as a general measure of satisfaction with the intervention.

Chapter 7 explores what smokers had to say in relation to each channel of the intervention and contrasts these with the views of key informants such as project staff, BC volunteers and smoking-related organizations in the community. The chapter begins by examining the experiences of smokers with their physicians concerning smoking cessation, and compares this to what physicians themselves said about helping their patients to quit, as well as what intervention staff and researchers considered to be the strengths and weaknesses of the Health Care Providers Task Force. Next, the impacts of the Worksites and Organizations Task Force are considered, though much of the discussion regarding workplace restrictions is relegated to Chapter 9. Several topics are considered under the purview of the Public Education Task Force: the profile of Brantford COMMIT in the community, the reactions of smokers to cessation and prevention messages in the media, and perceived changes in the social acceptability of smoking. The role of the Cessation Resources and Services Task Force (CRTF) was focussed on increasing the awareness and use of smoking cessation activities and programs amongst smokers, and for improving the coordination of such services amongst voluntary organizations. The topics examined using interviews with smokers in the section relevant to the CRTF include (a) their perceptions of self-help literature, cessation courses and support groups (the most common forms of assistance

available); and (b) their impressions of other smoking-related organizations such as the Lung Association and Cancer Society.

In Chapter 8, both the expressed and implied needs of smokers vis a vis assistance with cessation is explored and contrasted with what BC had to offer. Several dimensions of need are considered, beginning with an examination of the self-articulated needs of interview and focus group respondents who were members of the BC Smokers' Network, and proceeding to consider needs as implied (or inferable) (a) from their own accounts of their cessation trajectory and difficulties experienced along the way, and (b) from their commentary on available and proposed services and forms of assistance. The implications for action, for the evaluation of BC, and for further research are considered in a concluding section of the chapter.

Chapter 9 draws upon interviews and focus groups conducted with smokers, using a critical-interpretive methodology to provide a contextualized understanding of how smokers perceive tobacco control in principle and in practice. The chapter begins with an examination of the rationale for tobacco control and the forms that it has taken in Canada to the present time. The rationale for developing an understanding of the smoker's experience of tobacco control is then considered. Although several substantive areas of tobacco control are explored in the study, the particular emphasis in this chapter is on the regulation of places where smoking is permitted. The chapter concludes by considering the implications of a lay smoker perspective for the practice of tobacco control in Canada.

One limitation of a client-centred evaluation is that many aspects of organizational development and other "behind the scenes" events are not available to target groups and service clientele. To understand more fully the challenges experienced by intervention staff and volunteers in Brantford COMMIT, a number of key informant groups were consulted. In-depth interviews were conducted with a variety of individuals from each of four groups: (a) Brantford COMMIT staff, (b) intervention volunteers, (c) related organizations in the community (e.g. local chapter of the Lung Association), and (d) university-based members of the Ontario COMMIT Research Group. In addition, a focus group of task force chairpersons

was convened to discuss the trial following its completion. Chapter 10 focuses on this key informant perspective regarding the lessons in community mobilization for smoking cessation. The chapter has two main sections. The first deals with issues arising from the application of a standardized COMMIT intervention protocol in Brantford. The second section deals with organizational issues involved in implementing a new intervention within an established organizational fabric: in particular, the logistics of setting up and managing task forces, relationship issues and mediating conflict.

In Chapter 11, the main themes arising from this evaluation exercise are summarized and their implications for the design, implementation and evaluation of other community-based health promotion interventions are discussed. The chapter concludes by suggesting a number of avenues for further research.

Table 1.1 Research objectives and study design

Generic issue:	how does one define and measure 'success' in a health promotion intervention?
Study objective:	establish the degree to which COMMIT has met the needs of smokers in Brantford
Methodology:	interviews and focus groups with members of the Smokers' Network
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Generic issue:	how does one account for the success (or failure) of *this* intervention in *this* community?.
Study objective:	identify the factors that appear to be inhibiting or facilitating program 'success', where success is defined in terms of meeting the needs of smokers for assistance in quitting
Methodology:	interviews and focus groups with members of the Smokers' Network interviews and focus group with key informants
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Generic issue:	how can one apply this knowledge to practice in 'similar' communities and interventions?
Study objective:	lessons from the Brantford COMMIT experience for the design and implementation of community-based programs in other communities
Methodology:	themes emerging from critical-interpretive comparative analysis of the experiences and opinions of smokers and key informants

Table 1.2 Phased research design for evaluating Brantford COMMIT

Data collection

- Depth interviews with individual smokers
- Focus groups with smokers
- Key informant interviews for protocol and implementation evaluation
- Focus group with key informants

Data analysis

- Qualitative data analysis: generating themes & grounded theory
- Critical and cultural analysis of context, the taken-for-granted; develop ideal-types
- Consult project documentation (Quarterly Reports, Protocol binder etc)
- Consult the literature re smoking cessation, tobacco control, channel-specific activities, community-based health promotion, as appropriate

CHAPTER TWO

LEARNING TO 'WALK OUR TALK': THE IMPLICATIONS OF SOCIOLOGICAL THEORY FOR RESEARCH METHODOLOGIES IN HEALTH PROMOTION[1]

2.1 INTRODUCTION

The expanded vision of health promotion espoused in policy statements by the World Health Organization (Ottawa Charter) and more recently in our own government's *Achieving Health for All* document (Epp 1986) calls for a more integrated promotion of health at the policy, legislative, social, community and individual levels. The health challenges identified, and the mechanisms and strategies proposed to remedy these, speak of reducing inequities, increasing prevention, and enhancing coping, fostering public participation, self-care and mutual aid, healthy environments and healthy public policies. While the language is 'user friendly' and 'motherhood' concepts universally appealing, the framework falls short of describing what the 'new' health promotion will look like in practice. In particular, how integrated will a multidimensional body of health promotion programs be? And how will they differ from the heritage of a more traditional health education as far as the implementation of individual behaviour change strategies is concerned? If implementation issues are central to the emerging character of the new health promotion, then more so is the type of information and research that will inform program design.

In this paper, it is argued that health promotion has, in its articulation of a new holistic and ecological stance, reached a crucial turning point in its evolution; that it

[1] This chapter has been adapted from a paper of the same title originally published in 1992 in the Canadian Journal of Public Health, Volume 83, Supplement 1, pages S31-S46. Permission to reproduce the material has been granted from the publisher (see Appendix A).

sits at the crossroads between continued reliance on methods and models rooted in positivist traditions of 'scientific research' on the one hand, and on the other the exploration of more qualitative and explicitly critical perspectives. The most problematic aspects of the natural science lineage of the new health promotion are reviewed. It is suggested that the way forward in health promotion research lies in the articulation and application of a new critical interpretive methodology. The balance of the paper is devoted to an exploration of what such a methodology, together with its theoretical underpinnings, might usefully look like. This is undertaken in the context of ongoing debates in social theory that closely parallel those currently troubling the health promotion field. It is argued that these debates form a 'decision tree' for the selection of one set of research methodologies over others. The concluding section provides a rationale for selecting an explicity critical and interpretive approach as the preferred candidate for a new paradigm in health promotion research

2.2 FROM HEALTH EDUCATION TO HEALTH PROMOTION: THE EMPEROR'S NEW CLOTHES?

In *Achieving Health for All: A Framework for Health Promotion*, Jake Epp (1986) identifies health promotion as the primary strategy for achieving health for all Canadians, and specifically for overcoming three health challenges: *reducing inequities* (most particularly those based on differentials in income), *increasing prevention* of disease and injury, and *enhancing coping* (with non-curable chronic physical and mental illness and with changes in employment, social roles and so-on). In this context health is defined as a resource for everyday living, and health promotion as "the process of enabling people to increase control over, and to improve, their health" (Epp 1986, 6). Three mechanisms are identified as 'intrinsic' to health promotion (Figure 2.1): *self care* (the promotion of individual health enhancing and health protecting behaviour), *mutual aid* (helping each other cope through social support such as AA and Block Parents), and the promotion of *healthy environments* (social, physical and economic surroundings conducive to health). The specific implementation strategies designed to achieve these goals include: *fostering public participation* in the production of health, *strengthening*

community health services through greater service coordination, community-based planning in response to local needs, and appropriate community-based care, and finally the coordination of *healthy public policy* (on income security, employment, education, recreation, housing etc) to "set the stage for health promotion, because they make it easier for people to make healthy choices" (ibid, 10).

The emphasis in the new health promotion framework is clearly on comprehensiveness and the integration of individual and social determinants of health. It acknowledges that earlier efforts at health education failed because they ignored (social and material) constraints to choice beyond each person's immediate control (for which practitioners were accused of 'blaming the victim'). What is implied, and at times directly suggested, is both the opportunity and the need to further our understanding of the social context of meanings people associate with health-related events and behaviours. In the words of the Ottawa Charter for Health Promotion, health "is created and lived by people in the settings of their everyday life, where they learn, work, play and love" (CJPH 1986, 427). In fact, these settings shape the attitudes and behaviours that are the concern of health professionals.

This shift in emphasis to the social from the individual is revolutionary, given the historical roots of health promotion in more traditional forms of health education. The majority of health education programming has been predicated on mechanistic models of (rational) human behaviour. These have often been derived from the elaborate statistical modelling of predictors (correlates) of observed behaviour that are drawn from cross-sectional structured surveys. Attitude theory provided the impetus for numerous investigations of the roles of knowledge and attitudes on behaviour and behavioural intentions. A logical extension of traditional biomedicine, the 'risk approach' has sought to isolate biological, psychological or social 'pathogens', or simply correlates without presumed direct etiologic relationship to health, that could be controlled or eliminated. Rigid adherence to positivistic principles of scientific enquiry meant that procedural rules (a standardized protocol) regarding hypothesis construction, coding, indicators, reliability and validity had to be followed for information to be considered 'objective' and therefore scientifically sound. Interventions were empirically tested by randomized control trial or the closest feasible approximation ethics and

experimental science would permit. The adherence to mechanistic and statistical models of human behaviour (an individualistic social engineering approach), resulted in the all too familiar reliance on fear tactics and appeals to rationality as a basis for behaviour modification.

What level of understanding of - and impact upon - health behaviour has the expenditure of effort (and research funding) at this level achieved? Despite a number of successes, people continue to behave 'poorly' despite the well-publicized dangers to their health. Something more than health education predicated on statistical modelling may be required. Quantitative modelling has not always adequately 'predicted' health-related behaviour, and attempts to model combinations of factors have often only 'explained' a fraction of the variability as measured by R-squared values (Norman 1986). It would appear that health behaviour is susceptible to situational factors that remain poorly understood. Furthermore, of the collection of positted risk factors and correlates of health behaviour, many of the strongest predictors (such as age and sex in the case of health service utilization, for example) are merely proxies for other less well understood underlying effects, with little demonstrated causal connection to health behaviour.

More unfortunate, however, is the limited understanding this 'natural science' approach has provided into the subjective meaning of health and health behaviour in the lifeworlds of individual citizens, as well as the dynamic social contextuality of such meanings. Meaning permeates and forms the basis of human thought and action, negotiated through interaction with others. The meanings one ascribes to phenomena strongly influence one's choice of available responses. In many cases, these meanings are shared with others to the extent of being taken entirely for granted, embedded in culture, and institutionalized in rituals, habits and social structures, which in turn influence individual socialization and behaviour. Adherence to the methods of the natural sciences has meant that the nature of lived experience and role of the intersubjective taken-for-granted in the evolution and maintenance of health-related significations, symbols and interactions remain largely unexplored despite their relevance to the design, implementation and evaluation of health promotion.

Given the need to reorient research in health promotion along more explicitly 'interpretive' or qualitative lines, and the presence of encouraging statements in this regard in recent policy documents such as the Ottawa Charter and in *Achieving Health for All*, it is disturbing to discover that the health education lineage of health promotion is still evident within both the rhetoric and the practice of health promotion. The involvement of health educators in the formulation of the new health promotion at the WHO's European Regional office and in discussion papers leading up to the Ottawa Charter, is evident. Of the five WHO health promotion target areas, the first three (healthy public policy, social environment, information and education) are clearly seen as preconditions for individual health-oriented behaviour, and two deal with health behaviour directly (positive and negative health behaviour: promoting well-being and preventing disease), while two deal with wider issues of reducing inequalities and developing 'health potential' (Kickbusch 1986). The rationale for the expanded focus is "how to make healthy choices easier choices" (Milio 1987). Here the language of health promotion policy suggests the operative model is rational choice behaviour constrained by external forces, which might help explain the recent popularity of 'social marketing' approaches in health promotion.[2] In other words, the previous conceptual model has been modified and rendered more complex, rather than replaced. Yet at first blush, replacement is what the proponents of the 'new' health promotion would seem to be implying is needed, though the subject of research methodology is rarely addressed.

Suggestive language that belies adherence to problematic methodological tenets also permeates the majority of the Canadian papers for knowledge development in health promotion (Health and Welfare 1989). References are made to 'equipping' people with information and skills to cope with stressors (Perrault and Malo 1989), scientific trials of self-care interventions (ibid), or the "experimental manipulation of coping resources" (Seraganion *et al.* 1989) as if they were tools to be parcelled out and deployed at conscious will. The literature review as well as research recommendation components of these papers, advanced as the leading edge of health promotion research at this time, make frequent reference to 'predictors' and

[2] It is instructive to note that the external factors positted are largely socio-cultural in nature rather than rooted in the inequitable distribution of factors such as income and housing. These factors are therefore often treated as capable of being overcome by individuals through an appeal to reason rather than being rooted in an inequitable economic and social system.

'correlates' of health behaviour. In the process of operational definition, terms such as 'empowerment' and 'coping' are subsumed within the dominant scientific paradigm and, one could argue, robbed of much of their intended meaning. The net result of extending the search for etiology and risk factors from the biological through the behavioural to the social is simply an expansion of the type and range of 'independent' variables accounted for in quantitative models.[3] It is unlikely that such an approach will add significantly to our understanding of people's subjective meanings rooted in everyday life that are so clearly the empirical context of health-oriented and health-related human social action.

Yet the 'new' health promotion, as articulated by Epp (1986) and the Ottawa Charter (1986), seeks an unambiguous marriage between individual and social determinants of health and the health-related behaviours of individuals and collectivities. The gap between the rhetorical spirit of the new health promotion and its operationalization in the research process clearly demands a rethinking of the paradigms of inquiry that define and colour, in particular, research inputs to the design and evaluation of health promotion interventions. There is also a political agenda behind every research methodology, and health promotion research is surely no exception. Critical analysis carries an injunction to make explicit this political agenda. It is therefore entirely appropriate to question who carries the authority of defining and measuring needs, how this is socially sanctioned, and how its biases are translated into the design, implementation and evaluation of interventions. Turning away from these issues contains a danger that the appealing rhetoric of 'empowerment' and 'promoting health' will serve as a cover for 'business as usual' and the conduct of research which is partronizing and disempowering. It is therefore a matter of professional integrity, and part of our commitment to our 'clients' and the taxpayers who finance us, that we consider the implications of concepts like 'empowerment' for how we conduct research and how programs are designed, implemented and evaluated.

The next section contains a review of several key debates that have received considerable attention in the literature on sociological theory, and which also closely

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[3] The very term 'independent' is both suggestive and a misleading representation of the empirical world.

parallel the theoretical and methodological issues currently faced at the leading edge of health promotion. It is intended that a review of these issues form a 'decision tree' to assist practitioners in selecting a research methodology most suited to the emerging consensus surrounding the conceptual tenets of health promotion.

2.3 KEY DEBATES IN SOCIAL THEORY CAN INFORM OUR CHOICE OF A NEW RESEARCH PARADIGM

Debate about theory is relatively new and remains, for whatever reason, far from common practice in health promotion. It is therefore important that the opportunity is not lost to draw guidance from the social theory literature as it has struggled with many of the theoretical issues that underlie the selection of methodologies available. In this context, a few words concerning the relevance of theory to research practice in health promotion seem called for.

Insofar as theory is a strategy or framework for description and explanation, methodology a framework for the choice and use of methods, and methods themselves strategies for data collection, it is clear that the three are inextricably linked. Methodology thus joins theory and method in the practice of research, and as such serves as a model of empirical investigation. It arises out of a larger conception of social life (social theory, or ontological framework), preferably with explicit recognition of the relationship between theory and method. It therefore has implications for one's choice of data collection methods and the manner in which methods are employed.

What follows is a selective review of a body of literature on social theory and sociological methods of inquiry that is too extensive to do more than partial introductory justice to here. An attempt has been made to present what are considered the 'core' features and issues in a manner accessible to health professionals and health promotion practitioners. But the literature is dense and repleat with jargon, so the hope is that in the process undue violence has not been done to the spirit of the concepts.

There are seven primary areas of debate in the social theory literature that would appear to have direct implications for research methodology in health promotion. They are as follows: (a) the admissibility of subjective data as 'evidence', (b) the relative influence of structure (the social) or of agency (the individual) in determining human action, (c) the willingness to (and basis for) deriving generalizable 'laws' about the social world, (d) the necessity for an historically situated explanation of social phenomena, (e) the role of 'rationality' in structuring human behaviour, (f) whether social theory and research should maintain a normative or positive stance, and (g) the proper relationship of theory to method. Each of these is discussed in turn as they concern issues relevant to the genesis of a new health promotion framework.

2.3.1 Objectivity and subjectivity: what is admissible data?

The relative merits of 'natural science' and interpretive perspectives on what constitutes admissible data for health promotion research have been discussed above. Although current scientific research is perhaps not the caricature of positivism implied in this analysis, there is sufficient common ground to warrant critique. As noted, traditional 'scientific' (quantitative) approaches have tended to treat the social world and subjective data such as attitudes and beliefs in a way which robs them of their historically rooted inter-subjective and personal meanings. In other words, the usual (e.g. epidemiological) focus on reliability in health research decontextualizes information by forcing responses into a predetermined standardized format that is not sensitive to variations in people's perceptions. The result is that frequently validity is sacrificed for reliability (a case of misplaced emphasis?).[4] I have argued that a more explicitly interpretive approach could make significant contributions to our understanding of the contextuality of health behaviour. This will be crucial to an integrated health promotion that challenges both individuals and natural, economic, political and social environments towards health-promoting change.

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[4] Ironically, many researchers in physics and other branches of science have come to terms with the fact that they cannot be wholly seperate from what is being observed; that 'objectivity' has been an elusive concept. Somehow, in its zeal to emulate the so-called 'hard' sciences, social science seems to have become fixated on a model of science that 'science' itself no longer upholds (c.f. Georgescu-Roegen 1971).

It is also clear that a change in focus of this nature will require that new subject matter and methods go hand in hand. This is not to say that quantitative methods do not have their place within even a mainly qualitative research agenda, but rather to suggest that their use not be attended by the usual damaging ontological baggage, such as assumptions of objectivity or value-neutrality. A combination of methods can therefore be unified within a broader research methodology designed to illuminate both micro and macro scale issues as they are constituted within a particular research problem. One may for example employ quantitative methods to ascertain the extent of a health problem such as smoking, and follow that with a more detailed qualitative analysis (c.f. Ferguson 1988) to uncover how and why people interpret things as they do, as a basis for the design and evaluation of interventions.

2.3.2 Structure and agency: determinism or interdependence?

Early social theories, as well as some models still operative in health promotion, have been largely deterministic and mechanistic in their conceptualization of the causes and dynamics of human behaviour. Behaviourist theories have concentrated on the makeup of the human psyche in terms of drives (e.g. Freud) or other relatively fixed components (such as attitudes) that provided largely psychological accounts of human action. In contrast, functionalist and structural functionalist theories have tended to be environmentally deterministic, portraying human actors as 'faceless pawns' in a largely pregiven world. Over time, the influence of structure (socialization, instututions, the 'system') on human agency (individual cognition and action) has been recognized by former adherents to behaviourism and behaviouralism, but conceived in the form of external constraints to freedom of choice.

This revised individualist position would appear to represent the mainstream of current thinking in health promotion, including that which informed the design of the COMMIT smoking cessation intervention trial. Although social marketing and other perspectives ostensibly target some of the contextual factors affecting behaviour such as peer pressure and social norms, health promotion efforts are still aimed primarily at individuals and at effecting individual behaviour change through appeals to rational choice. The new rhetoric calls for encouraging the development

of coping skills, self-care and mutual aid, and although the Epp framework also calls for reducing inequities and producing physical, social and economic surroundings conducive to health, these are often beyond the purview of the health care system and are not pursued as vigourously as they should be. Thus the bureaucratic context (in particular its fragmentation and 'turf battles' between departments) in which health promotion is conceived and implemented restricts its ability to follow through on its own laudable rhetoric. But there is also a larger socio-economic and cultural context that merits attention: individualism and the profit-oriented world capitalist economy provide very real ideological and practical limits to the ability of state-sponsored agencies to tackle the broad social issues that are the major influences on health and health-related behaviour in our society. These include consumerism, advertising reinforcement of health-adverse products and behaviours, and the social distribution of material goods such as housing.

Social theorists have begun to see the necessity and importance of a more balanced and thorough integration of structure and agency. Debate has consequently shifted to how best to characterize their fundamental interdependence. In particular, attention has been focussed on the role of human agency in the (re)creation and maintenance of social structures (norms, institutions), that in turn are integral to the development of humans as fundamentally social beings. The focus for these theorists has thus shifted from the duality to the dualism of structure and agency. The adoption of a theoretical stance or conceptual framework that recognizes this dualism would reinforce the rhetorical commitment of health promotion practitioners to integrating social and individual influences on health and human action and to identify the full extent of these systemic/structural factors. It is argued below that such a perspective would require a critical appraisal of socio-cultural influences on people's perceptions: in other words, that we go beyond purely interpretive approaches to the use of qualitative methods by exercising a willingness to question commonsense or taken-for-granted assumptions guiding daily action, (see Appendix B). These issues are central to the health promotion project insofar as it has been recast in more global terms, since I have argued that this will require explicit recognition of the (inter)subjectivity and contextuality of health-related behaviour, and therefore of the role and relationship of individual and environment in the re-creation of each.

2.3.3 Ideographic and nomothetic research: trivial truths or significant uncertainties?

The majority of social theories and models of human social behaviour are *nomothetic:* that is, they seek explanations of the social world upon which to base generalizations, and in some cases the derivation of behavioural and social 'laws' equivalent to those of the natural sciences. In sociological circles this has made strange bedfellows of phenomenology, in which Husserl sought to bracket out presuppositions to discover 'absolute knowledge' (Knockelmans 1967) or the true essenses of phenomena (properties of objects as given), and of critical theory, symbolic interactionism and structuration theory.

Ideographic research, on the other hand, is particularizing and treats every interactional text as unique. At the extremes, one is left with potentially trivial truths (apparently unsystematic detail, relativism) or 'significant uncertainties' (generalizations too broad to be meaningful or untested grand theory)(Bailey 1984), both of which are to be avoided. However, one may seek explanation at a variety of levels of generalization in the hope of uniting micro and macro phenomenon as they impinge on the research problem.

Ideally, the researcher uses 'thick description' of events that are biographically and historically situated, particularly appropriate in the study of formative and transformational experiences (i.e. epiphanies: see Denzin 1989). Thick description, as articulated by Geertz (1973), involves sorting out structures of signification and socially constructed public meanings in terms of context, intentionality, audiences, hierarchies of meaning structures, and symbols. But it should also extend beyond an attempt at the 'true' representation of lived experience as perceived by respondents, since they may not be privy to the nature of the given (the taken for granted). According to Schutz (1962) the role of the 'scientist-as-stranger' is to produce, not nature transposed, but nature clarified. This is what Denzin has called 'thick interpretation'. In this way, the practice of ethnography and cultural analysis involves the interpretation of social discourse so as to fix the said in perusable terms. This necessarily demands a degree of abstraction and generalization, but it is limited to the construction of typifications of (and rooted in) the commonsense

world. It is therefore locally and historically specific, yet summarizes multiple instances of shared experience and clarifies aspects of the taken-for-granted (Denzin 1989a). This is probably the most useful scale at which to conduct research, but as with locality studies (see footnote 6), broader perspectives (e.g. structural context) and specific details provide much-needed clues to context and to the variability of individual perception regarding the issue under investigation. The level of generalizability chosen must ultimately also reflect the subject matter under consideration as well as the intended application of results.

2.3.4 Historicity

The constant weighing of the past on the present (in private and public social life) is testimony to the importance of properly situating interpretive accounts in historical context. This is true not only of wider social history, but also of individual biographies, which are critical to understanding transformational experiences (Denzin 1989a), learning, and behaviour change. An historical appreciation of the roots and evolution of cultural practices, social norms and individual 'attitudes' can greatly enhance the explanatory power of accounts that, in the health sciences, have traditionally been based on crossectional data. In the context of smoking cessation for example, the individual's 'cessation trajectory' and history of prior quit attempts has a bearing on what steps they are willing to take and what forms of assistance they consider important (see Chapters 6 and 8).

2.3.5 Rationality and irrationality

Social theories differ in the attention paid to emotional and ritual/habitual components of lived experience. Frequently only 'rational' components of human thought and action are considered, or in some cases, all thought and action are characterized in this manner. In critical theory, for example, human intentionality is construed in relation to the presentation and negotiation of validity claims and to types of (rational) interests. Dramaturgical accounts of agency in symbolic interactionism also presuppose rationality as a basis for action. Rational actor models are common in economic and some psychological models. They make assumptions about choice behaviour involving satisficing or maximizing 'utilities' under constraining conditions of limited information or limited resources. Health education programs have frequently assumed rational choice models, yet proponents

and critics alike have bemoaned the fact that providing more (or more 'accurate') information on which to base rational choice has been insufficient to motivate the intended behaviour modifications in some people (Norman 1986; Naidoo 1986).

Assumptions of rationality are problematic on three grounds. First, assessments of the rationality and logical coherence of other's behaviours and accounts involve judgment calls that are strongly influenced by one's own perspective, and on one's ability to comprehend context and to empathize. Consider the frequency with which the actions of others appear 'irrational' until the context is (reasons are) explained/clarified. Because the academic community places a premium on scientific rationality within a shared world view, the failure to fully appreciate the qualitative context of the behaviour of other social groups therefore risks imposing our own views of rationality and acceptable behaviour on them. Second, we are used to having to account for our actions in rational terms. In fact as part of the reflexive 'looking glass self' (Cooley), we account for our actions to ourselves as well as to others. But *ex post facto* rationalizations can bear little resemblance to the actual process that went into determining a course of action in the first place. As the adage goes, "we are better at finding reasons for what we do, than in doing what we find reasons for". Questionnaires seeking rational accounts of health-related behaviour may collect explanations rationally articulated after the fact but nevertheless fail to illuminate the real processes determining action. Third, the role of habit, of spontaneity, and of emotional responses should not be overlooked, particularly in their contribution to the creation of meaning structures and to the development of behavioural responses rooted therein. The implication is that the imposition of particular conceptualizations of rationality limits our ability to truly understand human social behaviour, and simultaneously risks imposing *a priori* concepts of what 'should be'. The result can be particularly *dis*empowering for those who feel betrayed and misunderstood by traditional scientific enquiry (particularly the under-privileged classes who are frequently accused of 'irrational' behaviour).

More empirically-oriented approaches such as phenomenology and ethnography, employing methods of participant observation and thick description, are ideographic and therefore truer to the emotive and apparently 'non-rational'

components of behaviour. Nomothetic theory has not been successful in generalizing these phenomena, because they do not appear to be consistent or reducible. On the other hand, the existentialist's fundamental concern with 'being-ness' gives primacy to feelings and lived experience, rather than action, as the basis for human agency (Ritzer 1983). In fact, existentialists see rationalism as a primary source of alienation and estrangement characterizing the human condition, because in forcing a separation between emotion and logic it creates inner conflict that violates a person's sense of authenticity. This in itself could be considered a fourth critique of the premium placed on rationality as a driving force of human action.

2.3.6 Normative and positive stances: deriving 'ought' from 'is'

Social theories are primarily designed to assist in the description and explanation of the social world. More often than not their prescriptive elements are limited to how we should perceive and organize our thinking about reality, rather than seeking to bring about change in that reality. In some cases, this implies that how things 'are' is how they should remain (acceptance of the status quo) or that they are not manipulable (resignation to the status quo). However, some social theorists have embedded explicit emancipatory or change-oriented aims in their writing (imperatives for social change) as part of a more general critical analysis of society. Habermas' quest for the 'ideal speech community' and his focus on critique as a vehicle for emancipation leads to a particular understanding of the role of the social scientist (Habermas 1972). To existentialists, on the other hand, the attainment and maintenance of 'authenticity' is of utmost importance.

The uncritical gaze engendered by research that claims to be objective and value-neutral (positivistic science) has often been implicitly supportive of the status quo, which may explain some of its tradition popularity with the political and economic elite. But choosing a research methodology should involve a critical appraisal of the role of the researcher as an agent of social change or in the reproduction of an unjust social order. As indicated earlier, there is an implicit political agenda behind all forms of research, and it behoves the researcher to make these explicit as a matter of personal and professional public commitment.

2.3.7 Theory, method, and validation

Glaser and Strauss (1967) define theory as "a strategy for handling data in research, providing modes of conceptualization for describing and explaining" (p.3). Method, on the other hand, can be equated with data collection and the gathering of evidence (Bailey, 1984). One's choice of theory may preclude certain methodologies that in turn indicate one's choice of methods and the manner of their use. But what is or should be the precise nature of this historically troubled relationship between theory and method, or theory and the empirical world? The manner in which theory is generated and verified in 'traditional' or 'natural' science has prompted accusations that it is too theory-determined: that the prevailing practice of testing hypotheses lacks validity because of the subconscious or systematic selection of evidence designed to support or refute *a priori* convictions, rather than a commitment to discovering the nature of lived reality as it reveals itself in everyday life. Few social scientists begin their research with a thorough understanding of the everyday experience of the people they will be studying, since they frequently move in separate social circles. But since the natural science approach to research is not designed to provide the necessary familiarity, researchers are unlikely to know what they are missing when they employ standardized formal survey techniques in specific contexts. In these cases, attention to replication and standardized protocol becomes a substitute for familiarity as a yardstick for assessing validity, even though research hypotheses rarely epitomize or completely cover the model or theory they are meant to support, and counterfactual evidence is rarely sought (Blumer 1969).

To interpretive social scientists, the procedures of natural science thus provide no assurance that premises, problems, data, relations, concepts and interpretations are empirically valid. Proponents of a more naturalistic (not natural science) approach argue that the portrayal of theory as proposition rather than as process puts undue emphasis on verification, which 'freezes' theory prematurely. Glaser and Strauss (1967) see theory as inseparable from the process by which it is generated, a process that is predicated on comparative analysis and that specifies that collection, coding and analysis of data be simultaneous and ongoing. In this way, the verification and validation of 'grounded theory' is resolved by the manner in which it is generated and is grounded in (arises from) empirical reality.

Blumer (1969) articulates a methodology for symbolic interactionism that consists of two components. The research act begins with a process of 'exploration' to breed familiarity: an honest and rigourous description of the problem area. At this stage theory is relegated to the role of 'sensitizing concepts' and the researcher must actively and continually question his or her presuppositions by searching out counterfactual evidence and considering alternate hypotheses. A second stage of 'inspection', more analytic in focus, is aimed at revealing generic relationships and deriving theory from the emerging description. The emergent theory is then to be tested (validated) against the empirical world to ensure that it is properly grounded in lived experience.[5]

Denzin's methodological formulation of 'interpretive interactionism' is also a two-staged process, involving 'thick description' and 'thick interpretation'. It is worth quoting Denzin at length on the subject:

> (Thick description) captures and records the voices of lived experience...(and) contextualizes experience. (It) does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard. (1989a, 83)

Thick interpretation elaborates and builds upon thick description by incorporating context, interaction and history in the study of symbolic and multiple meanings at a variety of levels in a way that is meaningful to the people studied (Denzin 1989a).

For both Blumer and Denzin, a commitment to grounded theory does not prevent the exploration of subjective experience using a variety of interpretive methods (participant observation, conversation analysis, text analysis, depth interviews and so-on). However, a grounded theory approach does require that methods be qualitative and essentially 'see-through' (faithful to lived experience), and

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[5] McPhail and Rexcoat (1979) see a fundamental contradiction here in Blumer's willingness to entertain theory testing at one point but not another, but they also acknowledge that experimental science is more appropriate to areas where a reasonable body of knowledge already exists. This suggests that research be staged according to the maturity of the field, that theory should be generated 'close to the ground' and then tested. This is not unlike what Blumer has suggested, but is closer still to Mead's social behaviourism.

that the generation and validation of theory be very explicitly and closely tied to this methodology.

The implications of this relationship between theory and method for health promotion research are profound: what seems to be urgently required is a 'grounded theory' for various areas of health promotion that can provide working models of individual-social (agency-structure) relationships, socialization, and empowerment based on a deep understanding of how social groups conceptualize health and health-related behaviour. Unfortunately, grounded theory is not common in the sociological literature (Bailey, 1984), nor, until recently, in health promotion research. Yet in addition, research should not be limited to a grounded qualitative understanding but also include critical components, because influences on social action extend beyond the awareness of individuals, and because purely interpretive research may unwittingly reinforce the status quo. In the health promotion literature, for example, qualitative methods are often conceived (and promoted?) as the means to fine-tuning behaviour modification strategies without explicit attention to the need for concomitant structural change. The assumption is that qualitative methods can be used to better understand 'how people tick' for the purpose of perfecting the design and delivery of manipulatory disease prevention interventions. The temptation to use qualitative research in this manner should be resisted (a) because people are not active willing participants in setting the agenda, since the attempt is to control their behaviour rather than assist them to assume control (which is the stated purpose of health promotion); and (b) because the assumptions and context behind what people say should be examined, rather than accepting their testimony at face value. In essence then, this requires that one adopt an explicit set of values guiding the practice of health promotion research, and that the research process itself be empowering for disadvantaged groups.

2.4 TOWARDS A NEW RESEARCH METHODOLOGY FOR HEALTH PROMOTION

Each of the critical areas of debate outlined in this chapter apply equally to research for an expanded health promotion as they do to social theory. It was argued that the requirements for a new paradigm for health promotion research include a

fundamental concern with the critical appraisal of subjective meanings as construed by human social agents, one that appreciates and struggles with the intersection of structure (as norms, codes of conduct, institutions) and human agency (individual volition cognition, personality, and biography) in a manner that remains sensitive to biographical and historical context and to the role of feelings as well as rationality, and finally also one that grounds theory in empirical reality. Thus what is called for is an explicitly critical-interpretive research methodology.

There may not be any single 'right' answer to the inevitable and pressing question of what this means in terms of a working methodological framework for health promotion research. However, I think it is instructive to consider two different research traditions in sociology (interpretive interactionism and cultural analysis), as well as the work of Paulo Freire when considering what approach to take. The emphasis in the review that follows is on articulating the spirit of an ideal methodology, rather than in specifying a recipe of precise methodological requirements. Given the infancy of these debates in health promotion, experimentation and critical debate will precede the development of a new methodological paradigm that is consistent with the rhetoric of the 'new' health promotion. The discussion that follows is meant to contribute to such debate rather than foreclose on it.

2.4.1 Key elements: the interpretive and the critical as embodied in interpretive interactionism and cultural analysis

One possible departure point in the articulation of a new research methodology for health promotion would be to combine two potentially complementary approaches: (a) qualitative research, particularly as exemplified by Denzin's interpretive interactionism, and (b) cultural analysis, as a means of articulating the critical and macro level components of a holistic explanation of human behaviour. A synthesis of these approaches, which may take a variety of specific forms, may provide the best chance at understanding behaviour which, while culturally mediated, nonetheless takes on very personal dimensions. This section is devoted to a description and analysis of these approaches.

Denzin (1989a) has argued that the *process* of conducting qualitative research using 'thick description' and 'thick interpretation' can be conceived in six stages. These are presented below in modified form, together with examples germaine to smoking cessation adapted from interpretive research on alcoholism. This interpretive interactionist approach represents a creative blending of elements of existential phenomenology, Blumer's symbolic interactionism, Glaser and Strauss' grounded theory, and work by Geertz on thick description. It is essentially an ideographic methodology most appropriate for the investigation of formative and transformational experiences (problematic events and behaviours), given its attention to both historical and biographical context. I think it can be usefully extended to the analysis of the formation (social learning) and sanctioning (norms) of health-related behaviours in specific individuals and groups, because it involves the construction of 'ideal types' which typify subjective lived experience. Its promise is in the provision of a much deeper and richer knowledge base from which to derive *effective* health promotion interventions that are sensitive to lived experience and that work with, not despite, meanings groups attach to certain behaviours. Denzin has also argued that an interpretive interactionist perspective is ideally suited to the evaluation of social policy and program interventions from the perspective of the client.

For Denzin, the first step of framing of the research question involves working from a 'sociological imagination' borne of one's own biographical experience and that of (a few) subjects who've experienced what the researcher wishes to study. But ideally all forms of knowledge inform this initial stage of the research process, so long as hypotheses are implicit and held as tentative organizing constructs. Denzin suggests that 'how' questions are of more interpretive interest than causal 'why' questions. The two research questions that Denzin posed in the *Alcoholic Self* and *The Recovering Alcoholic* could be adapted to a study of smoking cessation as follows: firstly, "how do ordinary men and women live and experience the smoking self active tobacco addiction produces?", and secondly, "how is the recovering self of the recently quit former smoker lived into existence?" (1989a, 50).

The second stage is one of deconstruction and critical analysis of prior conceptions of the problem. At this point it is important that the researcher lay bare his or her prior conceptions of the phenomenon in question. The reality of the

hermeneutic circle prevents us from 'bracketting' them out completely as a basis for presuppositionless enquiry, but it is nevertheless crucial that the researcher make them explicit so that the reader can determine for him/herself their influence on the research project (Eyles 1982). At this stage Denzin feels that preconceptions in the literature should also be explicated. Deconstruction thus refers to the process of laying bare the way in which a phenomenon such as smoking is typically presented, studied and analyzed in the existing literature.

Capturing the phenomenon, including locating and situating it in the natural world and obtaining multiple instances of it, constitutes the third stage of Denzin's interactionist research process. This stage presupposes a basic familiarity with the language of participants (symbolic meanings particular to the group under investigation), which the researcher must learn. Personal histories and self-stories that embody the phenomenon need to be acquired through qualitative methods such as participant observation, depth interviews, conversation analysis, and text analysis. In his research on alcoholism, Denzin began by attending AA meetings to familiarize himself with the setting and language of interaction, cultivated friendships with recovering alcoholics, and documented their biographically situated stories. The same could be done with smokers through Nicotine Anonymous. Recent research on lay health beliefs using depth interviews (Eyles and Donovan 1986) and on unequal power relations in a community health planning committee using conversation analysis (Paap and Hanson 1982) provide interesting examples of these types of qualitative approaches.

Denzin's fourth stage involves bracketting the phenomenon, reducing it to its essential elements, and cutting it loose from the natural world so that its essential structures and features may be uncovered. Here subject matter must be confronted on its own terms. A semiotic reading of text (data) to get at its larger meanings involves an analysis of particular words and phrases as symbols, metaphors and metonyms. Coding and classification arises out of regularities across the multiple instances that have particular meanings for subjects. Denzin divides the bracketting process into the following stages: "(a) locating within the personal experience, or self-story, key phrases and statements that speak directly to the phenomenon in question; (b) interpreting the meanings of these phrases, as an informed reader; (c)

obtaining the subject's interpretations of these phrases, if possible; (d) inspecting these meanings for what they reveal about the essential, recurring features of the phenomenon being studied; and finally (e) offering a tentative statement, or definition, of the phenomenon in terms of the essential recurring features identified in (d)" (1989a, 56). In other words, what is involved is not so much the search for phenomenological essences or universal truths as the discovery of patterns of phrases and turns of speech that are common denominators and indicative of ideal-typical social constructions.

Construction, or putting the phenomenon back together in terms of its essential parts, pieces, and structures constitutes the fifth of Denzin's stages in the interpretive research process. This involves the classification, ordering and re-assembly of bracketted phenomena (back) into a coherent whole, or as Denzin put it, to "recreate lived experience in terms of its constituent, analytic elements" (1989a, 59). It involves the construction of 'typical' examples of the general patterns disclosed during analysis of the data. In the case of research on alcoholism, it may involve typifying the stages or emotions 'commonly' experienced in developing tobacco addiction or in recovering from it, and relating these analytic parts to a coherent whole. Since codification can never be completely free of theoretical constructs, it is appropriate to use theory explicitly in helping to order the data.

Lastly, Denzin advocates relocating the phenomenon back in the natural social world as a process of recontextualization. "Contextualization takes what has been learned about the phenomenon, through bracketting, and fits that knowledge (back in)to the social world where it occurs" (Denzin, 1989, p.60). Variations in the phenomenon are illuminated through contrasting stories that embody the essential features of the phenomenon, allowing the main themes to be synthesized into a reformulated statement of process. Here the reconstructed (stage 5) typifications of phenomena bracketted from empirical data (stage 4) are re-situated in social/experiencial context; a process of breathing life back into the typifications created by the researcher. While the emergent grounded theory is thus reinfused

with the stories of participants, it also uses counterfactual evidence to illustrate the limitations or 'robustness' of theory.[6]

Denzin's six-part research process provides an excellent strategy for ordering and summarizing subjective lived experience in a manner that is firmly grounded in empirical reality. Individual accounts are vital for sensitizing those engaged in research for health promotion to the flavour of lived experience as it impacts health. On the other hand, behaviour and experience are also rooted in a wider socio-cultural context, since most human behaviour is learned, rather than merely instinctual or biologically determined. That learning does not occur in a vacuum, but is socio-culturally mediated, incorporating aspects of individual subjectivity and perceptions as well as cultural 'norms'. As a result, it is possible that an interpretive approach, by ignoring social determinants of many health problems and health-related behaviour, will be conducive to 'blaming the victim'. If individuals are to be empowered to alter culturally-mediated behaviour or to facilitate their own emerging critical awareness and process of taking control, then this wider context can not be ignored. It may, for example, be useful to explore with participants their experience of social constraints to behaviour. However, there is reason to believe that a considerable proportion of the circumstances guiding human action will remain opaque to situated actors, embedded in the taken-for-granted macrocosm of culture. Therefore, the interpretive must be infused with the critical. Cultural analysis provides this perspective, and therefore constitutes a critical adjunct to interpretive research.

But what is culture, and how do we apprehend it? The nature of culture, its generation and evolution, and its impacts on human behaviour have been the subject of considerable debate in the social sciences. Wuthnow et al (1987) have characterized culture as the 'symbolic-expressive' component of human behaviour, neither reducible to more concrete forms of social structure nor comprised (uniquely) of subjective meanings (c.f. Fiske 1989). Culture is generally conceived as mediating between structure and agency, although often in simplistic terms that posit a kind of "Newtonian cultural mechanics" (Willis 1977), with culture as static,

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[6] For expanded discussions of the validation of qualitative research, see Athens (1984), Denzin (1989a), Eyles (1982), and Glaser and Straus (1967).

reified and institutionalized in the form of cultural artifacts and universal tastes and norms (Denzin 1989b). Pelto and Pelto suggest one focus on "distinct cultural styles in a particular microecological context" (1978, 403) rather than uniformist cultural theories of pervasive 'norms'. But more pluralistic concepts of culture such as Shutz's (1962) 'finite provinces of meaning' or Kleinman's (1991) 'local moral cultures' raise questions about the spatiality of cultural manifestations, and by extention, the relationship of culture to community, and to locality.[7]

My intention is therefore to distinguish between popular culture and the connotations of culture as 'high art', 'fine' cuisine, theatre, *'haute cuture'*, or high intellect (academia). Popular culture is sometimes conceived in terms of the legacy of 'quaint' traditional practices ('folklore') that distinguish one particular cultural or ethnic group from another. This reading of culture corresponds with the first of three perspectives on popular culture presented by Fiske (1989): popular culture celebrated as a democratic entity without situating it in a model of power relations (based on class, gender, race etc). Its antithesis is the tendency among some marxist theorists to locate popular culture so firmly within a model of power and ideological domination that it resembles the 'mass culture' of a passified public. A third perspective favoured by Fiske (1989) is to view popular culture as the site of struggle, involving tactics by which the forces of domination are coped with, evaded and/or resisted. From this perspective the apparently crass, garish and unsophisticated nature of the popular is a testimony to its subversive nature. The use of puns, inuendoes and satirical humor in popular texts (e.g. tabloid newspapers, rap music) thus represents a deliberate questioning (even mockery) of the dominant ideology and status quo in a way that the disenfranchised can readily identify with.

But in the process of struggle, dominant values such as capitalism, consumerism, individualism, and the ideals of the liberal welfare state are unintentionally extended and reproduced because the struggle is always in

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[7] This raises interesting questions about the social and temporal patterning of social practices. If one considers that there may be meta-narratives (or meta-cultures) such as television, the national outlook, or general regional ontologies that transcend and are differentially absorbed by a variety of local 'sub-cultures', one is compelled to ask what constitutes an appropriate scale of inquiry in cultural analysis. For further discussion of some of these issues see Labonte (1989) on concepts of community as they relate to the health promotion agenda. For a sampling of the issues intrinsic to locality research, see Beauregard (1988), Cochrane (1987), Cox and Mair (1989), Duncan and Savage (1990), Johnson, Gregory and Smith (1986), Savage and Duncan (1990), and Urry (1987).

opposition to a state of affairs largely determined by those possessing economic and political power who thereby control the agenda. For example, smoking is seen by many teenagers as an act of rebellion, but it also plays into the hands of powerful tobacco companies and their advertising agents.[8]

How does this apply to health promotion? Fiske (1989) offers the example of the human body as a site of struggle between popular culture and official sanctioned versions of reality. It can be shown that historically "law and medicine in the nineteenth and twentieth centuries.. joined hands with religion in attempting to exercise social control through disciplining the meanings and behaviours of the individual body... as the site where social power is most compellingly exerted" (1989, 90-91). Capitalism relies on the labour of the body yet seeks to conceal that vulnerability, by seeking to control, desexualize, and aestheticize the body. It is not suggested that this is consciously intended by individual members of the dominant upper middle class. The perhaps unintended, but no less inevitable, consequence of controlling the legal, medical and religious institutions is that what elites consider self-evident and true becomes written into the codes of conduct of those institutions is used to guide the conduct of others in the production of an 'orderly' society. Taken-for-granted assumptions such as the valuing of health above immediate gratification are not always shared by disadvantaged groups. It is therefore important to consider the ideological, distributive/exploitative and potentially manipulative consequences of health promotion.

There are numerous examples of "medicine's attempt to exert discursive control over the pleasures of the subordinate and to establish as medically bad for the individual the pleasures that escaped, and thus threatened, patriarchal control"

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[8] Fiske examines the significance of wearing torn jeans as an example of this symbiosis between dominant cultural mores and the forms of adaptive resistance employed by traditionally disenfranchised subgroups. Briefly, it is significant that certain youth tear jeans before wearing them because in a sense there is nothing more all-American than bluejeans and their being 'defaced' is a statement of rejecting aspects of the dominant culture. Yet it is also significant that it is blue jeans that are torn and worn, and not cords or overalls: some of the connotations of both belonging and individualism, and of freedom are retained in the wearing of jeans even though the tearing of them indicates that that membership is sought conditionally and so that control over its meaning(s) is (are) retained. Thus the wearing of torn jeans both extends and resists dominant cultural values as part of an ongoing struggle. Similar conclusions can be made about the wearing of faded jeans. Note that the bluejean companies were subsequently successful in marketing 'pre-faded' jeans and thus to subsume what had previously been a resistive discourse. And so the struggle for control and autonomy continues as an evolving dynamic.

(Fiske 1989, 92). For example, the reading of novels in the late 1800's was considered to be the cause of uterine disease among women because of the 'unfortunate excitement' that it caused (Kellog 1882). More subtle forms of social control may well lie in the recent medicalization of childbirth, fertility and sexual behaviour (c.f. Foucault 1979). Is it possible that mounting public distrust of the justice system, of biomedicine, and of religious institutions, has provided the opening for health promotion to become the new discourse of morality designed to cleanse and manipulate the body public?

> The process...in which a social law or power is transformed by an instrumental apparatus onto a body [is] a process of 'intextuation'. This incarnation of the law and intextuation of the body occur not only at the moments of transgression, though they occur most clearly and insistently there; they are also at work in ordinary, everyday practices. Clothing, cosmetics, slimming, jogging are all means of incarnating rules and intextuating the body... The meanings of health are [therefore] social and not [primarily] physical... (Fiske 1989, 91-2)

Women's magazines are full of advertisements for products designed to help them conform to dominent social norms governing public appearance, marketed as health products. Thus "being defiantly fat, can ... be an offensive and resisting statement, a bodily blasphemy. 'Fat is a feminist issue' (as the title of a book by Orbach has it) precisely because it refuses the incarnation of patriarchy upon the female body: being fat can then become an empowering utterance" (1989, 93). Can other health-related behaviours such as smoking similarly be construed as empowering on the grounds that they are symbols of resistance to the dominance of healthism? Is there a conflict between the 'empowerment' rhetoric of health promotion and its stated intentions to reduce the prevalence of behaviours such as smoking? Consider Fiske's analysis of bourgois and working-class sport:

> Sport's celebration of the body beautiful becomes, by contrast, a depoliticized ideological celebration of physical labour in capitalism. The sporting male body is, consequently, an active hegemonic agent. The sporting values of fairness and equality for all its players, of respect for the loser and proper celebration of the winner, are the moral equivalent of the body beautiful and represent the dominant ideology by which democratic capitalism values itself. But if sport is clean, if capitalism is clean, then wrestling is triumphantly, defiantly dirty. For Douglas (1966), dirt is matter out of place, and the terror it invokes in the respectable bourgeoisie derives from it power to demonstrate the fragility of the conceptual categories by which semiotic and social control are exercised over unruliness and the forces of deception. Dirt disrupts and threatens social control because it fractures the categories upon which that control depends. ... Cleanliness is order - social, semiotic, and moral (it is, after all, next to godliness) - so dirt is disorder, is threatening and undisciplined. The body is inherently "dirty": all its orifices produce dirt... The aestheticized body is a body without dirt that offers no categorical challenges to

> social control and disciplined 'cleanliness'. So the bourgeois body, applauding politely at the end of a ballet, and keeping to its category as audience, is clean and unthreatening. But the working-class body, shouting its billingsgate or fighting in the ailes, erupting out of its category as audience, is dirty and threatening.
> (1989, 98-9)

Whereas social rules of conduct concerning the apprehension of disorder and 'dirt' are designed to bring public behaviour into line with the moral values of the dominant class, subversive popular culture turns some of the 'educative' programs of the bourgoisie 'on their heads'. In other words, labelling smoking as 'dirty' in an attempt to discourage it may actually enhance its appeal for the rebelious. If this is the case, then appeals based on the assumed universality of values such as cleanliness and order may alienate some of the 'hard to reach'. Efforts by health professionals to fashion education programs 'in their own image' become counter-productive.

An examination of culture illuminates the (shifting) foundations of individual and group behaviour as it relates to health and highlights the role cultural differences play in the effectiveness of interventions. It also raises some disturbing and perplexing questions about the unwritten intentions and iatrogenic side effects of health promotion as it is currently conceived and practiced in North America (see Chapter 9 re tobacco control).

In order to include the study of culture in health promotion *research*, it may be necessary to more fully explain the nature and function of culture in society and how this impacts upon the health of the individual. Culture orders and mediates the interpretations and behaviours of individuals and groups in ways that are not entirely accessible through the subjective perceptions of 'situated actors', but which are nevertheless firmly embedded in them. How does one apprehend culture, as historically and materially situated, when unconscious structures of knowledge remain elusive? Wuthnow et al (1987) review a number of approaches that have surfaced from theoretical traditions that populate sociological theory. In particular they discuss the work of Berger, Douglas, Foucault and Habermas, coming from diverse theoretical backgrounds that encompas phenomenology, cultural anthropology, poststructuralism and critical theory respectively. Giddens (structuration theory) presents an additional avenue to cultural analysis that would

appear to merit closer attention.[9] It is instructive to briefly review these approaches so as to indicate how cultural analysis has been variously defined and operationalized, and how therefore it might contribute a critical understanding of the forces within and beyond the immediate perview of the individual that shape his or her perceptions, values and behaviour within different collectivities.

Working from a primarily phenomenological perspective, Peter Berger is crucially concerned with the social construction of reality as inter-subjective systems of meaning, and the internalization of values and norms.[10] For Berger, culture is constructed and reconstructed through a continual process of social exchange. Its building blocks are signs and systems of symbols (media such as language, art and religion) that convey, and are imbued with, subjective meanings.[11] The sense of coherence that this engenders is both biologically and psychologically necessary and is achieved through a processs of 'externalization' designed to overcome the lack of instinctual guidance received at birth by creating an apparent 'objective' reality 'out there', through reification and objectification (Wuthnow et al 1987). But these apparently external social structures are also internalized or 'reabsorbed into consciousness', primarily through socialization, thereby completing the three 'moments' of the Bergerian dialectic between the individual and the social-cultural world. And while individual identity is a product of culture through socialization, it is also individualized through human intentionality.[12] For Berger then, drawing on Shutz, common-sense or intersubjective (fundamental, shared) knowledge is

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[9] This is a highly selective review of the literature on cultural analysis. Another useful reference besides those of Fiske (1989) and Wuthnow *et al.* (1987) is a volume of collected works edited by Alexander and Seidman (1990) that summarizes a variety of perspectives on culture, including articles by such emminent theorists as Dilthey, Parsons, Gramsci, Saussure, Merton, Goffman, Geertz, Bordieu, Adorno, Marcuse, Lyotard, and others (including those reviewed in greater detail by Wuthnow et al). The material on cultural analysis which follows draws heavily on these sources.

[10] See for example Berger and Luckman's *The Social Construction of Reality* (1966), perhaps one of his best-known works in sociology.

[11] The pervasive power of the medium to shape the message, to control the nature of human communication, is most apparent in the postmodern shift from a print-based culture to one based on the visual imagery of the TV. For a particularly lucid and disturbing analysis of the implications of this trend for the evolution of culture, see Postman (1985) and Kellner (1990).

[12] From this perspective then, our own private provinces of meaning (identity, personality) represent our own biographical trajectories through cultural space and time, coloured by our (individual but again culturally mediated) understandings and interpretations.

therefore the foundation of the lifeworlds of individuals, and it is the role of the social scientist, through phenomenological reduction, to construct ideal-typical representations of these shared meanings. These largely taken-for-granted provinces of knowledge and meaning are frequently sustained through institutions, at both the macro (such as organizations, bureacracies) and micro scales (as roles and informal rules of conduct, etiquette), through the vehicle of conversation. It is worth quoting Wuthnow *et al.* at length on the implications of Berger's approach:

> Berger can be credited with...building the framework for a bridge between ...(the micro and macro) spheres. In this synthesis the inter-relatedness of intersubjective meanings, primary relationships, role, identity, institution, social structure and symbolic universe is firmly established. Among other things, this enables the social scientist to comprehend the various dimensions of culture simultaneously as social facts and intersubjective meanings. In this, social psychological reality and micro-sociological phenomena are adequately placed in the context of a particular social structure, yet social structure is not reified into a static, lifeless form detached from the social processes out of which it was originally constructed and continues to be maintained. Given the state of social theory at the time Berger published these writings, this was no small feat. (1987, 54)

However, Berger's attempt to build a framework to bridge the micro and macro social worlds is incomplete because it remains largely descriptive, as opposed to explanatory, and therefore theoretically under-developed (Wuthnow *et al.* 1987). Berger's work also raises difficult questions about the limitations of relying on actor's own accounts as a means of validating one's analyses, for which there appear to be no easy solutions.

From the perspective of cultural anthropology, Mary Douglas has focussed her attention on social control is maintained through classification systems guiding interpretation and action, particularly as embodied in culturally-sanctioned rituals. This emphasis on symbolism has directed Douglas to an ever deeper analysis of the moral order presupposed within systems of classification; the 'oughts' and 'shoulds' which define the sacred and the profane. She points out that culturally-prescribed rituals permeate the most mundane dimensions of daily life. For example, while the need for food is biologically determined, what is eaten, when, with whom, in what combinations and order, and how, are prescribed elements of a daily ritual ceremony that is a slightly personalized expression of culture. Likewise, despite the addictive nature of tobacco products, the uptake of smoking and the circumstances and rituals surrounding the use of tobacco are socially determined. Similarly, we make use of

economic goods not so much for their physical properties but as a means of communicating with others particularly in the representation of self. Buying into a certain style, like a vocabulary, is a means of conveying socially sanctioned meanings in an attempt to fashion a desired image of self. Advertisers understand this cultivation of self-image through consumption as the 'real' source of demand for their products, and gear their advertising accordingly (c.f. Eyles 1988). Like Berger, though from a different perspective, Douglas has succeeded in demonstrating the fundamental dualism of structure and agency by illustrating how cultural rituals permeate everyday life. Individual identity and behaviour are in large measure culturally derived.

Culture is more than a container or context for behaviour: it is firmly implicated in and woven through it. Rituals (habitual, shared and patterned behaviour) surrounding the preparation and consumption of food, smoking, sexual activity, and many other forms of social activity and interaction thus provide fertile ground for cultural analysis relevant to dimensions of health and health promotion.

Foucault's post-structuralist approach provides an historical critique of the evolution of knowledge and discourse, and of how events, phenomena, scientific and social change are understood. His primary interest lay in articulating the interstices of knowlege and power and how they are constituted in society, which he achieved primarily through textual analysis and the deconstruction of language. Taking this perspective on health promotion might seek a critical examination of the historical evolution of discourse in health education and health promotion, elite definitions of 'appropriate' behaviour, and the ways in which language is subtly employed (often unintentionally) as a means of social control, so that terms such as 'empowerment' come to be used in ways that are particularly *dis*empowering for traditionally disenfranchised groups in society. For Foucault then, power is insidiously bound up in the differential deployment and availability of knowledge. In modern society, power is exercised not through brute force, but through a more subtle coercion implied by the internalization of rules of conduct as a form of self-censorship, such as worrying what others will think. The application of psychology, the social sciences, medicine and other domains of knowledge to 'understanding' the 'deviance' (variously termed 'non-compliance', 'non-rational' behaviour, 'uninformed choice') of

health-adverse behaviour such as smoking therefore becomes an essential element of social control, not merely by the state, but more insidiously embedded in the very discourse of these disciplines. The stigmatization of smokers is a case in point (see Chapter 9). In this way, power is exercised without conscious intention, as the morality implicit in the definitions of acceptable behaviour goes unquestioned and becomes enforced and reproduced in daily social interaction. Furthermore, the discourse of the health professions carries a double-meaning that both reinforces and masks its coercive nature. For example, the simultaneously liberating and benevolent, as well as potentially coercive and paternalistic connotations of terms such as 'empowerment' ensures that some forms of health promotion that, on the surface, appear benign and benevolant ('empowering'), in fact may achieve the opposite because elite control of the power to define the agenda is maintained. The implication of Foucault's work for health promotion research is that health professionals examine the cultural context and iatrogenic side effects of their own work and not just that of their 'clients'.

Habermas (1972) also examines the regulative properties of language as a medium of communication (rendering communication meaningful) rather than focussing on the specific (and situationally transient) meanings themselves. For Habermas, structural linguistics are at the core of cultural evolution, and the internalization of (this linguistically mediated) culture are a prerequisite for social competence. The emancipatory thrust of Habermas' critical theory is aimed at the restructuring of communication in more rational (and presumably egalitarian) directions. However, the intended process of cultural rationalization as collective argumentation leading to consensual redefinition of societal norms is compromised by the tendency for expert cultures to take over the process of legitimising norms, which in turn leads to a loss of both individual freedom and meaningful public input into social change. This ostensibly occurs through what Habermas terms the 'inner colonization of the lifeworld' by systemic media such as money and bureaucracy which are dominated by the 'expert cultures'. Habermas' formulation of critical theory is complex and difficult to digest, but it raises several pressing issues. In particular, what avenues for *critical* dialogue health professionals created or allowed that encourage meaningful participation of those 'targetted' for educational or health

promoting interventions, and to what extent has a 'behaviour modification' agenda within health promotion excluded this?

Giddens (1981, 1984) has succeeded in overcoming some of these difficulties in his formulation of structuration theory by more tightly specifing the mechanisms binding the macro and micro scale. His retheorization of the relationship between agency and social structure resulted in a set of principles of social analysis that are both widely applicable and deeply contextualizing (Thrift 1985). The result is a complex and abstract theorization of social change that specifies in a non-deterministic way the recursive inter-relationships between reflexive agents, social systems as patterned behaviour, and social structures as context-specific consellations of rules and resources for action (particularly as embedded in institutions), and the impact of these elements and relations on social reproduction and social change. His conceptualization of power embedded in the 'time-space distanciation' of social systems and structures which permits their reproduction without the need for face-to-face contact, might be particularly helpful in thinking about the diffusion of changes in social norms and institutions. Giddens' work points to the need for a contextual understanding of social systems and structures and the ways in which knowledgeable individuals draw upon these in the creation and recreation of their own realities, which feed recursively back into structural context and the external conditions of others. Giddens' four tiers of a balanced research agenda also merit consideration: (a) the hermeneutic investigation of frames of meaning, (b) the investigation of practical consciousness, (c) the identification of the bounds of agents' knowlegeability, and (d) the identification of the main institutional components of social systems. Such a research agenda is both interpretive and critical in outlook, concerned with subjective meanings in their wider (cultural) contexts.

The analysis of culture and the cultural components of behaviour would appear to lead away from the victim-blaming that has characterized health education in the past. The importance of 'healthy public policy' and social norms to smoking cessation has been recognized in the COMMIT trial and other tobacco control initiatives. Health professionals have engaged in the practice of social engineering through manipulation of legislation, the media and other avenues designed to

influence the social acceptability of smoking. The effort seems justified on the grounds that tobacco industry is waging a similar war in favour of tobacco consumption, and because smoking is manifestly detrimental to one's physical health. On the other hand, 'creating environments conducive to health' has been dominated by a professional middle class agenda (e.g. attacking smoking versus industrial pollutants) and gives the appearance of doing things *to*, as opposed to with, others. While the ethics of coercive tobacco control can be persuasively argued for, a critical and cultural-analytic perspective, when coupled with an interpretive agenda, suggests that reforms at the individual and community level be defined in relation to the priorities of under-privileged groups, and that the process of change be managed by professionals as consultants, partners and even catalysts, but not without the active participation of those affected. Indeed, the *process* of change in terms of how policies are implemented is at least as important as the direction and rate of change. In the next section, it is argued that an approach such as Freire's education for critical consciousness best approximates an emancipatory social change process by involving people in the identification of systemic as well as individual barriers to change.

2.4.2 Application in practice: Freire's education for critical consciousness

A research methodology of the kind outlined above is very much in keeping with Freire's agenda for critical education.[13] Freire argues that facilitating meaningful social change requires that one first understand the people, where they are coming from, their agendas and vocabularies, and experiences of 'oppression' (e.g. service dependence, powerlessness, alienation). This is essentially an interpretive interactionist agenda, accessible through Denzin's staged research methodology outlined above. Freire's second step involves facilitating the germination of critical consciousness, which he sees as empowering because it encourages participants to question taken-for-granted assumptions and explanations of the world (and their place in it) from which can arise new and more liberating ways of thinking and acting that are consciously goal-oriented. Cultural analysis

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[13] Freire's methods of 'education for critical consciousness' are discussed by Abadi (1982), Minkler and Cox (1980), Schipani (1984), Smith (1976) and Taylor (1980), but for original sources in English see also Freire (1970, 1972, 1973, 1978 and 1985).

could inform the choice of questions Frierian educators pose in dialogue with participants to foster their critical awareness of the root causes of problems they face, because these root causes are embedded in culture and reproduced through it. This is the essence of critical theory (I use the term loosely here): explicit emancipatory aims based on critical analysis of the root causes of social injustice. The agenda of the health professional is one of empowerment as defined by Labonte (1989): something people must do themselves and on their own terms, ultimately necessitating structural transformations in the material-cultural contexts of these people's lives.

The implications for tobacco control are relatively straightforward, though difficult to implement. Education for critical consciousness means helping smokers identify the psychological and social reasons they smoke, and situating this in a broader cultural context. How is it that large bureaucracies, capitalist interests, and other barriers to social justice have required the oppressed and socio-economically disadvantaged come to rely on tobacco as a coping mechanism? How is it that society permits the production and promotion of addictive lethal substances such as tobacco? To use the words of one key informant in my study of Brantford COMMIT, how can smokers be made more effectively angry towards the tobacco industry? It is instructive to consider how these questions are different from, yet still contribute to, the traditional focus on 'how to get smokers to quit'?

The difficulty in utilizing a Freire-type of approach lies in the fact that people are not used to thinking in these terms, and they are sometimes also reluctant to do so. For example, when I asked smokers in Brantford about what they thought of the tobacco industry, the vast majority answered that they felt concerned about the plight of farmers. Few mentioned the tobacco companies, and when asked about this many defended the industry's 'right' to produce and promote a 'legal' product in a free enterprise economy. What proponents of Freirian methods in health promotion may be missing is what Habermas has termed the 'inner colonization of the lifeworld', whereby the 'oppressed' have internalized self-blame and the values of the 'oppressors' through socialization and deference to 'experts'. It is possible that the individualist ideology and the North American mythology of free choice have trained many people not to think about the systemic roots of inequalities in health.

Comparative analysis of Freire-style interventions in the Honduras and in the U.S. (Minkler and Cox 1980; Pereira 1977) indeed suggests that the application of Freire's approach is more problematic in a North American context. Freire recognizes the internalization of self-blame ('playing host to the oppressor') as one of the three levels of consciousness that he sought to help the oppressed transcend. These include 'magical' consciousness (characterized by fatalism) and two transitional stages of 'naive' consciousness (modelling the oppressor's dress, habits and values, and a 'fanatical' aggressive confrontational stance). All three stand in stark contrast to the 'critical' consciousness he sought to promote, to be based on a more complex understanding of oppression as a systemic - rather than purely individual - problem which coerces/coopts both oppressor and oppressed into unwittingly colluding to maintain the oppressive system.

Freire sought cultural transformation through dialogue with the oppressed that would be rooted in their experiencial world. In this sense his approach truly exemplifies a critical interpretive methodology. It also highlights the utility of cultural analysis as a means of transcending the taken-for-granted understandings of situated actors to examine larger forces that are taken-for-granted in everyday life.

This examination of Freire's work suggests that with a critical interpretive approach the research process becomes part of the 'intervention'. A recurrent theme throughout this chapter has been to make health promotion empowering. Empowerment is "hard to define but you know it when you see it" (Rappaport 1985). It might well include the following: (a) fostering *critical thinking*, (b) encouraging *personal growth* and a sense of self-efficacy and self-esteem, and (c) providing a context in which critical self-reflection together with a sense of personal power can be translated into effective *social action* in the form of mutual support and collective action vis a vis systemic forces and structural barriers to the achievement of one's full health potential (Figure 2.2). Defined in this way, the concept of empowerment as a fundamental health promotion goal brings together the methods of Freire (education for critical consciousness) with those of Denzin (interpretive interactionism) and the critical and cultural analysts.

A critical interpretive research methodology for health promotion involves more than merely beefing up socio-cultural information on 'target' groups so as to better design and implement educational interventions, or to make them more palatable. Rather, it demands an examination of the 'helping' professions themselves in terms of whose interests are really served, not at the level of rhetoric, but in everyday practical interaction with 'clients'. Critical hermeneutics is incomplete if its gaze is selective or purely other-oriented. Furthermore, culture and social relations also take on certain institutional and other structural and resource-allocative forms. In turn, these culturally constituted material conditions constrain action within any given cultural context, in addition to the more direct psychosocial constraints imposed by culture itself. This needs to be emphasized lest it appear that only psychosocial/cultural dimensions affect human behaviour. The degree of autonomy of culture from the social and the material world has been a source of ongoing debate (Alexander and Seidman 1990).

2.5 CONCLUSION

In this chapter, it has been argued that health promotion has, in its articulation of a new holistic and ecological stance, reached a turning point in its conceptual evolution that must be accompanied by the adoption of a more explicitly critical and interpretive research methodology. Such a shift is commensurate with the call for health promotion to be empowering and to use a community development approach that involves health professionals as partners with lay people in the process of assisting communities and individuals with social change in a particular historical and geographic context. It was suggested that the selection of a new methodology would benefit from attention to, and an appreciation of, major social theories as they have struggled with fundamental issues about the nature of social life. The seven debates covered in this chapter are issues that a new expanded health promotion now also must face more directly and conscientiously. They also constitutes a 'decision tree' for selecting specific research methodologies for research in health promotion in a way that is mindful of their theoretical implications, and ultimately of their implications for the empowerment or disempowerment of traditionally disenfranchised groups in society.

Based on criteria derived from an assessment of each of these debates, it was suggested that Denzin's interpretive interactionism, and particularly his formulation of a staged methodology of the research process provides a promising point of departure for one component of a new paradigm in health promotion research. The other - a critical component - should be predicated on an analysis of culture as it affects and is embedded in human social action, and without which research becomes narrow, conservative and prone to blaming the victim. From a vast literature on culture analysis, the views of Fiske, Berger, Douglas, Foucault, Habermas, and Giddens in particular were briefly reviewed as examples of some available options for - and conceptualizations of - cultural analysis.

The question necessarily arises as to how these two rather different perspectives or stances can be most usefully combined. Giddens, perhaps more directly than the other cultural theorists, demonstrates that the cultural analytic perspective does not of necessity preclude analysis of the spatial and social variability of cultural form, or of actors' subjective understandings or typifications of them. But examining the meaning of symbols presupposes an understanding of the conditions, patterns, and rules of use which render symbols necessary and meaningful. In this sense interactionist and cultural analytic approaches can be complementary cornerstones in a new health promotion methodology that is both critical and interpretive. This permits - in fact suggests - that research for health promotion 'tune in' to the subjective lifeworlds of situated individuals using qualitative methods, but that it also examine culture using historical, textual and linguistic analysis. Furthermore, the two can be more fully integrated in an investigation of how culture is consciously apprehended by individuals, as well as its taken-for-granted and unperceived impacts on interpretation and behaviour, the power relationships embedded in the agency-structure interaction, and the role of health promotion in this wider context. The application of Freire-style methods of critical education to focus groups is both a promising critical-interpretive research strategy and a powerful 'intervention' in its own right.

Of course, it may not always be feasible or appropriate to conduct research for health promotion in this manner. In some respects, the approaches indicated in this chapter could be taken as a 'gold standard' (but not necessarily the *only* gold

standard) for health promotion research. But much remains to be discovered about when the use of a critical-interpretive approach is warranted, how it can be operationalized in different environments, what skills are necessary for researchers and informants 'to make a good go of it', and what criteria might be used for evaluating the results of a critical-interpretive inquiry. At the simplest level however, the injunction should still stand to be aware of how others perceive things and to gently but firmly question the origins and implications of these perceptions for program design, implementation and evaluation in health promotion.

In this chapter it has been suggested that the agenda of the 'new' health promotion might be furthered by 'mainstreaming' the use of a variety of qualitative and critical-interpretive methods to complement the use of quantitative methods. Hopefully, a continued debate of the issues will ensure that the current methodological uncertainties in health promotion are interpreted as a challenge to develop a critical-interpretive research orientation for the discipline.

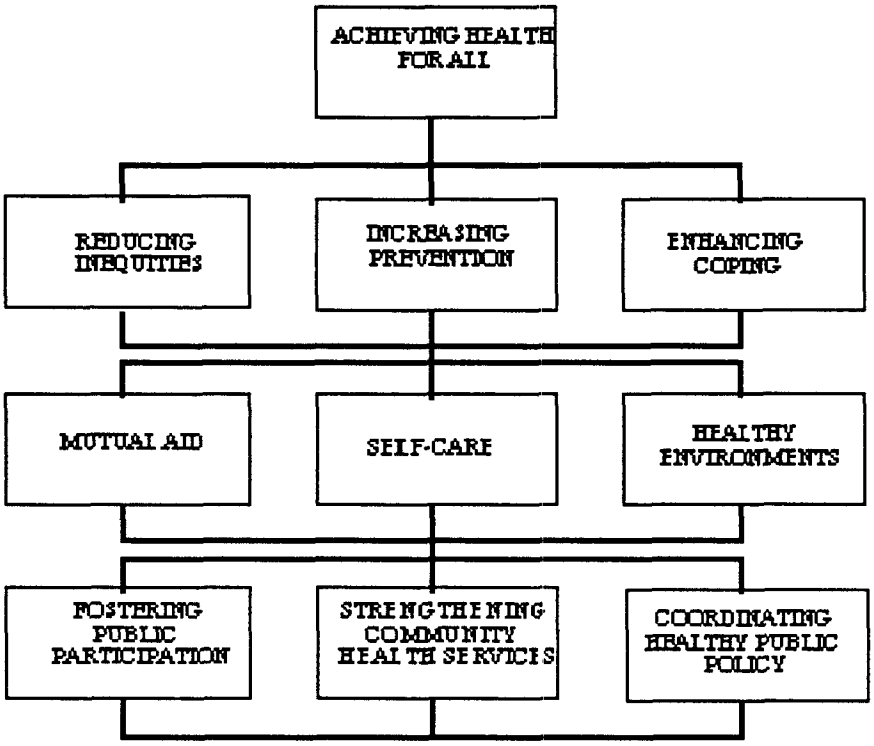

Figure 2.1 The Epp Framework for Health Promotion

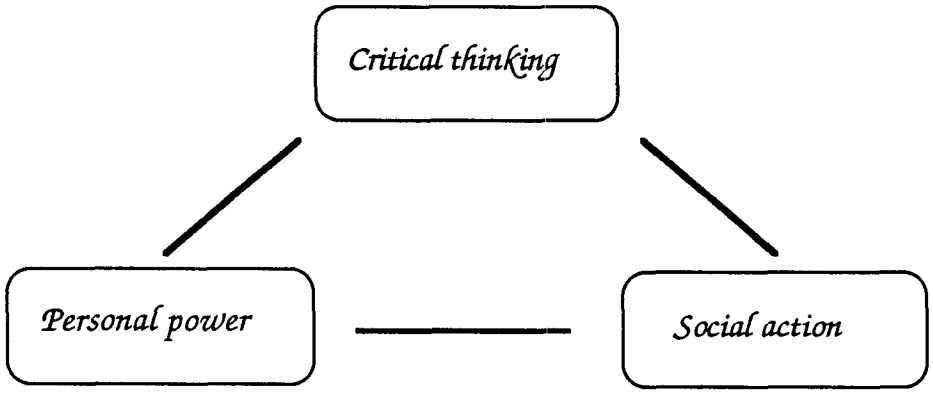

Figure 2.2 A simple conceptual model of empowerment

CHAPTER THREE

SOME PROMISES AND PITFALLS OF LAY PERCEPTION RESEARCH IN THE SOCIAL AND HEALTH SCIENCES[1]

3.1 INTRODUCTION

In the social and health sciences there has been growing interest in recent years in finding out what "ordinary" people think about a range of issues and in linking this to health-related behaviour and political support for public policy initiatives. The assumption is that this will help decision-makers and service providers better tailor policy and service provision to contribute to the well-being of the general public. However, the most appropriate methods for studying lay perception have been the subject of considerable debate, though this is not always acknowledged in papers discussing empirical research findings. Still less frequently discussed is the theoretical framework guiding such work and the need to be mindful of how research is used. In this chapter I maintain that we need to be more aware of the effects of our research on disenfranchised groups and that lay perception research should contribute to their empowerment and to social justice. This is particularly important in lay perception research where we create expectations in soliciting the views of the public that these views will not be distorted, but instead will be honored, and will serve as a basis for subsequent action addressing the expressed needs or concerns of those consulted.

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[1] This chapter has been adapted from a paper of the same title originally published in 1993 in *The Operational Geographer*, Volume 11, Number 1, pages 23-27. Permission to reproduce the material has been granted from the publisher (see Appendix A).

This chapter has three main sections. First, I wish to briefly define lay perception and review some of the many ways in which it has been researched and used, with particular emphasis on the health and social sciences as they pertain to health (the 'promises'). Second, I introduce a number of considerations that researchers should be mindful of when studying lay perception, under the assumption that the failure to do so may result in doing more harm than good under some circumstances (the 'pitfalls'). Lastly, and on the basis of this discussion, I offer a few recommendations for how lay perception research might best be approached.

3.2 THE PROMISES

The term "lay perception" generally refers to the feelings, opinions and attitudes (i.e. perceptions) of non-professionals, and in health studies has tended to pertain more specifically to what non-physicians (or non health professionals) consider to be the nature and causes of health and illness. Of course non-professionals are a heterogeneous group, and someone can be a professional in one arena and not others.

The study of lay perception has been undertaken in many contexts and for a variety of purposes. Opinion polls, hearings and other public consultation proceedings are designed, at least in theory, to provide democratic input into policy formation by conveying to decision-makers the opinions and values of the general public (e.g. Iglehart, 1984; Pederson et al, 1986). District Health Councils and Public Health Departments in Ontario now have citizen representatives on many of their committees (Eyles, 1992). Needs assessment that goes beyond formal statistical data to surveying the target population is predicated on the assumption that involvement of those affected will improve their commitment to the program and that the resultant program design, in addressing substantive issues of concern, will be more effective in reaching its objectives. Indeed, this rationale also extends to the evaluation of service delivery, which now often contains a client-centred component (e.g. Nehemkis, Gerber and Charter, 1984; Wallace and Haines, 1984; Wilson and McNamara, 1982). Also, lay perception is becoming an important component of evaluation research in general insofar as recognition is growing of the need to

consult a range of stakeholders (as opposed to an earlier managerial focus that often ignored the concerns of the target population) (Guba and Lincoln, 1989).

As the contributions of personal 'lifestyle' behaviour and socio-political environment to health are increasingly recognized (Lalonde, 1974; Epp, 1986), the need to investigate lay perception as a basis for understanding human behaviour affecting health (sick role, utilization of health care, compliance with physician recommendations, risk-taking behaviour etc) also assumes greater urgency. Indeed, a substantial literature has accumulated on the subject of lay perceptions of health and illness (e.g. Blaxter, 1983; Kleinman, 1988), as well as specific areas such as risk perception (Fischhoff, Slovic & Lichtenstein, 1982; Love and Thurman, 1991; Weinstein, 1984; and others). Within health promotion and illness prevention, behaviour modification programs targetting individual health risk behaviours like smoking, diet and exercise have spawned a series of health attitude and behaviour surveys designed to help professionals identify gaps in lay knowledge and better tailor health education campaigns to address these. All of these developments point to the growing realization that knowing what the lay public thinks, wants and knows is useful in practical ways to professionals charged with policy development or program design.

Parallel developments in the social sciences such as the 'humanistic' turn have been fuelled by the recognition that the meanings we ascribe to other people, events and actions are central determinants of our future actions and reactions to these phenomena. But this has also been tempered more recently by a realization of the importance of context in human behaviour, and the need to incorporate both agency and structure in social theory (e.g. Giddens, 1984). Of particular relevance, therefore, are the ways in which people apprehend (recognize and create meanings about) the various environments (opportunities and constraints, rules and resources) around them and the impact that this has on their health and on their health-related (intentionally or unintentionally health-seeking or health-adverse) behaviour. For example, what does smoking symbolize for those who engage in it, and what are the contexts in which smoking is perceived as acceptable or even required behaviour?

In addition to drawing upon lay perception in order to better understand human behaviour, and the necessity of doing so given the diminished importance of medical care relative to behaviour and environment as determinants of population health, public and professional norms have shifted in favour of a moral (in addition to merely strategic) imperative to address lay perception as a matter of accountability and social justice. In other words, emergent values (and legal imperatives, in some cases) surrounding the need for public participation in decision-making require that lay perception be front and centre in social and health service planning. The rationale in the realm of health promotion is one of empowerment, or "enabling people to increase control over, and to improve, their health" (Abelin et al, 1987; 653) as a result of critical analysis of self and of the social and political context (Rappaport, 1985). Making heard the voices of the powerless in society thus becomes important in its own right.

3.3 THE PITFALLS

It is evident from the preceding section that lay perception research can serve a variety of purposes and be conducted using a range of methods. The central issue would appear not to be *whether* but rather *how* to access and incorporate lay perception into health research. In my opinion the 'solution' needs to be framed with an awareness of power relations and inequities in access to resources generative of health, so that lay perception research is used to give the disenfranchised a voice, and in so doing enhance their participation and empowerment. And it is with this in mind that I review several potential pitfalls inherent in the ways lay perception is measured and used that would seem on the surface to be consistent with these principles. These are organized into several categories according to stages in the research process: (a) sampling and generalizability, (b) measurement issues, (c) interpretation of results, (d) uses of results. In some cases solutions as such are not readily forthcoming, but it is still advisable to be aware of the potential for problems and to approach the research process with integrity.

3.3.1 *Sampling and generalizability*

While formal sample survey designers are often careful to document the representativeness of their samples, the same cannot be said of every lay perception

study and public participation mechanism. It is well known, for example, that public hearings frequently draw a vocal minority of special interest groups and individuals generally of higher socio-economic status. Even when others are present, it is not clear under what conditions (or mechanisms of accountability?) they can be considered to be meaningfully representing their peers (Eyles, 1992). The problem is our tendency to want to generalize from small samples and say that "now we know what the public thinks" or "we've heard what the public has to say". Closely related to this is the tendency to stereotype groups of people based on limited experience or one-off surveys or focus groups that may not be representative of the broader group from which they were drawn (low response rates may indicate a need to examine response bias). In fact there are multiple publics with competing and even contradictory agendas that change over time, which require that generalizations beyond the data be labelled as speculative and made with caution.

3.3.2 *Measuring lay perceptions*

The sometimes awkward and problematic task of investigating lay perception can be approached using a variety of methods, each with their own assumptions, strengths and weaknesses.

At times perception is simply inferred from observed behaviour, such as when statistics on tobacco sales are used as an indicator of social norms surrounding smoking, or when behavioural experiments such as the 'lost letter technique' are used to guage real-life attitudes (for example having someone drop trash or a letter or other belongings and observing whether others pick it up or draw it to the attention of those who dropped it).

Formal survey instruments are often administered by telephone, mailed questionnaire or in a face to face interview to elicit public attitudes and behaviour, but they must be carefully designed, administered and interpreted to avoid drawing spurious conclusions. Formal survey instruments, by limiting responses to a series of categorized response options, risk imposing the investigator's conceptions of the problem or research area on respondents. The variability of respondents' interpretation concerning the meaning and significance of the response options available to them is not often acknowledged by investigators who may see only their

own interpretations as the 'obvious' ones (Fischhoff, Slovic and Lichtenstein, 1982). Furthermore, many of the significant variables (such as age, sex and income) in statistical modelling of human perception and behaviour are proxies for little-understood underlying effects. And the implicit relationship between attitudes and behaviour that drive much of this type of research, far from being a linear one-to-one relationship, is mediated by a host of contextual factors that are rarely included in the same measurement instruments. Formal survey methods are therefore perhaps most appropriately employed in cases where a field is well-researched and specific hypotheses or trends need verification in larger samples than feasible using more qualitative methods. When this is not the case, the specificity and narrow response option sets required in formal survey design, by failing to allow for new understandings and terms to emerge in people's own language, may result in premature closure, and may suggest spurious conclusions of little substantive or theoretical value (i.e. reliable and perhaps even reproducible, but not particularly valid, meaningful or relevant).

Qualitative methods offer a valuable alternative to formal survey techniques, particularly for exploratory or hypothesis-generating research, for better understanding the intricacies of lay experience and knowledge. And the centrality of meaning to human behaviour coupled with the contextual nature of both, means that qualitative methods that allow respondents to tell their own stories in their own words provide a much richer account of lived experience upon which to build grounded theory. Nonetheless, the depth and validity of individual depth interviews and focus group research depends in part upon the personability of the researcher, the nature of the interview setting, degree of formality, sensitivity of the topic, overall disposition and mood of interviewer and respondent, and other factors (see Chapter 5). There are established procedures for ensuring the rigor (validity and reliability) of qualitative research methods, be those semi-structured focus group discussions or very open-ended interview discussions and diaries, that should be followed (Athens, 1984; Kirk and Miller, 1986; Denzin, 1989).

In addition, given that we frequently ask respondents to reflect on issues that are taken for granted in daily life and are not common topics of discussion, it is desirable that people be given the opportunity for informed reflection. Often public

consultation on complex issues is undertaken without providing adequate background information, which is patronizing towards respondents and makes it too easy for planners and policy-makers to dismiss public opinion as ill-informed or unsophisticated. A recursive research process, on the other hand, allows respondents to revise, refine and better articulate their position on a more equal footing with professionals, and fosters a learning process that is important in its own right. In the Brantford COMMIT evaluation study, when first asked about their needs for assistance in quitting, smokers were often unable to articulate a response, having not thought about it in those terms (perhaps because they are more used to being told what they need or should do than being asked?). Part of the solution involved rephrasing the question in ways that would tap their own personal experiences more directly, but the opportunity to review a summary of what others had said and reconvene later as a group also helped respondents reflect critically on their own needs both individually and as a group.

3.3.3 *Interpreting lay perception*

Several issues arise when interpreting the results of lay perception research regardless of the methods used. First, how should the researcher interpret or resolve internal inconsistencies that might occur within a single respondent or within stakeholder groups? For example, many of the smokers I interviewed were adamant that taxes don't work as a way of getting people to quit smoking, but elsewhere in the interview they also acknowledged cost as a major factor in their decision (or desire) to quit. Others said they thought a buddy system or peer support such as Nicotine Anonymous would be great, but a few minutes later when asked if they would attend N.A. meetings in their area they indicated they probably would not. To some extent the researcher can explore differences in depth or emphasis to resolve these apparent contradictions, engage respondents reflexively to comment on the apparent discrepancy, or work at achieving consensus within stakeholder groups. Preliminary analysis of the interview transcripts with smokers suggests that people envisaged a 'buddy system' to mean support from peers with whom they felt comfortable, whereas going to AA-type meetings required a period of discomfort while forging new relationships with strangers who were not yet 'buddies'.

Equally, when consulting *multiple* constituencies, whose views count and how should the researcher interpret or resolve contradictions between stakeholder groups? For example, what if smokers and cessation intervention staff hold very different views about the nature and efficacy of the program? We should be inclined to favour the opinions of those most likely to know whether the program was helpful (i.e. in this case smokers themselves rather than 'experts'), but what about cases in which each party has an equally strong but competing claim to know?

A related difficulty in interpretation concerns assumptions of rationality sometimes used to assess the 'competence' of lay perception, assumptions which are problematic on several grounds (Poland, 1992). Some health education programming, with its emphasis on the provision of information appears to assume rational choice on the basis of the evidence concerning health risks. Yet many other factors (peer pressure, lack of time, limited access to resources etc) may influence human behaviour, and in the absence of information on these other factors, people's actions may appear irrational. In other words, empathy and understanding of the context in which other people make decisions helps to reveal a different kind of rationality than what we had expected (that which we had previously, at first blush, deemed 'irrational'). This contextual information is often not captured using quantitative measurement tools. The second difficulty with applying standards of formal logic to lay perception is that the sort of rationality we apply to our behaviour after the fact may not be what led us to behave that way in the first place, but rather our own attempt to rationalize or make sense of it. Third, assumptions of rationality leave little room for habit, spontaneity or emotion as motivators of action or as the basis for public opinion.

It is important also to recognize, when attempting to make sense of lay perception, that participants are not all-knowing and that the taken-for-granted is often opaque in normal daily life. This too argues for placing lay knowledge in its larger socio-cultural context. For example, why do we not eat cereal for desert or roast beef for breakfast, and why is dinner traditionally more of a 'together time' for families than breakfast? Understanding peoples' dietary habits means placing individual choices in the context of the prevailing economic and social structure of the 'working day' and societal norms surrounding the meaning and nature of meal-

times and what constitutes an appropriate choice set of foods for each meal, even though lay respondents may not be aware of the impact of these factors upon themselves and therefore cannot or do not articulate them (Douglas, 1978). It is therefore desirable to go beyond what respondents tell us using a cultural-analytic perspective, while being mindful not to distort what we have been told or use this as an excuse to infuse the findings with too much of our own agenda (Denzin, 1992; Poland, 1992; Wuthnow et al, 1987). The critical-interpretive methods used in the research for this dissertation were in keeping with this.

A related issue that is not often discussed in the literature is the need to re-interpret the results of lay perception research for decision-makers in a way that is most compelling for them. Too often, the issues and concerns expressed by the public are phrased in terms foreign to the decision-making elite, the former being from different social circles and not as 'articulate'. Our experience with public forums conducted by the Task Force on Sustainable Development in Hamilton (Ontario) indicates that unless researchers can distil the essence of public submissions and comments and present these in a compelling fashion using some of the language, logic and concepts familiar to decision-makers (as opposed to mere summary or categorization), these voices get lost and those of professionals predominate instead. The challenge in the cases where this is necessary is not to violate the spirit of what one has been told by the public during "translation".

3.3.4 Use of lay perception research

While apparently benign, lay perception research does not always serve the interests of the disenfranchised. Much depends not only on the methods used in data collection and analysis but what use is made of the results. For example, evaluators must resist the temptation to 'mobilize' the community around the predetermined agenda of a participating agency under the guise of research. And selective reference to the results of lay perception research can make existing programs more saleable to funding agencies without in fact honoring the true spirit of all that was said. Also, there seems to be a great deal of interest within the health sciences in qualitative methods as a basis for fine-tuning rather manipulatory behaviour modification programming (regarding lifestyle behaviours like smoking,

diet, exercise, seatbelt use etc). This sort of social marketing is a tantamount to using people's own ideas against them in their presumed 'best interest', and is not the same thing as engaging people in a dialogue and process of critical reflection that encourages and empowers them to identify and 'slay their own dragons'. Instead it paternalistically tells them what behaviour is acceptable according to the tenets of formal logic, where epidemiologic evidence and health are taken as pre-eminent priorities for living. We must be careful in accepting the apparently commonsense logic of social marketing to remind ourselves that in the long run empowerment, social justice and the elimination of poverty are more important than more immediate modest changes in individual behaviours affecting health.

Underlying many of the issues discussed here are fundamental assumptions concerning the nature and origins of lay perception. Behavioural and cognitive models (attitude theory, attribution theory, personal construct theory) underlie many traditional survey-based approaches to lay perception, wherein perception is seen as an internal (mostly biological) process of apprehending an external reality. More recent attention to culturally derived shared meanings and socialization represent a variation on this theme (Gergen and Semin, 1990). The phenomenological alternative to the traditional mind-object duality emphasizes experience as (rather than separate from) reality, but in so doing introduces an insider-outsider duality that makes accessing the experience and perceptions of others problematic (ibid). From a discursive constructivist perspective, it is socially mediated language as repository of meaning, that is of greatest interest. These underlying epistemological issues raise questions about the nature and purpose of scientific inquiry and about the measurement and interpretation of lay perception that go beyond what can be addressed in this chapter.

3.4 CONCLUSION

I would like to suggest three guiding principles for lay perception research in the social and health sciences that address some of the concerns I have raised in this paper.

First, be mindful of power relations in the social production of knowledge. Who is given a voice and whose interests are served by the research process? Consider and honor the spirit and meaning of empowerment, so that the research process is itself empowering. And be mindful of the role of the academic in supporting or challenging the status quo, particularly concerning inequities (social justice).

Second, involve multiple stakeholders whenever feasible and appropriate. Particularly in the case of program evaluation, all those who have a stake in the results have a right to be heard, and the researcher should consider it a moral and ethical responsibility to do so.

Third, adhere to grounded theory methodology in working with qualitative data on lay perceptions (Glaser and Strauss, 1967; Strauss and Corbin, 1990), but bring a critical-hermeneutic perspective to bear on the creation and interpretation of emergent concepts and grounded theory (Poland, 1992).

I have applied each of these principles in the research for this dissertation as faithfully as I could. The methods employed are described in greater detail in Chapter 5. First, a brief overview of the COMMIT trial is presented in Chapter 4.

CHAPTER FOUR

AN OVERVIEW OF THE COMMUNITY INTERVENTION TRIAL (COMMIT) FOR SMOKING CESSATION

4.1 RATIONALE BEHIND THE COMMIT TRIAL

Although smoking is generally on the decline, cessation rates are low among heavy smokers (25 or more cigarettes per day) and low income groups (COMMIT Research Group 1988, Pierce et al 1989). Research evidence from a number of major intervention trials such as the North Karelia Study (Puska 1984), the Stanford 3-Community and 5-City Studies (Farquhar et al 1984, 1985 and 1990), the Minnesota Heart Health Program (Blackburn et al 1984) and the Pawtucket Heart Health Project (Lasater et al 1984) suggests that while health education and clinic-based activities can have an impact on smoking prevalence rates among the general public, the most effective means of assisting heavy smokers to quit might be to intervene on several levels to change social norms and build community-wide support for non-smoking (Sorensen, Glasgow and Corbett 1990-91). As mentioned, the rationale for a community based approach to health promotion is threefold: (a) circumstances affecting smoker's decision to quit, initiate quitting and maintain abstinence are largely social ones (Farquhar, Magnus and Maccoby 1981), (b) a broad-based approach is likely to reach a larger segment of the population on a more sustained basis, and (c) 'ownership', crucial for the local legitimacy and longterm viability of community smoking cessation efforts, is best achieved through a community mobilization approach.[1] However, methodological weaknesses of previous studies (non-randomized design, small sample sizes, inadequate evaluation,

[1] One of the ironies of the community oriented movement in health promotion is that the notion of 'community' is so conceptually impoverished and empirically underesearched. This is surprising given the aims of community-based health promotion, which include making a lasting impact on community dynamics (akin to a community development approach).

failure to demonstrate sustained differences in prevalence rates beyond a 6 or 12 month period) suggest that results regarding specific interventions be interpreted with cautious optimism. On the other hand, the evidence from these and other trials is nevertheless clearly in favour of a multifacetted approach (Lichtenstein, Wallack and Pechacek 1990-91).

4.2 OVERVIEW OF THE COMMIT TRIAL DESIGN

On the basis of the accumulated evidence, the National Cancer Institute undertook the design and implementation of COMMIT: the largest smoking cessation intervention trial in the world (involving over two million participants in 11 North American sites), with an explicit emphasis on heavy smokers (Table 4.1).

As 'stage IV' research (Table 4.2), the primary aim of the project was the evaluation of a defined intervention protocol (established on the basis of research in stages I to III) in a large well-defined population, prior to full-scale dissemination on a national scale.

Four primary goals governed the design and implementation of COMMIT: (a) *increase the priority of smoking as a public health issue in the community* (in other words as a matter of concern to the entire community rather than as merely an issue of individual 'choice', and with potential solutions at both levels), (b) *improve the community's capacity to modify smoking behaviour*, by developing systems of smoking cessation resources for interested individuals, and systems of information about these (not just clinical services but opportunities built into the daily living environments of community members: for example the workplace), (c) *increase the influence of existing policy and economic factors that discourage smoking*, such as taxation, advertising restrictions, laws governing the sale of tobacco to minors, and non-smoking bylaws, and finally (d) *increase social norms and values supporting non-smoking* (the perceived social acceptability of smoking). Two principles also guided design and implementation, for reasons cited above: (a) the need to *foster community ownership/participation* through community mobilization so as to ensure enduring change, build on existing local structures and local capacity, and

minimize reliance on outside resources, and (b) the *use of multiple channels* to maximize the reach of the intervention (breadth and depth) in modifying social norms by exploiting the hoped-for synergistic effects of several simultaneous interventions.

The resulting intervention protocol relied on an organizational framework that encouraged partnerships between the research institution for each site (responsible for trial integrity, financial administration and initial community mobilization) and a community board comprised of representatives of local organizations and groups involved in smoking cessation, including smokers themselves. A minimum of four task forces were also established in each of the 11 intervention communities, as illustrated in Figure 4.1.

The Public Education Task Force was responsible for media and youth (school-based health promotion). The function of the media component was to (a) increase the visibility of COMMIT (kickoff event, press conferences for Annual Action Plans, and magnet event such as 'Weedless Wednesday and National Non-Smoking Week), (b) promote individual attempts to quit, and (c) enhance news coverage of smoking issues (through 'media advocacy'). Media channels have always played an important role in health promotion programming, but the 'media advocacy' approach advocated by COMMIT went beyond the traditional public relations or public service announcement models by attempting to use media to stimulate public debate about smoking, to set an agenda (ie not what to think, but what to think *about*), and often to confront the industry's own use of the media. Media advocacy training was provided to all Field Directors. In addition to those listed in Table 4.3, protocol requirements included a minimum of eight press releases on local angles of major smoking-related stories each year in each intervention community.

The Health Care Providers Task Force was concerned with two major issues. First, because 70 percent of smokers see their doctors at least once a year and are credible sources of health-related information, they can take advantage of clinical opportunities to motivate patients to quit (in fact research demonstrates that health care providers can have an impact on cessation rates when trained to use specific

intervention skills; Ockene et al 1990-91). However, baseline surveys in COMMIT communities indicated that in reality fewer than 39 percent of patients are told to stop smoking by their physician or dentist, so one of this task force's goals is to encourage doctors and dentists to intervene in normal medical encounters in favour of smoking cessation, and to do so by training physicians (under the CME credit system) to use these skills. Second, the task force wished to ensure the passage (and enforcement) of smoke-free policies in all health care institutions in the intervention communities.

Seventy percent of adults aged 18 to 65 in the trial communities were employed, and many of these were apparently low income, minorities and members of other typically hard to reach groups (Sorensen, Glasgow and Corbett 1990-91). Churches, fraternal and civic organizations serve members of these and other age groups, as well as the unemployed. The Worksites and Organizations Task Force promoted the adoption of workplace smoking restrictions and the availability of self-help materials and cessation services in workplaces and organizations. In Brantford, although the majority of smokers and non-smokers felt that there should be workplace restrictions on smoking, baseline surveys showed only 24 percent of smokers reporting workplace restrictions and 18 percent reporting work-based stop smoking programs: these are the lowest figures of all the intervention sites, well below the COMMIT targets of 65 and 70 percent respectively (Sorensen, Glasgow and Corbett 1990-91). Because there is a local tobacco farming economy in the Brantford region, it has proven difficult to recruit and keep members on this board in the face of pressure from the tobacco industry.

A fourth task force was concerned with local cessation resources and services. Because (a) the majority quit without formal assistance, (b) smokers prefer to quit on their own, and (c) of 416 cessation trials reviewed in the Surgeon General's report on smoking (USDHSS 1989), the few differences that were apparent in success rates had as much or more to do with how the intervention was marketed or matched with the needs of participants than in the specific techniques themselves, COMMIT has therefore chosen to emphasize existing cessation resources and services and stress motivation and access to self-help materials. In Brantford, a smoking cessation guide book was mailed to each household, a smokers' network

established which now has approximately 700 members (which will act as the proposed sampling frame for qualitative interviews with smokers), and a semi-annual newsletter produced by the local COMMIT office was circulated to network members, worksites, health care provider offices and other locations/groups.

In keeping with the goals and objectives of each task force (Table 4.3), a number of specified activities were mandated in the standardized COMMIT protocol for each channel, but there was leeway for some local input on timing, implementation and additional activities. The evolution of the community mobilization process in each community is illustrated in Figure 4.2, which was situated within the longer study timetable illustrated in Figure 4.3.

4.3 NCI'S EVALUATION OF THE COMMIT TRIAL

The trial-wide evaluation protocol for COMMIT included four components, of which the first was entirely devoted to behavioural measures: (a) *outcome assessment* (changes in smoking behaviour), (b) *impact assessment* (changes in factors thought to facilitate community-wide change), (c) *process evaluation* (adequacy of intervention implementation), and (d) *economic evaluation* (cost-effectiveness)(Mattson et al 1990-91). As previously indicated, the primary *outcome measure* for the intervention was to be the change in the quit rate among heavy smokers (the goal being 10 percentage points above the comparison community). Prevalence rates were determined community-wide (baseline and follow-up prevalence surveys), yearly within cohorts of heavy (400) and light-medium-ex-never (100 each = 400) smokers in each intervention community, and among youth through a random sample of classrooms across several school grade levels (Tables 4.4 and 4.5).

Impact assessment centred on the factors targetted by the intervention as contributing to community-wide action on smoking cessation: attitudes and beliefs among the smoking and non-smoking public (established via surveys among the evaluation cohorts), as well as impact measures for each of the task force areas. Program impact on health care providers was measured via (a) telephone surveys of 30 physician and 30 dentist offices regarding cessation resources available to

patients and office smoking policies, (b) a mailed census survey of all individual practitioners concerning tobacco counselling practices, (c) the patient's perspective on physician/dentist cessation counselling, collected in the evaluation cohort interviews (Table 4.5). A telephone survey of up to 30 worksites per community in each of three size categories (50-99, 100-249, 250+ employees) was conducted in 1990 (intervention community only) and 1993 (both intervention and control) concerning worksite smoking policies, cessation services and incentive programs. An employee perspective was to be gleaned from the evaluation cohort surveys. Telephone surveys in all 22 sites at baseline (fall 1989), midpoint (fall 1991) and end of the intervention (fall 1993) determined the availability and utilization of classes, guides, self-help materials, events, workshops and other resources and services among seven categories of organizations: voluntaries, hospitals, libraries, health maintenance organizations, medical and dental societies (municipal and regional), and proprietary smoking cessation programs. Finally, the impact of media advocacy was evaluated through (a) monitoring newsprint media in all 22 communities through a commercial clipping service (clips coded for format, length, focus, message type, keyword, and newspaper) and (b) monitoring a sample of 20 billboards per community on a semi-annual basis.

Process evaluation of protocol implementation essentially served to measure the nature and 'dose' of intervention administered in each intervention community, and was conducted using three main approaches (Corbett et al 1990-91). First, a computerized program records system monitored each site's progress in implementing the 51 required activities specified in the COMMIT protocol. Second, quarterly reports prepared by COMMIT staff in each intervention site summarized activities and implementation difficulties at the end of each quarter in each of the four task force areas, in addition to tracking legislation and contextual changes, monitoring newspapers, providing case history reports on selected activities, and supplying information on community board and task force activities (e.g. minutes of meetings). Lastly, 'community tracking' monitored events related to COMMIT (ie impacting smoking issues) but not initiated by it (such as the federal 'Break Free' campaign).

Economic evaluation, or the measuring of cost-effectiveness, was not acheived by monitoring the costs of COMMIT per se, which are unlikely to be replicated if the approach is disseminated more widely, but rather the "marginal societal costs" of different levels of local committment to COMMIT-type activities (Mattson et al 1990-91).

The importance of carefully conducted evaluation of the sort described above cannot be underestimated: it permits an assessment of the impact of an intervention (outcome and impact assessment) and the likelihood that outcomes are linked to variations in the implementation of the program (process evaluation). However, for a program of the complexity of COMMIT, there is no guarantee that variations in outcome/impact and process can be straightforwardly linked, or, more importantly, why and how they should be. In other words, without more qualitative assessment of the needs and experiences of smokers and channels it will be difficult to ascertain exactly what worked best or was problematic and why. For this, a different type of evaluation is necessary, based on a critical-interpretive methodology. The basic tenets of such an approach were outlined in generic form in Chapter 2. In the next chapter, the specific blend of methods employed in this evaluation study of Brantford COMMIT are described in detail.

Table 4.1 Research centres and the 11 community pairs in COMMIT

Research centres	Community Pairs (I/C)*	Population Size	Smoking Prevalence**
American Health Foundation	Yonkers (I)	63,278	29.4%
New York, New York	New Rochelle (C)	57,493	28.9
Fred Hutchinson Cancer Ctr	Bellingham (I)	65,632	23.9
Seattle, Washington	Longview/Kelso (C)	60,424	28.5
Kaiser Foundation Research Inst.	Vallejo (I)	89,046	28.7
Oakland, California	Hayward (C)	121,134	28.0
Lovelace Medical Foundation	Santa Fe (I)	57,572	23.2
Albuquerque, New Mexico	Las Cruces (C)	53,757	22.6
New Jersey Univ. of Medicine and Dentistry	Paterson (I)	138,317	31.3
Newark, New Jersey	Trenton (C)	91,726	34.7
Oregon Research Institute	Medford/Ashland (I)	58,929	24.5
Eugene, Oregon	Albany/Corvallis (C)	73,452	23.1
Research Triangle Institute	Raleigh (I)	163,036	24.9
Research Triangle, N. Carolina	Greensboro (C)	166,824	29.3
Roswell Park Cancer Institute	Utica (I)	85,490	32.4
Buffalo, New York	Binghamton/Johnson City (C)	76,418	31.4
University of Iowa	Cedar Rapids (I)	144,835	26.8
Iowa City, Iowa	Davenport (C)	136,408	29.1
University of Mass. Medical Schl	Fitchburg/Leominster (I)	75,805	31.2
Worcester, Massachusetts	Lowell (C)	92,418	33.7
Waterloo Research Institute	Brantford (I)	86,985	35.2
Waterloo, Ontario	Peterborough (C)	84,800	33.7

* I = Intervention community; C = Comparison community

** Smoking prevalence estimates based on the baseline survey of adult smokers aged 25-64 years, conducted in 1988.

Source: Mattson et al 1990-91

Table 4.2 National Cancer Institute Research Phases

STAGE I:	HYPOTHESIS DEVELOPMENT regarding potential intervention strategies
STAGE II:	METHODS DEVELOPMENT: design & pilot testing of needed measures & procedures
STAGE III:	CONTROLLED INTERVENTION TRIALS: randomized controlled trials to compare alternative risk reduction strategies in samples of convenience; focus on efficacy
STAGE IV:	DEFINED POPULATION STUDIES: intervention trials on a large representative population sample; focus on effectiveness, implementation barriers, and impact/ outcome assessment
STAGE V:	DEMONSTRATION & IMPLEMENTATION: wide dissemination of a proven intervention strategy so as to effect a national impact on disease rates

Source: adapted from Lichtenstein, Wallack and Pechacek (1990-91) and from Glynn and Cullen (1989)

Table 4.3

Goals, impact objectives (1993) and mandated activities for each of the four community task forces as per the standardized COMMIT protocol

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TRIAL-WIDE

Goals:

1. Increase the priority of smoking as a public health issue by:
   (a) relating smoking to other community interests and priorities
   (b) increasing acceptance of smoking as a social issue for both smokers and non-smokers
   (c) increasing public knowledge about risks of both active and passive smoking

2. Increase the community capacity to modify smoking behaviour by:
   (a) increasing resources allocated to smoking control
   (b) creating (or enhancing) an infrastructure to coordinate
   (c) creating a community action plan for smoking control

3. Increase the influence of existing policy and economic factors that discourage smoking within the community by:
   (a) enhancing implementation of and compliance with existing smoking control policies
   (b) increasing quantity of smoke-free envirnoments throughout community
   (c) increasing influence of advertising and promotion of smoking within the community
   (d) decreasing resistance from community interests opposed to change

4. Increase social norms and values supporting non-smoking by:
   (a) increasing positive values associated with good health
   (b) decreasing social acceptability of smoking
   (c) increasing public knowledge about benefits and feasibility of quitting
   (d) increasing social support for cessation

Primary trial-wide objective:

"the implementation of a defined protocol, delivered through multiple community groups and organizations and using limited external resources, will result in a quit rate among heavy smokers that is at least ten percentage points greater (e.g. 25% versus 15%) than the quit rate observed among heavy smokers in the comprarison communities" (Mattson et al 1990-91, 274)

TABLE 4.3 CONTINUED...

PUBLIC EDUCATION CHANNEL

Goals:

1. promote social norms and actions toward a smoke-free community
2. promote the importance of smoking as a public health issue
3. enhance the effectiveness of smoking control in other program areas

Impact objectives:

1. increase the percentage of people identifying smoking as a serious public health issue to 75 percent
2. increase the percentage of people perceiving strong community norms supporting a smoke-free environment to 60 percent
3. increase the percentage of heavy smokers who attempt to quit during the Great American Smokeout (an annual event sponsored by the American Cancer Society) to 35 percent
4. increase the percentage of non-smokers who participate in smoking control activities to 12 percent

Mandated activities:

1. media advocacy training of the community board
2. implement kick-off event
3. publicize smoking control and annual action plans
4. establish a community network to enhance local coverage of national and regional news
5. design and implement magnet events
6. publicize smoking control activities in other task force areas

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HEALTH CARE PROVIDERS CHANNEL

Goals:

1. health care providers will be aware of, promote, and play an active role in smoking intervention efforts in the community
2. health care providers will regard smoking cessation advice as the minimal standard of practice; some providers will go beyond providing advice
3. all health care facilities will adopt and effectively implement policies for a smoke-free environment
4. smoking patients will more actively seek assistance from the health care system to stop smoking

Impact objectives:

1. among heavy smokers who have visited a physician or dentist in the past twelve months increase the percentage who report having been told to stop smoking or set a quit date by their physician or dentist:
   - 60 percent of smokers will report having been told by a physician and 35 percent by a dentist to stop smoking
   - 25 percent of smokers will report having been asked to set a date for stopping smoking by a physician and 20 percent by a dentist
2. increase the percentage of physicians and dentists who report setting stop smoking dates with patients most of the time: 25% of physicians and 20 percent of dentists will report setting stop smoking dates with patients most of the time
3. increase the percentage of health care facilities (e.g. doctors/dentist offices, clinics, hospitals) that do not allow smoking by either patients or staff: 90 percent of physicians and dentists offices and other health care facilities will be smoke-free

TABLE 4.3 CONTINUED...

Mandated activities:

1. training leaders for basic and comprehensive continuing education sessions for physicians and dental health professionals
2. providing basic continuing education sessions for physicians
3. providing comprehensive continuing education sessions for physicians
4. providing basic continuing education sessions for dental health professionals
5. providing comprehensive continuing education sessions for dental health professionals
6. strategies for motivating and training office staff
7. promotion of smokers' network
8. influencial training of physicians and dental health professionals
9. promotion of smoke-free policies in health care facilities

WORKSITES AND ORGANIZATIONS CHANNEL

Goals:

1. to increase smoking cessation among workers and members of organizations who smoke
2. to produce changes in worksite and organization norms to support nonsmokers
3. to increase adoption and effective implementation of comprehensive worksite and organization nonsmoking policies
4. to enhance support for nonsmoking in the business, labor and social sectors of the community

Impact objectives:

1. 65 percent of employed heavy smokers will report that their worksite bans smoking completely or restricts smoking to designated areas
2. 60 percent of heavy smokers will report feeling pressure to quit smoking from co-workers
3. 8 percent of heavy smokers will report having participated in stop smoking programs or contests and lotteries to promote cessation at their place of work
4. 70 percent of targeted worksites will report offering lectures, classes, materials, or other programs to help or encourage employees to quit smoking within the last twelve months

Mandated activities:

1. smoking policy presentations
2. annual smoking policy workshops
3. on-site smoking policy consultations
4. worksite smoking policy network
5. promotional activities in the worksite accompanying the Great American Smoke-Out, Non-Dependence Day and other magnet events
6. promotion of worksite stop-smoking incentives
7. between worksites challenges and competitions
8. dispersal of self-help materials
9. promotion of smoker's network

TABLE 4.3 CONTINUED...

CESSATION RESOURCES AND SERVICES CHANNEL

Goals:

1. coordinate cessation services providers
2. increase participation in cessation programs
3. increase awareness of smoking control activities

Impact objectives:

1. 80 percent of smokers will be aware of the availability of stop-smoking programs or classes in their community as measured in the evaluation cohort survey
2. cessation materials will be distributed to the equivalent of 20 percent of smokers as measured by the cessation resources survey
3. cessation clinics will have been attended by the equivalent of 8 percent of smokers as measured by teh cessation resources survey
4. the Smokers' Network will have enrolled 8 percent of heavy smokers as measured by program records

Mandated activities:

1. develop and maintain a cessation resources guide
2. recruit heavy smokers into the smoker's network through hotline, magnet events and youth activities
3. prepare and distribute a semi-annual newsletter
4. special recruitment activities (optional)
5. symposium on smoking cessation (optional)

Source: adapted from Wallack and Sciandra (1990-91), Ockene et al (1990-91), Sorensen, Glasgow and Corbett (1990-91), Pomrehn et al (1990-91), Mattson et al (1990-91), and the Ontario Smoking Cessation Research Group (1988)

Table 4.4: Major features of the trial-wide prevalence & cohort COMMIT surveys

Survey	Objectives	Data Collection Method	Year(s)	Sample Size	Content of Survey
Baseline	- estimate prevalence - identify smoker cohorts	- centrally conducted telephone survey	1988	- 6000 hseholds per community	- smoking history - smoking status of hsehold members - demographics - cohort tracking info.
Endpoint cohort	- estimate cessation rate in heavy, light-moderate cohorts identified in baseline survey	- centrally conducted telephone survey	1989-93 annually	- 400 heavy smokers per community - 400 light/mod. smokers per community	- current cigarette smoking status
Final prevalence	- estimate smoking prevalence - measure attitudes about smoking	- centrally conducted telephone survey	1993	- 1500 hseholds per community	- smoking status of hsehold members - attitudes/beliefs re tobacco use - demographics - exposure to smoking control activities
Evaluation cohort	- measure knowledge and attitudes about tobacco use - measure exposure to smoking control activities delivered via media, at work, from health care providers	- centrally conducted telephone survey	1989 1991 1993	- 100 heavy smokers - 100 light/mod. smokers - 100 recent ex-smokers - 100 nonsmkrs (per community)	- knowledge of dangers of smoking - beliefs about benefits of stopping - attitudes about restricting smoking - exposure to smoking control activities

Source: Mattson et al 1990-91

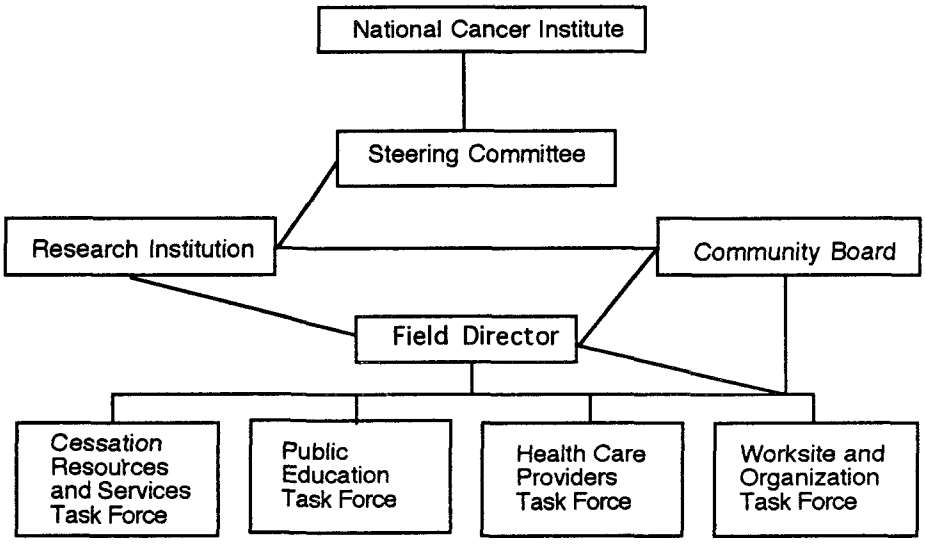
Table 4.5: Major features of the trial-wide intervention channel COMMIT surveys

Survey	Objectives	Data Collection Method	Year(s)	Sample Size	Content of Survey
Youth	- estimate tobacco use habits of adolescents - measure attitudes about tobacco use	- locally conducted classroom survey of 9th grade students	1990 1993	- 450 students per community	- current and past tobacco use - attitudes/beliefs re tobacco use - exposure to tobacco prevention information at school, in media
Health care provider	- measure physician and dentist tobacco counselling practices	- centrally conducted mailed survey of physicians and dentists	1990a 1993	- all primary care physicians and general practice dentists	- tobacco counselling practices
Health care offices	- estimate prevalence of smokefree facilities - assess availability of cessation resources	- locally conducted telephone survey of physician & dental offices	1990a	- random sample of 30 private physicians & 30 dental offices per community	- presence/type of smoking policy - availability of tobacco education materials - office characteristics
Worksites	- estimate prevalence of smokefree worksites - assess availability of cessation assistance for employees	- centrally conducted telephone survey	1990a	- random sample of 30 worksites with 50-99 workers, 30 worksites with 100-249 workers, and 30 worksites with 250+ workers per community (incl. schools)	- presence/type of smoking policy - availability/type of cessation services for employees - worksite characteristics
Religious organizations	- estimate prevalence of smokefree religious organizations	- centrally conducted telephone survey	1990a 1993	- random sample of 50 churches or synagogues per community	- presence/type of smoking policy - availability/type of cessation services for members - characteristics of each organization
Cessation resources	- estimate number of local agencies providing smoking control services - assess type and quantity of cessation services available in the community	- locally conducted telephone survey	1989 1991 1993	- all of these agencies in each community: voluntaries, hospitals, health departments HMOs, medical/ dental societies, libraries, proprietary programs	- type of services provided - frequency & use of service - characteristics of agency

Note: a = intervention community only (all other surveys conducted in both intervention & comparison communities)

Source: Mattson et al 1990-91

Figure 4.1 COMMIT organizational chart



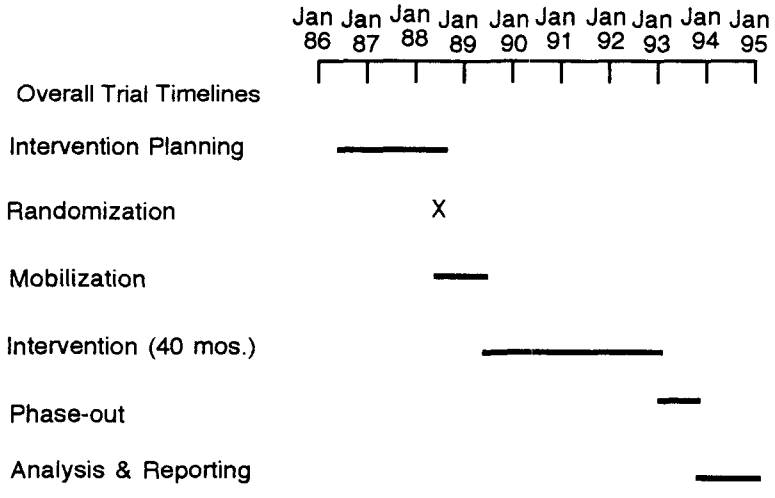
Source: Lichenstein, Wallack and Pechacek (1990-91), 178.

Figure 4.2: Phases of community mobilization in the COMMIT intervention

PRELIMINARY COMMUNITY ANALYSIS	
Ø	
RANDOMIZATION	• 11 intervention & 11 matched control communities
Ø	
IN-DEPTH COMMUNITY ANALYSIS	• identify key influencials, assess community readiness (potential barriers/aids)
Ø	
COMMUNITY PLANNING GROUP	• refine community analysis • hire field director
Ø	• establish more permanent community board & programme office
COMMUNITY BOARD	• Public Education Task Force • Health Care Provider Task Force
Ø	• Worksites and Organizations Task Force • Cessation Resources and Services Task Force
SMOKING CONTROL PLAN	• data on local smoking problem & initial plan for local COMMIT-based action
Ø	
ANNUAL ACTION PLAN(S)	• detailed who-does-what-by-when plans (updated annually)
Ø	
KICKOFF EVENT	• public media event to introduce COMMIT to the community, promote local initiatives, publicize the issues

Source: adapted from Cernada (1990-91)

Figure 4.3: COMMIT trial timetable



Source: Lichenstein, Wallack and Pechacek (1990-91), 179.

CHAPTER FIVE

METHOD

This chapter comprises three main sections. First, an overview of the general methodological approach is provided. More detailed information is given in the next section concerning each stage in the collection and analysis of data for the study. Third, relevant biographical details of the author as researcher and research instrument are discussed.

5.1 OVERVIEW OF STUDY METHODS

This section provides a brief overview of the study methodology together with justification for the approach used. The primary objectives of this research (discussed more fully in Chapter 1) were twofold. One key focus was to determine the extent to which Brantford COMMIT had been able to meet the needs of heavy smokers in the community, specifically vis a vis needs for assistance with quitting smoking. This demanded a client-centered approach that (a) documented and contextualized the experience of the intervention by members of the BC Smokers' Network (Chapters 6 and 7); and (b) sought to uncover both felt and latent needs for assistance (Chapter 8). A second major objective was to identify factors that inhibited or facilitated program success, where 'success' is interpreted in terms of (a) NCI goals, and (b) meeting the needs of smokers (Chapters 6-8 and 10). This involved seeking the opinions of a variety of stakeholder groups in addition to those of Network members (Chapter 10).

Within the context of these research objectives, the generic rationale for a critical-interpretive methodology presented in Chapters 2 and 3 assumes a more

specific appropriateness for this study. The virtues of a qualitative client-centered approach to evaluation and needs assessment include that they are naturalistic, holistic and acknowledge the subjectivity of human behaviour (Lord 1989). By 'going to the people', one better understands the reality of their lives and how a program or intervention fits into that reality (Lord, Schnarr and Hutchison 1987). In this context, 'participative' evaluation is based on client needs rather than on program goals, the latter being the basis of many traditional evaluations (Scriven 1972; Fricke and Gill 1989; Guba and Lincoln 1989; Broughton 1991).

Qualitative approaches to program evaluation provide a rich array of information beyond what is typically generated from quantitative experimental approaches. It has been said that "interpretive geography is in sum concerned with the understanding and analysis of meanings in specific contexts" (Eyles 1988; 2). Likewise, "contextual evaluations seek to understand how programs work, how they fit into particular settings, how they achieve results, and how they can be improved" (Britan 1981, 49) in part through richly textured description, the critical examination of premises, intended and unintended outcomes, and reasons for participation. By elucidating the internal dynamics of the intervention and program implementation in a way that is responsive to different stakeholder perspectives, which are likely to differ on the meaning of success and how it is to be measured, qualitative evaluation can add depth, detail and meaning to statistical or survey findings (Patton 1987). In so doing, the questions posed as primary research objectives become answerable in ways unanticipated in - but complementary to - the NCI evaluation protocol described in Chapter 4.[1]

In this context, several aspects of the methodology deserve special mention. First, for many of the reasons outlined here and in Chapters 2 and 3, a range of primarily qualitative methods were used which included individual depth interviews and focus groups, the analysis of program documentation, and observation (these are more fully described in section 5.2). Second, these methods are applied to a

[1] The complementarity remains unexplored at this time because the results of the formal evaluation conducted by NCI have yet to be released. However, it is anticipated that richly textured qualitative information about the intervention will shed light on the meaning of some of the quantitative results and suggest explanations for the observed outcomes.

range of stakeholder groups: not just with members of the Smokers' Network but also with intervention staff, project volunteers, and key influentials both inside and outside the community. Seeking multiple perspectives is increasingly the norm in qualitative program evaluation (e.g. Fricke and Gill 1989; Patton 1990).

Third, the combination of these characteristics indicates that the research follows an 'embedded single-case design' (Yin 1989), in that multiple sources of evidence are considered relative to a single intervention site. In general, the case study approach is the preferred method when 'how' or 'why' questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context in that it "investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident... [and when the]...causal links in real-life interventions.. are too complex for survey or experimental strategies" (Yin 1989, 23-25). To some extent, the depth of information collected in a detailed case study comes at the expense of the generalizability of the results to other sites or interventions. Yin (1989) has argued that the scientific contributions of case studies are to be found in the generation and refinement of theory, which can subsequently be verified across settings using a variety of quantitative and qualitative techniques. In fact, a number of hypotheses and 'key lessons' are discussed throughout the dissertation (and particularly in Chapter 11) in terms of implications for the design and implementation of similar interventions in the future.

Fourth, the study methodology is not just interpretive but also critical. It was critical in that it took as problematic, rather than given, the design of the trial and its intervention goals. This is consistent with Rossi and Freeman's definition of evaluation as "the systematic application of social research procedures in assessing the conceptualization and design, implementation, and utility of social intervention programs" (1985, 19). The evaluation was also critical insofar as it used a variety of methods applied to a range of stakeholder groups to elucidate competing perspectives and enhance the validity of the conclusions presented in Chapters 6 to 10 through methodological triangulation.[2] Part of the critical-interpretive approach

[2] Triangulation was necessarily partial insofar as (a) multiple methods were only applied to a subset of interview respondents; and (b) the subject matter covered with multiple stakeholder

also involves (a) an appraisal of regularities or commonalities in subjective intentions and experience, bounded by (b) an appraisal of the objective conditions within which actors operate (c.f. Dorr-Bremme 1985; Valone 1976). In this manner, the testimony of respondents is not taken altogether at face value, but (in Chapters 9 and 10 in particular) is considered in the context of having made issues of power, social control and social class explicit (see Chapters 2 and 3).

Few evaluations of this sort have been conducted in community trials or smoking cessation interventions. The major community risk factor reduction trials with a smoking cessation component of the past two decades (e.g. Pawtucket, Stanford 5-community, Minnesota Heart Health trials) have placed greater emphasis on epidemiological and quantitative methods than on qualitative research techniques. While some qualitative research has been conducted on the experiences of smokers trying to quit (e.g. Ferguson 1988) and physician-based smoking cessation interventions (e.g. Willms, Johnson and White 1992; Willms *et al.* 1990), to the best of my knowledge none have tackled a multifaceted community intervention such as COMMIT. In fact, relatively little qualitative research appears to have been conducted evaluating interventions of any kind that purport to use community mobilization approaches in the health field, despite the apparent popularity of the approach in health promotion and public health circles. A critical-interpretive analysis of Brantford COMMIT therefore has the potential to inform community intervention design for issues other than smoking cessation alone.

Finally, a few words about conceptual models are relevant. The methodological imperatives discussed in Chapters 2 and 3 presuppose a limited range of theoretical positions that are both critical and hermeneutic, but leave room for flexibility nonetheless. While I do not subscribe to any single 'grand theory' or conceptual framework, I find socio-ecological models of health (White 1981), structuration theory (Giddens 1984; c.f. Thrift 1985) and critical theory more generally (e.g. Held 1980) convincing for their explicit treatment of agency in structural context. I treat

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groups did not overlap completely (interview content for smokers focussed on quitting experience and BC as resource for quitting, whereas interview content for key informants focussed on community mobilization, organizational dynamics, protocol issues, and issues of social class biases in program planning; see Section 5.2.3).

community interventions as complex sets of relationships at different levels, where community context is crucial and different participant perspectives are valid and necessary for understanding an intervention more completely and holistically. In particular, I value approaches that make explicit issues of equity, social justice, human social welfare and the role of the academic as social change agent. This being said, readers will notice that I make relatively little use of 'grand' theory in the empirical chapters of this dissertation. In this case I feel that the respondents' testimony and accompanying critical-interpretive analysis speaks for itself, particularly as the focus is on the evaluation of a specific community smoking cessation intervention, rather than the explication of a more general domain such as the social construction of smoking, smoking cessation, or tobacco control.

5.2 METHODOLOGICAL SPECIFICS

In this section, details are provided as to how respondents were sampled, interviews and focus groups conducted, and the resulting transcript material coded and analyzed.

5.2.1 *Sampling*

In qualitative methods, sampling is purposeful rather than purposefully random, and can include convenience samples, maximum variation sampling, snowball sampling and domain sampling (Kuzel 1992; Patton 1990; Miles and Huberman 1984; Glaser and Strauss 1967). Somewhat different strategies were chosen for identifying smokers and key informants.

5.2.1.1 Smokers' Network members

Because it was important to learn about how Brantford COMMIT fit into the lives and 'cessation trajectories' of smokers in the community, the BC Smokers' Network was chosen as the sampling frame for part of the study. It was felt that these smokers would be the most familiar with BC, and therefore the most able to comment on the appropriateness of the program vis a vis their own needs for

assistance.[3] Furthermore, the Network was a convenient sampling frame because computerized records maintained in the Brantford office contained not only members' names and addresses, but also their age, sex, smoking status on sign-up, referral point, and length of time that they had been members. This facilitated a stratified random sampling approach, so that equal numbers of heavy and light-moderate smokers could be identified. Working from two separate lists for each group and selecting every eighth name from the list, it was possible to generate an initial sample size of 104. While this is comparatively large for a qualitative study, the rationale was that (a) we could expect only a modest proportion of this number to actually be interviewed, assuming a response rate of approximately 50 percent; and (b) we wanted to have sufficient cell sizes (by age, sex and smoking status) to permit analysis within subgroups of lay smoker respondents. As it turned out, the volume of material collected, time constraints, and the lack of sharp distinctions between respondents in these categories limited the amount of subgroup analysis that was carried out.

Potential respondents were contacted by mail and a follow-up phone call to identify those willing to be interviewed. In order to avoid the implication that confidentiality might have been breached by releasing Network names to an outside organization, BC letterhead was used. While this probably also made it easier for people to agree to an interview, respondents mistook me as a BC employee on a number of occasions, despite wording in the letter to the contrary (see Appendix C). The implication that some of them might have been reluctant to speak their minds is diminished by the observation that in practice, I found people to be frank in their discussions of BC. If anything, people assumed an opportunity to make direct suggestions and that I would be able to go back to the office and implement (e.g., the buddy system type of support system for smokers; see Chapters 6 and 8). In these and subsequent interactions, confidentiality was promised and maintained: transcripts and quotations used in the writing of each chapter had only fictitious

[3] Potential knowledge about Brantford COMMIT was therefore valued above representativeness vis a vis all smokers in Brantford, though clearly the sample was more appropriate to the evaluation of BC activities (Chapters 6 and 7) than to a wider assessment of need (Chapter 8) or of views on tobacco control legislation (Chapter 9). For further discusion about various types of representativeness, see Table 5.1.

names attached. The letter of invitation to participate also indicated that we would share with them how other smokers were coping.

Prospective interviewees were informed that I was doing a survey on behalf of BC, and that they had been chosen along with a small number of other Network members to help us better understand (a) problems they faced in trying to quit and remain smoke-free; (b) how they felt about BC and the help available in Brantford; and (c) what their needs for assistance were. In order to maximize response rates, it was decided that rather than include a response card for people to return indicating willingness to participate (and risk losing many through failure to mail the card rather than genuine disinterest), we would give people the option of calling the office to opt *out* of the study by a given date (two weeks), with the understanding that otherwise they would be contacted by phone to set the time and place for an interview. Of the sample of 104, 9 contacted the BC office by November 15, 1991 to opt out of the study, and 2 letters were returned by Canada Post as undeliverable.

On November 19th and 20th, all of the remaining 93 potential respondents were phoned and again invited to participate in the study. Calls were made in the late afternoon and evening (Appendix D). In these first two days, 47 people agreed to participate, and in most cases interview times were arranged (although some of these fell through: no shows or cancellations or unable to schedule a time). Another 19 people refused to participate. The remainder could not be reached (were away, had moved, or had changed phone number). Those reachable by phone were called back at least 5 times, to ensure that contact was made (usually successful in the first 2 or 3 attempts). Searching in the phone book, calls to 411 and to parents (in the case of teens who had moved away from home) turned up phone numbers for several of the others. In addition, half a dozen people who had unlisted numbers or who did not have phones, were either called at work (if the Network database supplied this information), or had a package dropped off in their mailbox that included a covering letter and a form to be filled out and left for me to pick up from their mailbox in the next day or two. This form indicated their willingness (or not) to participate in the study, and a number of time slots and locations (home, work, coffee shop, BC office) for the interview to take place (see Appendix E).

As a result, 45 members of the Smokers' Network were interviewed, usually in their homes (see Table 5.2). Respondents were equally split between heavy and light-moderate smokers, with fewer men than women, primarily working class (see section 5.2.2 for description) and the majority in the 26 to 35 year old age group (Table 5.2).

5.2.1.2 Sampling key informants

Fricke and Gill (1989, 17) define stakeholders as "a group of decision-makers and their audiences", where decision-makers are those responsible for making program choices. However, in government, large organizations and large intervention trials, "decisions are not discrete events; they are part of a process that extends over time, that is affected by many variables, and that no single individual can be identified as having made" (Palumbo and Wright 1981). Audiences can include those affected by, but not participating directly in, decision-making. Guba and Lincoln (1989) suggest maximizing the scope of divergent constructions about the program by including agency staff, volunteers, and the putative and unforeseen beneficiaries of the intervention in its evaluation. Because many smokers, including those on the Smokers' Network, were not intimately involved in the day-to-day operations of the intervention in Brantford, it was considered important to interview program staff, volunteers and researchers. In addition, other key influentials in the community and key informants close to the target group were sampled. The result was a purposeful non-random sampling of 8 groups (Table 5.3).

The key informant interviews and focus group were arranged and conducted after all the interviews and focus groups with smokers had been completed, had been transcribed, and a preliminary analysis of the material had been made. This meant that sampling of key informants did not occur until late in the spring of 1992. Since many of the respondents were aware of my study by that time (I had, for example, presented my research design to the Community Board six months before), I contacted them by phone at their place of work to set a time for an interview. As indicated in Table 5.3, only one of the 35 key informants contacted refused to be interviewed.

5.2.2 *Data collection*

5.2.2.1 Smokers' Network members

Semi-structured depth interviews were conducted with 45 members of the Smokers' Network. Semi-structured interviews are preferable to formal or rigid questionnaire formats because they provide a more natural and comfortable environment for respondents (Burgess 1984). The semi-structured interview format is most appropriate when the researcher knows the main boundaries, issues and components of the phenomenon but cannot anticipate all the possible response types and wishes to be open to the experiences of respondents and their ways of seeing (Morse 1992). Since totally unstructured interview or presuppositionless research is neither feasible nor desirable, one approaches the interview with a pre-defined agenda, but also with sensitivity to and interest in what people have to offer on their own terms and in their own words (Jones 1985). The structure that is included, in the form of a topic checklist, ensures some comparability across respondents, while at the same time allowing respondents the freedom to participate in the creation of a *conversation.*

The topic checklist used for question prompts during the interviews with smokers covered a number of general topic areas including personal and family/peer smoking history, previous quit attempts, interaction with Brantford COMMIT and exposure to other sources of assistance, reactions to various forms of tobacco control legislation, and a few general health status questions (Appendix F). In addition to the research objectives established for this evaluation study, the development of the checklist was guided by input from 3 other sources: (a) the checklist and coding categories used in a similar local qualitative study of smokers conducted by Willms and colleagues (Willms *et al.* 1990; Willms, Johnson and White 1992); (b) pretest with two graduate student colleagues who smoke; and (c) revision of the checklist after the first 10 interviews in the field.

I found that as time progressed I retained most of the topics in my head and consulted the checklist only near the end of the interview to ensure that the main topics had been covered. I felt that the interviews went surprisingly well, given the earlier trepidation I had felt about my 'debut' as a qualitative researcher (see Section 5.3). My conversations with smokers were rarely stilted and often very rewarding.

On the whole people were very welcoming and happy to share their experiences with me. In some cases, spending an hour or two sharing with someone about aspects of their lives that they may have little other opportunity to reflect upon or talk about developed a feeling in me of an unspoken bond between us.

Of course, rapport developed more easily with some people than others, and people varied in terms of their inclination to elaborate: the unelaborated "yes/no", "it was ok", "I dunno" type of responses feeling the most awkward. Amongst respondents, I was least comfortable in my encounters with some of the younger working class men who seemed aggressive in their style of relating to people. Because I have witnessed people relating to each other this way between friends, I do not think it was directed at me so much as it was a general communication style. In any case, interviews were, at a minimum, polite exchanges, and the majority quite friendly. I also did my best to alter my language and demeanor to suit the circumstances. In addition, I dressed informally. To keep track of which interviews I felt the most/least comfortable in, I used a MC ('my comfort') rating on a 5-point Likert scale on the fieldnote information sheet for each interview. In fact, a review of these scores indicated that no score was below 2.5 (1 being 'poor' and 5 being 'excellent' rapport), and only 4 interviews were scored below 3.

The field note information form upon which these scores were recorded was a single generic sheet that included (a) background information that was filled out the evening before the interview; and (b) field notes filled out right after the interview had occurred (Appendix G). Background information recorded on the form included interview day/time/location, smoking status (heavy or light-moderate, recorded from the Network database), and information volunteered in earlier telephone conversation(s) regarding current smoking status and other relevant life events. Information that was recorded immediately following the interview included its duration, my level of comfort and assessment of their level of comfort (on a Likert scale from 1 to 5), topic areas not covered, what material was handed out (if any), and a crude rating of socioeconomic status (SES). The SES rating sought to distinguish 'professional' from 'working class', based on an intuitive assessment of level of education, employment status and type of employment, and residential location, The SES rank score also distinguished two working class groupings: those

who were employed and appeared to own their own homes and be materially comfortable (Wkg1) and those who did not have stable employment, were tenants and/or single parents, and were not as materially secure (Wkg2).[4] The fieldnote form also contained a large section of blank lines so that initial impressions (content and method) from the interviews could be recorded. There were also boxes to tick off if people requested a copy of the interview transcript, a synopsis of the lay smoker interviews, or had expressed a willingness to participate in the follow-up focus group discussions. All this information was added to the computerized interview transcripts and coded (see Section 5.2.3).

While interviewing in respondents' homes no doubt made it more convenient and comfortable for them, and assisted me in ranking SES and better understanding their own circumstances, the home as an interview setting also had its drawbacks. For one thing, it was difficult to control noise and other distractions (phone calls, visitors etc.), particularly in cases where small children were present. Not only was the interview disrupted but the quality of the interview tapes (and thus the printed transcripts) suffered accordingly (see section 5.2.3.1 on transcription errors). In addition, there were times when other things were going on (relationship problems, unforeseen events). Nonetheless, when I showed up at the door, people were very gracious in insisting the interview go ahead. Typically interviews lasted about an hour, but ranged from as little as 30 minutes to over 3 hours.

With the bulk of the 45 interviews scheduled over 14 days in a 3 week period, as many as 6 interviews were completed in a day, although the norm was between 2 and 4 a day. This minimized the number of commutes to Brantford from my home in Hamilton, but it also meant that this stage of the field research unfolded very quickly, with the time between interviews consumed by logistical arrangements for subsequent interviews rather than by lengthily reflection on the unfolding research project. On the busiest days, some interviews were scheduled too close together to allow for detailed field notes to be taken right away, and these were instead

[4] For the few cases where interviews were not conducted in the home, I had to base the SES ranking on educational attainment, employment status and occupation, and other visual markers of "yuppydom" (dress, demeanor etc). For those who were retired or homemakers, former employment (where relevant) supplemented education and material surroundings as markers for SES ranking.

completed at the earliest available time. And because respondents could not reach me in Hamilton or at the BC office concerning last-minute cancellations, I was 'stood up' on a number of occasions.

In retrospect, I would probably have done fewer interviews with smokers. After 25 interviews the 'yield' in terms of new information had diminished, although even near the end there were some very 'colourful' respondents whom I am glad not to have missed. I also would have spent more time collecting people's stories of how they had been helped in the past by others, rather than asking them directly about self-perceived needs for assistance. These more abstract questions seemed to catch people a bit off guard and left them nonplused (see Chapter 8).

One or two respondents made a point of quitting the day of our interview so that they could claim to be smoke-free. Several others alluded to my visit as part of the continuum of things they received from BC, suggesting that the interview was for them part of the intervention and one more sign that COMMIT cared about them and how they were doing.[5] On two occasions, a letter or newsletter from BC arrived during our interview, which reinforced the feeling that BC was active and that "you guys really follow through", as one fellow put it. My interviews with smokers had a profound effect on me as well. Not only did I feel a bond develop with many of the people , but I began to empathize with what Ferguson (1988) calls "the smoker's dilemma" of being caught in the grip of the addiction in the face of increasingly restrictive tobacco control measures and growing public distaste for smoking and smokers. This sensitization to the smoker's perspective was somewhat intentional on my part in that I had arranged to complete the lay smoker interviews before approaching key informants, so as to be better informed of BC's impact among the target population.

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[5] When this ancillary qualitative study was first proposed, some concern was expressed on the part of researchers that my research would 'contaminate' the results. However, I interviewed only 45 of the 1800 smokers in the Network, and the evaluation cohort was drawn from the entire smoking community rather than just from the Smokers' Network. Therefore, the probability was very low that the one or two people who I may have influenced (a) remained quit for the ensuing 6 months (to be counted as a 'success') and (b) were part of the small evaluation cohort drawn from approximately 16,000 smokers in the community.

Delays in the transcription and preliminary analysis of the 1043 pages of transcript material from this first stage of the project resulted in summaries from the lay smoker interviews not being sent to respondents until the third week in February 1992. In the meantime, letters were sent to all respondents on February 5th apologizing for the delay and reminding participants that a results summary was on its way (Appendix H). The package that went out to respondents on the 24th included (a) a summary of the main findings of the lay smoker interviews, (b) a copy of our interview (only when requested), (c) a sign-up sheet for the upcoming focus groups, (d) a comment sheet for those who wished to clarify aspects of their interview, respond to the summary, or add something to their testimony that they thought of after the interview (only one comment sheet was returned), and (e) some literature (pamphlets) from Nicotine Anonymous, given that many people had asked about AA-style buddy systems for smokers (complete package in Appendix I). The summary itself focused particularly on the experiences smokers had shared about quitting and what had worked or not worked for them in the past, since this is what respondents were most interested in when I spoke with them. The content was based on my recollection of the interviews together with a preliminary read through the transcripts, since it was clear that (a) waiting to have all the material coded and formally analyzed would take too long and would delay the next stages of the research, but also (b) this depth of analysis was not required if the summary was to be limited to a readable 4 pages. By that time I had immersed myself in the literature on 12-step recovery programs, used the terms "we" and "us" in the summary as if I was helping them write to each other through me. This gave the 4 page document a less academic feel, as my hope was to make the document accessible to all of the respondents.

Focus groups with smokers

Two focus groups were conducted at the end of March with a subset of the original lay smoker interviewees, for the purpose of (a) expanding upon themes arising from the depth interviews (particularly regarding tobacco control); (b) observing interaction between respondents and how they negotiate consensus on certain issues;[6] and (c) validating earlier findings and themes through methodo-

[6] As it turned out, disagreements were not significant and pertained mostly to the advisability of specific cessation techniques, so their negotiation is not reported upon in this disertation, given

logical triangulation (comparison of focus group and interview results). The focus group method has been increasingly popular in health research both on its own and in combination with individual depth interviewing as an efficient means of gathering feedback from lay target groups (e.g. Willms, Johnson and White 1992; Willms and Lange 1992; Pucci and Haglund 1992). Although several models have been proposed for how to conduct such groups (e.g. small-group problem-solving and brainstorming), the traditional approach is one of mediated group discussion, which requires more guidance from the facilitator than the individual interview to ensure that the group stays on track and that the conversation is not dominated by a vocal minority (Krueger 1988; Morgan 1988; Stewart and Shamdasani 1990).

At the end of each of the previous individual interviews in November and December 1991, participants were asked if they would be willing to participate in a discussion group in the new year. At that time, 28 indicated an interest in participating (6 others said "maybe" and 9 were not asked because I forgot, the interview was cut short, or it did not seem appropriate at the time). As indicated above, a sign-up sheet for discussion groups was part of the package sent to interviewees. This was flagged twice in the covering letter in that package. People were given 4 dates at the end of March to choose from, and asked to return the form in a pre-addressed postage paid envelope. They had three weeks to respond (one of which was March break), but only 5 forms were returned. Two people had moved since the interviews and most likely did not receive the material. Two more were too sick to be able to accept the invitation to participate. The week before the first scheduled discussion group meeting, I began phoning all 38 remaining eligible participants (see Appendix J). Initial acceptances (19) indicated a response rate of over 60 percent, but when I made reminder calls the night before each meeting I lost a few more. In the end only two meetings were scheduled, and all of those willing to participate at time of phone call were able to make one of the two final dates. But despite promises the night before, 10 of the confirmed attendees did not show up for the meetings themselves, bringing the total participation to only 9. Unfortunately, those that failed to attend were among the ones with the most varied opinions, so that

the final composition of the groups was more homogenous than intended (typically of higher socio-economic status).[7]

Both focus group meetings were held in the evening at the COMMIT office. We had originally considered holding the meetings on more 'neutral' territory (and had made arrangements to use a local church hall), but logistic difficulties combined with the feeling that members of the Smoker's Network would not be too intimidated by COMMIT led us to stick with the office location. Both meetings began at 8pm and lasted or one and a half to two hours.

The room that was used for the discussion groups was organized so that we all sat around a oblong table. Another table was used to display literature of four principal types (a) material from Nicotine Anonymous, (b) books on the experience of smoking/quitting, (c) academic books on smoking, (d) COMMIT literature (for a complete list see Appendix J). I also took the liberty of dispensing COMMIT key chains to participants as a token appreciation of their participation. Both evenings I brought a non-participant to help me keep track of the order of participants 'taking the floor' (to facilitate transcription), and they were introduced to the group as such (a fellow graduate student on Wednesday March 25th, and my wife Brenda on the 30th). I also asked for these helpers' comments on the session and tried to record (on tape at the time, or later in writing) the gist of their remarks. Coffee, juice, cookies and grapes were made available during the meetings.

Typically the first person arrived 10 to 15 minutes before the discussion began. At first I was concerned that making small-talk would be awkward. I encouraged people to browse the literature, and introduced each person to the others as they came in. In these early informal minutes, people were usually quick to ask each other whether they had quit, how they had quit, and how long they had smoked. On both evenings people seemed to make informal conversation with relative ease and enthusiasm. The second group got into a heated discussion about the merits of hypnosis as we were waiting for people to turn up.

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[7] For example, in the first group, a vocal smokers' rights nurse and two working class men (currently on welfare) failed to show. A heavy smoker nurse, a single mom (visible minority), and smoking staff member of a local health-related agency affiliated with Brantford COMMIT were among those who failed to turn up for the second meeting.

I began each meeting by introducing myself and my 'assistant'. I said that the discussion group was an opportunity (a) for people to swap stories and experiences first-hand, and (b) to discuss some of the things coming out of the interviews and the summary I had sent them. I encouraged people to treat this as a discussion (rather than interview) and bring their own topics and issues to the fore even if I had a few things already planned for us to discuss. This was only partially successful. I emphasized that all contributions and opinions were valid. I also asked that we try to ensure that only one person was talking at once, to facilitate transcription.

The formal component of the group discussion began with people sharing a bit about themselves with the group. I led off, mentioning how I first started smoking occasionally at age 10 or 11, including how we used to light up used butts off the street with lipstick still on them, which drew laughter from the group. I also told them that I had been a "party smoker" on and off through my high school and undergraduate years. Each person shared a little bit about themselves, and this often drew questions from other participants about how they had quit or why they had started again, as people compared experiences. The conversation usually turned to the difficulties of quitting, which allowed me an in to ask whether there were ever times when it felt like it was not worth trying to quit, and if so how they persisted. I then solicited stories from them about times when they had been helped by others and times when they had had negative interactions with people about their smoking. Appendix J contains a short list of discussion topics used in these focus groups. I prefaced my questions about COMMIT by saying that, while I was sharing in a general way some of my findings with COMMIT, I was not a BC employee and was conducting an impartial evaluation, and that therefore they should feel free to speak their minds, if they had not already. I projected an overhead of the four goals of the COMMIT intervention and subheadings, paraphrased into more accessible language (Appendix J). People had few comments on this other than not liking the idea that COMMIT was out to limit the influence of smokers' rights groups, and that smokers' rights were akin to human rights and not at all the same thing as a pro-smoking lobby, if in fact the latter existed.

We were able to cover more than the prescribed topics in the one and a half to two hours that each discussion lasted. I tried to devote extra time to those issues of particular interest to me: smokers' rights, control/respect vis a vis health promotion, and the importance of risk in health education messages. However, I left each evening disappointed that I had not found the depth that I had hoped for. I think I had unrealistically expected that on the basis of an interview before Christmas, a read through a short summary some weeks before, and their own personal experiences, that they could help me generate some of the second order constructs and generalizations that would synthesize and build upon the earlier material. This initial disappointment was reduced considerably upon listening to the group discussions a few months later while correcting the transcription errors, when I was struck by the depth and richness of the conversation, as well as the 'fun' that people seemed to be having (lots of laughter).

One of the things that bothered me greatly at the time and still perplexes me was the lack of initiative shown by participants for taking action on self-defined needs. In the group discussions, as in the individual interviews, participants emphasized how great they thought something like a buddy system would be. Yet they did not say "Hey, why don't we do that amongst ourselves?". Were they waiting for me to suggest it, as moderator, or for COMMIT to set it up? Should I have openly suggested they form a buddy system amongst themselves? A few months later I phoned all those who had indicated an interest in participating in such a group to suggest that they might wish to join the newly formed local chapter of Nicotine Anonymous. In addition, with their permission, I drafted an advertisement that was placed in the BC newsletter announcing the formation of the local N.A. chapter. Without the knowledge of these respondents, I attended all the meetings of this group until December 1992. During this time, none of the 21 people I contacted attended these meetings.

5.2.2.2 Key informants

Key informant interviews were conducted with 35 individuals involved with the direct administration of the COMMIT intervention in Brantford (program staff, task force volunteers, research institution CRG members) or otherwise implicated in the intervention in the community (local print and electronic media, politicians, labour

representatives, social service agencies and community groups) as well as provincially (within the Ministry of Health and other provincial smoking-related groups). Key informants were contacted by telephone, informed of the nature of the study, and invited to participate by consenting to a private taped interview of approximately 1 to 1.5 hours in length at a location and time of their convenience. Response rates were very high (only one refusal in 35).

Respondents were advised of the intention to maintain confidentiality,[8] and were offered the opportunity to receive a printed transcript of their interview. Interviews were conducted in the spring of 1992 at the informant's usual place of employment during working hours, or (on occasion) in their home. In each case a customized topic checklist was developed to help guide the conversation, but every attempt was made to create an informal conversational atmosphere.

In many cases I was able to supply respondents with a copy of the checklist prior to the interview, so that they might have time to consider their responses. The types of questions posed varied according to the person's involvement with Brantford COMMIT, but a core set of questions addressed the following general topics: (a) their own personal background; (b) the mobilization experience; (c) their participation at the Task Force level (or other level); (d) impact of the program in the community; (e) what they would do differently if it was to do over again; (f) ability to reach low income heavy smokers and barriers to doing so; (g) working with the Smokers' Network; (h) notable tensions, if any; and (i) Brantford as a setting. A generic topic template can be found in Appendix K, as well as the full collection of interviewee-specific topic checklists. All interviews were taped and transcribed for subsequent computer-based coding and analysis using standard qualitative techniques. This round of interviews generated 958 pages of printed transcripts.

Where appropriate (i.e. for those familiar with COMMIT over a reasonable period of time), a structured questionnaire using Likert scale response options was administered prior to the 'conversation' part of the interview. This permitted

[8] Informants were assured that their responses would be kept in confidence in the sense that insofar as possible results would not be reported in such a way as to reveal their identity; although in the case of the mayor, for example, this seemed neither possible nor necessary.

comparability between respondents on key dimensions related to their opinions regarding the project, protocol design, program experiences and so-forth. The 16 items on this questionnaire included rating the likelihood of 'reaching the delta', how smokers were treated (how much assistance, how appropriately assisted, what tone of interaction), resolving conflicts between BC and other agencies or individuals, flexibility of the protocol, and the intervention's ability to reach low income heavy smokers. (The questionnaire, together with group mean scores, is reproduced in Appendix L).

On March 30, 1993, a focus group of Task Force chairs and selected members of the Community Board was convened to reflect on the trial. (The original BC intervention volunteer groups had, by this time, disbanded). All but one of the 6 participants had been previously interviewed for this study. This phase of the research was added near the end of the project in consultation with members of the Canadian COMMIT Research Group (CRG), who were concerned that the formal NCI evaluation protocol and their own paper-writing efforts had not or would not sufficiently tap the operation of the Task Forces and Community Board (challenges, successes, changes over time) and the factors involved in attracting and maintaining volunteer interest. A preliminary report on the key informant interviews that had been prepared for the CRG was edited down to a series of background notes and an annotated focus group agenda that was faxed to participants a week before we met (see Appendix M).

The group discussion took place in the BC boardroom on March 30th. A topic checklist guided the discussion in this focus group with key informants (Appendix N). We began by discussing what their advice would be to the members of the new Brant COMMIT, based on their experience with Brantford COMMIT. We also discussed what worked well or not so well, and the operation of the Task Forces and Board, attracting and maintaining volunteer interest, and relations with other organizations and with NCI. Largely by choice of the participants, discussion was particularly focused on the nature of Brantford as a setting for a community mobilization project (reluctance to ruffle feathers, inter-organizational tensions about turf, lack of political leadership etc.) and how that affected the BC intervention. Participants seemed genuinely thankful for the opportunity to meet again and reflect

on their experiences together. The entire discussion was tape recorded and transcribed for subsequent coding and analysis.

5.2.2.3 Research journal

During the course of this project I maintained a journal to keep track of the decision-making process during the research design, data collection, and analysis stages, albeit with varying consistency. Rather than a daily log of events and thoughts, it became a central repository for notes that did not otherwise seem to fit into the coding process or into the series of interim reports produced for the advisory committee or the CRG. Often these were reflections on the research process in general (goals, implementation dilemmas, relevant literature) that were entered as the need arose, particularly after meetings with the supervisory committee. Journal entries, beginning October 1991 and continuing to April 1993, were entered directly into the computer, and totaled 109 pages by the end of the project. The journal entries were subsequently coded using a condensed version of the coding scheme developed for the interviews with smokers and with key informants (Appendix O), which permitted more selective and parsimonious retrieval of notes on a disparate range of topics for analysis. It should be noted that interview-specific field notes as a rule, were not included in the journal because they were captured on fieldnote forms and appended directly to the relevant interview transcript.

5.2.2.4 NCI and Brantford COMMIT documentation

The COMMIT project generated a wealth of printed material. This included articles in academic journals and protocol manuals at the central level, as well as site-specific materials, including annual action plans, quarterly reports, minutes of all meetings, and media analysis and Task Force summaries prepared by the community analyst. My original intention had been to consider scanning all these documents into an Optical Character Recognition software program that would facilitate detailed coding and textual analysis. However, this was more expensive and technologically complicated than I had originally foreseen, and as time progressed it seemed less relevant to how the research was evolving. Instead, I collected the quarterly reports, annual action plans, Task Force summaries, journal articles and the protocol orientation manual to be used as reference material during analysis and write-up.

5.2.3 Data processing and analysis

5.2.3.1 Transcription of taped interviews and focus groups

The combination of 80 interviews and 3 focus groups with smokers and key informants generated a total of 95 hours of tape. The Canadian COMMIT Research Group provided the funds for someone to be hired to transcribe this material. The relatively good overall quality of the transcripts (errors relative to the original tape) sometimes suffered when tape quality was poor (i.e. significant background noise, garbled speech, faint voices. To ensure uniform quality, I reviewed every transcript on the computer while the interview or focus group tape was running and corrected all the errors. At first I kept a running tab of the number of errors and maintained a cut-and-paste file of them (containing versions both as given and as it should have appeared), but this became too time consuming to do for all the transcripts.

A review of these transcription error files reveals that they were of four major types. First, because people tend to talk in run-on sentences, there are judgment calls to be made about where to begin and end sentences. The insertion of a period or comma sometimes dramatically altered the meaning of the written words. A second category of errors revolved around the failure to use quotation marks to identify when people are paraphrasing or mimicking others, or when respondents quote things they told themselves or others told them. In these cases, the intonation and context of the testimony help, but transcribers who do not have a stake in the content of the material and are struggling word for word to get the material committed to paper will not necessarily take the extra time and effort that is required. A third category includes omissions that occur when transcribers go forwards and backwards in the tape when they need to listen to a passage more than once, with the danger that they do not pick up exactly where they left off. For example, in one case "I lost a very close friend of mine to cancer" should have read "I lost a very close friend to lung cancer". The fourth type of error was the most common: mistaking words or phrases for similar ones that may or may not make sense in the context of what is being said. For example, "consultation" is mistaken for "confrontation", "self-definitional acts" became "self definitional axe", "get rid of them altogether" became "get rid of them all today", "holistic measurement" became "ballistic measurement", "an evaluation model" became "and violation of the model", and "not

all smokers are for smoking" became "not all smokers are non-smoking" (see also Table 5.4). Furthermore, quality was highly variable: some transcripts had many errors (affecting as much as 60 percent of passages), whereas many others were virtually error-free.

Some of the potentially common errors were avoided by having drafted a set of conventions or guidelines for the transcriber(s) to follow, which specified that testimony was to be recorded verbatim rather than 'tidied up' (i.e. to include coughs, laughs, stutters, and pauses using standardized notation). Because the transcripts were done in bulk and the pressure was to move to the next phase of data collection, it was difficult to catch trends in transcription errors before most of the 'damage' had been done. This made my job of tidying up the transcripts much more time-consuming, but because they were all checked, the quality of the transcripts used for analysis purposes should have been uniformly good. It should be noted that it does not appear to be common practice to subject the transcripts to such detailed cross-examination.

5.2.3.1 Coding the transcripts

Coding involves categorization of the interview material into meaningful conceptual groupings, and is therefore a crucial first step in the analysis of the data. A careful balance has to be struck between making the emergent coding structure on the one hand theoretically informed and relevant to the research agenda and on the other hand properly grounded in the testimony of respondents. In this study, separate coding schemes were developed for the material collected from smokers and from key informants. In both cases, the topic checklist employed for the interviews and focus groups provided a natural starting point. For the lay smoker material this was already informed by similar work conducted by Willms and colleagues (Willms *et al.* 1991). To further develop the coding scheme and ensure that it was well grounded in the data (c.f. Glaser and Strauss1967), 6 transcripts were selected (to maximize variation) and carefully read through. This involved a process of 'open coding' (Strauss and Corbin 1990): posing questions of the data (what is this? what does it represent?) and developing, through comparisons, categories of concepts and 'in vivo' codes comprised of phrases used by respondents themselves (e.g. "falling off the wagon"). This process involved 5 or 6 major

revisions of the coding scheme before a useful template was decided upon. As coding of the data proceeded, alterations (additions and collapsing of the categories) occurred throughout the process and, where appropriate, were made retroactive. Between July and October 1992, the coding scheme for smokers went through 12 iterations. All changes were logged and dated.

The coding scheme that emerged, in the case of the material from smokers, had 325 codes organized into 32 major headings (content categories), (see Table 5.5, and Appendix P for the full coding scheme). Since each line corresponded to one 'text unit', these 325 codes were applied to each of 53 thousand lines of text (1043 pages) in 44 transcripts (one interview was not transcribable) and a further 125 pages of focus group material. The same passage of text could (and often did) have multiple codes attached to it, and codes could overlap in terms of what text numbers they began and ended with. In addition, a series of codes applicable to respondents and entire transcripts (as opposed to selected passages within transcripts) was also developed (see Appendix P). These kept track of respondent characteristics (age group, sex, etc.), contextual factors (interview site and duration; smoking status of friends and family, workplace restrictions) and issues such as respondent opinions on key issues (e.g. whether they expressed interest in buddy system).

The coding process itself required a number of steps. First, a line-numbered copy of the transcript was generated so that codes could be attached to specific ranges of text units (lines). A printout of the coding scheme was used to enter the text numbers associated with each 'cleaned' transcript. Because the text passages applying to different codes were sometimes quite long and overlapping, entering text unit range numbers on a generic coding sheet seemed to be the most straightforward coding method.[9] Typically, 4 transcripts could be coded on the same form before it was full, so different colours of ink were used for each. Any changes made to the coding scheme were reflected in the 'blank' code printout for the subsequent set of

[9] Another alternative would have been to enter the codes alongside the relevant passages in the text, which would have facilitated reviews of the transcript-specific coding later on. However, a code-oriented (rather than text unit oriented) approach was chosen because it minimized coding errors and greatly simplified the inputting of codes into the qualitative analysis software program.

transcripts. Codes were then input into the computer as a set. The entire process took roughly 6 to 8 hours for each transcript (depending on length).

The qualitative analysis software employed carried the acronym 'NUDIST', which stands for Nonnumerical Unstructured Data Indexing, Searching and Theorizing. Computerized text management was invaluable given the large volume of material to be coded and analyzed (over 2000 pages and 998 possible codes; see Table 5.6). The NUDIST system also had the advantage of being able to shuffle (nest, unpack etc.) coding 'nodes' and append comments to any nodes, while maintaining its own log of the nature and timing of changes. In effect, these and other capabilities provided a capable foundation for generating grounded theory and a level of sophistication virtually unmatched by other packages available for the Macintosh or IBM platforms such as Ethnograph or HyperQual (Richards and Richards 1991a, 1991b).

Many of the same procedures were employed for coding the interviews and focus group with key informants. The coding scheme was developed initially using the topic checklist and fleshed out with a detailed review of a handful of transcripts, then applied to all the key informant material. The full coding scheme for key informants can be found in Appendix Q.

The frequency of errors in entering codes into NUDIST was checked for all transcripts and found to be less than 10 percent (all errors were rectified). Attempts to recode several of the same transcripts indicated that approximately 10 to 20 percent of codes were being missed or coded differently, but with several hundred codes that is probably to be expected. As coding progressed it became clear that some codes were more 'reliable' than others. With reference to material from smokers in particular, the consistency of coding material pertaining to Brantford COMMIT, needs for assistance, "falling off the wagon" (relapses), reasons to quit or not to quit, strategies for quitting, and tobacco control was high. Coding for peripheral themes, behaviours and feelings, as well as for interaction with others about smoking was less consistent, in part because these were frequently subsumed within other codes. Coding was generally more consistent for the key informant

material because the topics covered were well-bounded both conceptually and in their placement in the text.

5.2.3.3 Detailed analysis, writing up the results

Once the coding was complete, the analysis was extended through a more careful analysis of the coding categorizations, including (a) retrieving complementary and contrasting codes together; (b) by documenting the variety contained within single codes; (c) by developing theoretical propositions linking together codes and material within coding categories; (d) by using counting to establish representativeness (i.e. most, many, some, a few, one or two); and (e) by actively searching for confirming and disconfirming evidence. Because the analysis focused particularly on those codes most closely linked to the research objectives, not all the data was used in the preparation of the dissertation.

The analysis procedures followed at this juncture had three stages. Before analysis of each code-specific text retrieval, I wrote as much as I could about my preconceptions and hunches concerning the data on that topic. Second, I read through the text retrieval, noting emergent themes and patterns, as well as 'inconsistencies' and contradictions. In another reading of the material I made more detailed notes including the following: (a) a brief 2 to 3 line summary of each person's testimony (to capture the gist of their ideas); (b) tracking confirming and disconfirming evidence for the working hypotheses developed earlier, modifying them as necessary; and (c) noting potential quotes that seemed to encapsulate certain phenomena or ways of thinking. It is these detailed notes that informed the writing of the thesis chapters. Thus the analysis was primarily data-driven, while retaining a tendency to treat testimony as problematic: not as deceitful or untrue, but as requiring contextualization, explication of the taken for granted (c.f. Silverman 1985; Silverman 1986). It was also at this point that a more thorough review of the literature was made during the writing of each chapter.

Together with the coding process, then, the analysis and writing stages conform to Taylor and Bogdan's (1984) proposed stages of 'discovery': (a) read and reread the data; (b) keep track of themes, hunches, interpretations, and ideas, using memos; (c) look for emerging themes; (d) construct typologies (e.g. how people

classify others); (e) develop sensitizing concepts and theoretical propositions linking them together; (f) read the literature; and (g) develop a storyline that unites the major themes (i.e. what is this research about?).

5.3 RESEARCHER AS INSTRUMENT: AN AUTOBIOGRAPHY

Inevitably some of the researcher comes through in qualitative analysis, even though the process outlined above was well grounded in the data. Because it is neither feasible nor appropriate to eliminate all 'bias' in qualitative research (indeed in any social research), it is best to clearly specify the methodology employed and identify where the author is coming from so that readers can draw their own conclusions about the validity of the results (c.f. Athens 1984; Kirk and Miller 1986; White 1993). Having undertaken a description of the methods employed in this study, I will therefore attempt to outline my own background as it relates to smoking. Four topics in particular appear to warrant special attention in this regard. First, I briefly discuss my early childhood development and general upbringing insofar as it casts insight upon the author as academic and researcher. Second, my own experience with smoking as a teenager is described. Third, my experience with - and reaction to- other smokers is related to my own experiences as an occasional smoker. Lastly, this research project is cast in the context of the development of my own professional career interests. One is never sure how much detail is warranted in these cases. I have been candid and perhaps erred on the side of over-inclusion.

I was born in Montreal in 1962, the only son of an unmarried university student couple of French and English Canadian descent living together in the downtown area. My sister was adopted in 1965 at the age of one, shortly after which my father took a one-year postdoctoral fellowship in Mathematics in Australia. Upon our return in 1967 we moved to Ottawa, which, despite considerable 'globe trotting' has been home base for our family ever since. Throughout childhood I was generally shy and introspective. Because of difficulties with 'bullies' at school, I attended an alternative private school (modelled to some extent after Summerhill) for a number of years in primary school. My upbringing can best be described as 'non-traditional middle-class': my parents' adherence to zen buddhist and new age ideologies meant a rather intentionally frugal anti-materialist environment, but not

one of material hardship. My mother completed a master's degree in sociology but devoted herself to full-time spiritual development rather than full-time employment, while my father maintained the life of an academic at the university. I received a scholarship to attend a small residential college in England devoted to the teachings of eastern philosopher Krishnamurti, which meant leaving home at age 16. When I returned to Canada I began university, first in Ottawa (including a one year exchange to the University of Massachusetts at Amherst), then in Hamilton at the Master's level.

I am therefore an educated white middle class male, which likely presents its own problems when interviewing minority working class respondents. Because the 'bullies' who I had come to fear in primary and secondary school were predominently working class, I had some trepidation about conducting this research. On the other hand, since my wife and I moved to Hamilton we have lived in predominently working class neighborhoods and have been struck by the relaxed friendliness and willingness to 'give you the shirt off their back' when you are in a pinch of the people there, albeit along with noise and lack of privacy. I believe that my willingness and ability to adjust my vocabulary and mannerisms to suit the social circumstances in which I find myself, was useful in creating rapport with respondents in this study. The welcoming nature of respondents and the interview experience itself was liberating for me, in that it reaffirmed my sense of social competence in different circumstances (as well as professionally as a qualitative researcher). I therefore remain somewhat ambivalent about the working class: concerned about social justice, but also somewhat apprehensive, formerly about being made fun of, but now primarily about noise from working class neighbours, since privacy and quiet surroundings are very important to us.

As far as my own experimentation with smoking is concerned, there was a period in my teens when I smoked. I can not now properly call myself an 'ex-smoker', since the definition presumes a degree of regularity (the 'habit') that never attended my explorations. I never made an 'addiction' (physiologically or otherwise) out of it (if 'making' can be presumed in the active sense). Looking back on it, it does not seem like 'me' to smoke. Rather, my sister was the more rebellious of the two of us, and she is the one who continues to smoke now.

One of my few memories of my grandmother centred around an argument we had over her smoking. I could not have been more than 7 or 8 years old. It was always a treat to visit her because she bought us things and we had more freedom than at home. One afternoon as I played with toy cars on her couch I must have blurted out something about her smoking bothering me. I remember the smoke would get rather thick at times, and debating whether to complain or not. She was understandably defensive about it, seemed hurt, and said something to the effect that she was a 'package deal': if you want grannie, it'll have to be a smoking grannie.

One of my earliest memories of myself 'smoking' must have occurred at almost the same time, perhaps not long after my grandmother died of cancer (the significance was lost on me at the time). I remember going to school on several winter mornings blowing air through a corn cob pipe to make it look like I was smoking. I guess I thought that was a cool thing to do. I remember getting a charge out of thinking that someone might suspect I was doing something illegal (because of my age) and might even stop me, only to discover that I was 'faking it'. Only a short while later, my sister and I started picking up and trying to smoke old used cigarette butts off the street that still had lipstick on them. I can imagine that one's first smoke is attended with plenty of coughing and sputtering even with 'fresh' mild cigarettes, and these stale Export A butts were especially raunchy. I cannot remember if we secretly agreed that it was not all it was cracked up to be. But I do remember coughing alot. Nonetheless, that was not the last of our experimentation.

At the alternative private primary school we attended downtown (a long bus ride from our house on the edge of town), Ali smoked. We called her 'alicat', and the subversive overtones seemed well-deserved. She was an assertive stout girl who wasn't afraid to pick a fight with anyone. She took it upon herself to ensure that we had all been properly instructed on how to smoke. Stephan and one or two other 'cool' people at school also smoked. We tried smoking once in a while with these school hotshots, and I think they took pleasure in 'teaching us how to be bad', just as we did in being taken temporarily under their wing. Although they might pick on us at other times, smoking seemed to be a bridge or passport to acceptance or membership, however temporary. I still feel badly that my sister continues to smoke

and that I might have instigated it, for it was I who started us on the 'old-butt-in-the-street smoking' as part of our trek in and out of the city to school each day. On the other hand, by highschool the friends she had were mostly street people and the rebellious crowd at school, all of whom smoked.

Our parents were fairly strict at home and it seemed that we had few friends to rely on for moral support or just plain fun. Smoking and other 'prohibited' activities such as the consumption of 'banned' junk foods (candy stolen from the corner store near school) may have been part of our need to make our own choices, to define ourselves. How does one psychoanalyse one's own inner child? It was not just that we could not choose what to wear or eat, but that we also felt victimized by the choices our parents made on our behalf: we were ostracized at school for the clothes we wore and for the 'weird' food we brought for lunch. Children can be cruel to each other, and being 'different' was no source of pride to us at the time.

With respect to smoking, I remember getting a bit worried that I might become addicted, even though I could not have smoked more than a pack in a month. For the longest time I only pretended to inhale, even by managing to blow it out my nose without breathing it in (again, the aspect of 'faking it'). But when it seemed people could tell I wasn't really inhaling, I decided that that kind of 'wimpy smoking' would be admitting you were really doing it just to be 'in', which might have been why everyone else began smoking too, but at least no-one admitted it. So I began inhaling, even though it often made me dizzy in a nauseous sort of way. Perhaps as a result, I stuck mainly to smoking on social occasions (e.g. parties), although I remember buying my own pack a few times (without hassle at the store). They usually went stale before I could finish them. I remember wondering whether to purchase a cigarette cases that I thought sophisticated people use to keep them fresh. As far as brands are concerned, I recall deciding DuMaurier suited me best because it seemed sophisticated. At one point I changed to Vantage or something similar to get a 'lighter' cigarette, thinking it would make me less dizzy and cause less harm, but then decided it was too much of a 'wussy' brand.

The irony about needing to be accepted by the same people that make fun of you at school is that it's mixed with a good deal of ambivalence. Although I wanted

to be accepted by the 'bullies' and the 'in' crowd, I can't remember really wanting to be like them or wanting to 'hang out' with them. Perhaps it was the resentment I felt towards them and the threatening violence of their ways. I guess smoking struck me as something the 'rebel' crowd did (the flunkies, the 'cool dudes', the bullies). On the whole, I tended not to be the rebellious type, and I had other people I needed acceptance from too (parents, teachers etc) which donning the rebel image would forfeit. As a result smoking was never really important as a symbol of rebellion to me the way I suspect it was was for my younger sister.

Although a few people smoked at the private boarding school I attended in England, it was deemed by the administration as cause for expulsion, and was in any case not common within the group I spent time with. Thereafter, I smoked occasionally in university at parties, perhaps most frequently the year I was at college in the United States, when I experimented with many things for the first time. Although I had effectively left home at age 16, the exchange year at the University of Massachusetts was the first away-from-home environment that was so permissive; in fact it conformed rather closely to the stereotypes of the American college scene. But even here, cigarette smoking was only an occasional thing for me, usually at parties. In the end, this quintessential college life did not bring the sense of inner worth or well-being we are socialized to imagine it would. It was something I needed to go through, but it held little lasting appeal for me, except to say that I could be 'hip' if I wanted to be. In reality, I've never been much of a joiner, and spend much of my time alone out of choice, even now.

When I returned to Ottawa, it was to live in residence as a don (which did not work out particularly well) and then subsequently off campus while completing my B.A. thesis and working a half-time job as assistant manager in the service industry. By then I had developed my own identity and relationships, as well as an interest in health and medical geography, and saw smoking as increasingly socially and physically undesirable.

The distaste for 'second-hand' smoke that I subsequently developed partly reflects the social meanings I ascribed to it. I used to assume that smokers were being almost deliberately inconsiderate, committing a personal affront (similar to a

guy putting out a cigarette on someone's coat in order to start a fight), or that their addiction symbolizes what I take to be typical of their 'class': that they are aggressive somewhat 'uncouth', and the embodiment of the 'bullies' who used to terrorize me as a child. At times I would slip into a kind of intellectual snobbery indicative of a wider non-smokers' cultural emphasis on willpower rather than on the addiction by attributing their smoking to their lack of education.

I recall in particular that as recently as a year before I began this research, I approached a person who was smoking in a non-smoking area of a restaurant and rather curtly requested that he put it out or move. Imagine, then, the revelation for me of 'walking in the shoes of the other' in the course of interviewing smokers. As the research progressed, I began to empathize with their plight and question the role of tobacco control as social control, viz. as a sort of subtle (and perhaps unconscious) class discrimination. This is very much the spirit of the discussion in Chapter 9. Professionally, as well as personally, then, I have moved from being a champion of the lifestyle modification agenda in health promotion to being one of its critics. This is not to say that people cannot (or ought not to be helped to) change their own health-adverse behaviour. Rather, I question the context for an emphasis on the individual and the way in which such an agenda is carried out in practice (see Chapter 2).

This critical thrust has been motivated also by my exposure to critical social theory and the adoption of explicit values about the role of academics as agents of social change and as advocates for disadvantaged groups. Exposure to the smokers' lay perspective with tobacco control and the writings of Illich, Freire and others have sensitized me to the middle class bias in health promotion and community mobilization. I suspect that my unconventional home and educational background has contributed to my willingness and tendency to assume the 'devil's advocate' with respect to conventional professional practice. In a moment of honesty I might also confess that lurking within the psyche of those who advocate a critical perspective is perhaps a competitive streak that seems to be encouraged in academia, since critiques, almost by definition, are often presented as being intellectually superior to what is being critiqued. Combined with an interest in social justice, this critical orientation has taken the form in the case of this study of questioning conventional

professional practice in the realm of tobacco control and community interventions. Hopefully humility about the limitations one's knowledge together with a reflexive critical gaze tempers any appearance of arrogance and the temptation to become infatuated with one's own ideas.

Lest these revelations be interpreted as cause for heavily 'biased' research, I have tried to give equal weight to confirming and disconfirming evidence, and I have taken care to ensure that I do not go beyond what is in the data. Nevertheless, the potential for 'skew' in favour of a 'hidden' agenda can not be ruled out altogether: I have of necessity had to be selective in what I take from the data. That is why it is important to provide these frank autobiographical details, so that others can judge for themselves.

5.4 EVALUATING THE QUALITY OF QUALITATIVE RESEARCH

What the discussion in this chapter raises is how one is to evaluate the quality of critical-interpretive work. Although there appear to be no hard and fast rules or accepted evaluative criteria, a number of guidelines have been suggested in the literature. The quality-assurance measures outlined in Table 5.7 were assembled with reference to Kirk and Miller (1990), Miles and Huberman (1984), Guba and Lincoln (1989) and Corbin and Strauss (1990). They can be implemented to varying depths and levels of completeness. Many of these issues were discussed elsewhere in this chapter, but Table 5.7 provides a useful summary of the issues, even though it is not an exhaustive list of possible criteria. In most cases, steps were taken to verify the quality of data collection and interpretation, but some measures were not feasible within the study design, and in hindsight it is evident that one or two others were not pursued as vigourously as they might have been.

Without any formal training in qualitative methods, I believe that I conducted the research competently and to the best of my ability at the time. The sheer volume of material and magnitude of the task necessitated precluded the formulation of thick description or thick interpretation as described in Chapter 2. For example, so many topics were covered with respondents that subjecting every working hypothesis and

piece of testimony to all of the checks and balances described in Table 5.7 would have made the study unmanageable. In fact, little is said in the literature about the realities of field research that necessitate compromises in the 'gold standard' approaches to qualitative research as described in methodological texts. Nonetheless, codes were developed for apparent contradictions (with-in person testimony), and a comparatve analaysis of negative evidence (opposing opinions and experiences) was routinely incorporated into the analysis of each topic, as described earlier in this chapter. In fact, lest this appear unecessarily apologetic, it should be noted that a variety of quality checks were built into each stage of the research, such that each of the major headings in Table 5.7 were addressed.

Table 5.1 Judging representativeness in qualitative research

Representativeness of views within a person
- variability over time, 'public' vs 'private' accounts (c.f. West 1990)
- can ask about consistency & truthfullness but may seem accusatory
- ideally spent a lot of time with respondents and supplement with participant observation, but in this case limited by essentially cross-sectional nature of data

Representativeness of views within the sample
- counting as one way to identify representativeness of views (e.g. report that "one, a few, some, many, most said xx...")
- sort responses by some other characteristic (e.g. smoking status)

Representativeness of views of sample vis a vis other members of the BC Smokers' Network
- explicate possible sources of volunteer bias
- compare characteristics of the sample vis a vis other members
- ensure broad range of perspectives included
  (e.g. purposeful sampling of key informants, but note that purposeful sampling such as maximum variation sampling tries to represent breadth of opinion and experience, rather than numerical equivalency; also note that SES data not available, that stratified random sample meant to oversample heavy smokers, and that sample fairly well distributed with respect to age, SES, smoking status and gender)

Representativeness of the Network vis a vis other smokers in Brantford
- compare with characteristics (socio-demographics & smoking status)
- more predisposed to quitting (since joining Network is voluntary; presumably more open to help, perhaps less opposed to tobacco control)
- more familiar with Brantford COMMIT (necessary for this study)

Table 5.2 Characteristics of lay smoker respondents

	Male	Female	Total
Smoking status			
heavy smoker (>25 cig/day)	10	13	23
light-moderate smoker	9	13	22
# of years respondent has smoked			
< 10 years	2	1	3
10-25 years	12	17	29
> 25 years	5	8	13
Age respondent began to smoke			
young (< 18 years old)	16	24	40
Age group			
18- 25 years old	1	2	3
26-35 years old	8	12	20
36-50 years old	5	9	14
51+ years old	5	3	8
Socio-economic status			
professional	7	9	16
working class 1	8	14	22
working class 2	4	3	7
Interview location			
respondent's home	13	22	35
BC office	3	3	5
coffee shop	3	0	3
respondent's place of work	0	1	2
Time on the Smokers' Network			
< 2 months	3	2	5
2-6 months	5	6	11
> 6 months & up to 1 year	6	10	16
> 1 year	5	8	13
Sample from the Smokers' Network	M = 19	F = 26	45

Table 5.3 Key informant groups sampled

	Category	# Respondents*
1.	intervention staff based at the site and in the affiliated research institutions	5
2.	BC volunteers (Task Force chairs, Board members)	10
3.	Key organizations with a mandate in smoking, smoking cessation or tobacco-related disease (Health Department, DHC, Lung Assoc. etc)	5
4.	Other key influencials in the community (media, politicians, etc)	4
5.	Researchers from affiliated research institutions (Waterloo & McMaster)	6
6.	People close to the target group (labour, social clubs, community worker in low income housing project, etc)	4
7.	Provincial representatives of organizations with related mandate	2
8.	Local tobacco farmer	1
	Total # of interviews	35 *

* numbers sum to more than 35 because some respondents fell into more than one category (interview content was adjusted accordingly: see Section 5.2.2). Note that only one person refused to be interviewed (from grouping #3) and is not represented in this table.

Table 5.4 Examples of transcription errors

TRANSCRIPT: ...it's kind of been a tough function but we, you would go with whatever the problems with health policies are...

WHAT WAS ACTUALLY SAID: ...its been kind of a tacit assumption that we would go with whatever the province's health policies are...

TRANSCRIPT: ...the government is almost saing to non-smokers well, you know, you were taught, like you either - you stand up and you give smokers hell

WHAT WAS ACTUALLY SAID: ..the government is almost saying to non-smokers "Well, you know, here its law. Its OK to stand up and give smokers hell"

TRANSRIPT: ...a broken cigarette is an (awful?) game. Now that's a proactive message

WHAT WAS ACTUALLY SAID: "A broken cigarette is a little freedom gained": now that's a proactive message.

TRANSCRIPT: You got to inhale all the diesel fumes. And that's worse, the way I see it anyway.

WHAT WAS ACTUALLY SAID: You've got to inhale all the diesel fumes. And that's worse than any cigarette ever will be.

TRANSCRIPT: I have no doubt that communities are the way to God!

WHAT WAS ACTUALLY SAID: I have no doubt that communities are the way to go.

TRANSCRIPT: ...I think we we're a blast with a really good investigative team...

WHAT WAS ACTUALLY SAID: ...I think we were blessed with a really good investigative team...

TRANSCRIPT: ..a more direct interactive community confrontation model... and intimate health promotion projects don't recognize that need, that we've got to build in a consultation process more

WHAT WAS ACTUALLY SAID: ..a more direct interactive community consultation model... and community health promotion projects have recognized that need and have tried to build in a consultation process more

Table 5.5 Major coding categories used for discussions with smokers

Base Codes - applies to entire document &/or respondent &/or interview

respondent (age, sex, SES, smoking status, time on Network, referral point...)
interviewer (level of comfort)
interview (location, duration, content codes)
other actors (smoking status of spouse, kids, siblings, parents, friends, coworkers; workplace restictions)
person & document type (smoker vs key informant; interview vs focus group)

Text Codes - applies to specific passages of text in transcript; can overlap

starting to smoke (when, where, why, with whom...)
current smoking status (timing, amount)
about cigarettes (brand, the tobacco industry: corporation, farmers)
second hand smoke (opinions about validity of ETS argument & how to act)
actors (self, smokers, family, coworkers, doctor/nurse...; combine with other codes)
interaction with others about smoking (anti-smoking and pro-smoking)
attributions about others (combine with actors codes)
smoking history of others, health of others, quitting experiences of others
against smoking
(reasons to quit: health, kids, cost, illness, pregnancy...)
strategies for quitting & maintaining abstinence
(cold turkey, gum, patch, treatments, keeping busy...)
reasons not to quit
(lack of willpower/motivation, enjoyment, stress, crutch, withdrawal, addiction, lack of support, synergy w/ coffee & booze, exposure to the smoke of others ...)
own quitting experiences (what happened when I quit or tried to quit before)
needs for assistance
(what I would need to quit successfully, what should be available, etc)
reflections on having quit (how hard was it, in what ways am I better off, etc)
plans to quit (intentions re when & how)
slips (falling off the wagon, planning to restart...)
social acceptability of smoking (stigma, rights, should society care? etc)
COMMIT
(joining, level of support, expectations, profile of BC in the community, mandate to change social norms, ideas on what Commit could be doing, quit pack, newsletters, Quit&Win, support group, hotline, etc...)
prevention & cessation resources / services / activities
(education in schools & media, statistics on health effects, taxation, legislation re access of minors, public places, workplace restrictions, advertising, cigarette pack warning labels, other cessation resource groups, young people smoking, reactions for/against restrictions)
health (compared with peers, health problems, determinants of health, other actions besides quitting, death)
changes over time (combine with codes like taxes or knowledge of health effects etc)
space (where comfortable or uncomfortable smoking)
contradictions
context (setting: Brantford, the economy, environment, crime, government...)
themes (choice vs peer pressure, blame, fatalism, respect, rights, deception...)
classic quotes (combine with topic area)
behaviour (accepting, rejecting, exagerating, rebelling, stealing...)
feelings (amused, depressed, disgusted, hopeful, confused, stupid, not stupid, defiant, guilty, bored, angry)
questions asked or info provided
(about COMMIT, my study, myself, techniques or resources available)
other participants (when spouse/kid is present & contributing to the discussion)
transcriber comments
fieldnotes (from fieldnote information form accompanying each interview)

Table 5.6 Coding statistics

	Smokers		Key Informants		
	Interviews	Focus Groups	Interviews	Focus Group	Total
# completed	45	2	35	1	80 / 3
# text units	52,897	6,647	49,785	2,583	117,912
# pages	1043	125	958	48	2268
# codes available	534	534	464	464	998
avg # codes used	110	105	63	72	88
avg # lines/code	11	31	25	36	26

Table 5.7 Quality checks in the conduct of qualitative research*

Checking the quality of transcripts
- tracking the nature and frequency of transcription errors & correcting them

Checking for representativeness
- counting (reporting the proportion of the sample adhering to a particular viewpoint)
- comparative analysis using alternative groupings
- report outliers and extreme cases
- see also Table 5.1

Triangulation
- multiple researchers (eg sharing methodology & results with supervisory committee)
- multiple methods (e.g. interviews & focus groups)
- using other informants (e.g. multiple stakeholder groups in key informant pool)
- other settings (e.g. public versus private; respondents encouraged to pick site they were most comfortable with)
- other questions (to get at the same issue; both within and between data collection methods)
- other times (multiple encounters; longitudinal data collection)

Check for researcher effects
- e.g. being seen to represent Brantford COMMIT (but as described in section 5.2.1.1 this does not appear to be significant, and a number of steps were taken to make respondents as comfortable as possible)

Check back with respondents
- with same respondents, during interview (e.g. restate what you heard & ask for clarification)
- with same respondents, later (e.g. through summary with feedback sheet attached)
- using new informants (sampling additional members of the Network or smokers in Brantford, which was not done)

Search for counter-factual evidence
- differences of opinion within same respondent (e.g. code for 'contradiction')
- differences of opinion between respondents in same sample (e.g. report negative evidence)
- differences of opinion between respondents of different groups (e.g. Network members versus key informants)

Check out rival hypotheses
- e.g. why some people do not appear to use what they ask for (Chapter 8)
- limited by nature of data collected (must explore these at time of interview to be able to ground speculation in the data)

Provide own assessment of data quality
- e.g. consistency and reliability of coding as first step in analysis and interpretation

* Compiled with reference to Kirk and Miller (1990), Miles and Huberman (1984), Guba and Lincoln (1989) and Corbin and Strauss (1990). However, this is neither an exhaustive list nor a full account of the measures taken (see rest of the chapter for fuller discussion).

CHAPTER SIX

A LAY SMOKER'S PERSPECTIVE ON BRANTFORD COMMIT
PART I: DIRECT EXPERIENCE WITH BC ACTIVITIES

6.1 INTRODUCTION

As discussed in Chapter 1, three basic questions are implied in the evaluation of a health promotion intervention: (a) how do we define and measure success in a health promotion intervention?; (b) how do we account for the success (or failure) of *this* intervention in *this* community?; and (c) how can we apply that knowledge to practice in 'similar' communities and interventions? The arguments in favour of a client-centered approach to evaluation were presented in chapters 1, 2, 3, and 5. On this basis, the primary corollary of the first evaluation question is to establish the degree to which COMMIT has met the cessation-related needs of smokers in Brantford. In order to gain a balanced picture of BC from the smokers' perspective, several approaches have been taken. The needs of smokers for assistance with quitting are considered in Chapter 8, and Chapter 9 examines the smoker's perspective on tobacco control. Transcript material from interviews and focus groups with smokers who have been involved with Brantford COMMIT (BC) are used to provide the target population's perspective on the intervention.

The purpose of this chapter is to explore the experience of smokers with the Brantford COMMIT (BC) intervention through their membership in the Smokers' Network. The chapter contains three sections. First, smokers' self-articulated reasons for joining the BC Smoker's Network and their expectations of the program are examined. Second, their experience of specific activities and resources such as

the Quit and Win contests, cessation package, newsletter and hotline is discussed. Third, the overall level of support perceived by smokers to have been available is discussed as a general measure of satisfaction.

6.2 REASONS FOR JOINING THE SMOKERS' NETWORK AND EXPECTATIONS ABOUT BEING A MEMBER

Given that Brantford COMMIT operated at a variety of levels and through a multiplicity of channels and mandated activities, one expects Network members to have heard about or joined through a number of possible points of referral or contact. When respondents were asked about how they first heard about BC and when they related their experiences of joining the Smokers' Network, the sources and influences mentioned differed somewhat from what was available on the computerized BC records, which contained the referral sources marked by respondents on a Network sign-up card and coded by BC staff into a finite number of categories (Table 6.1). It may be that referral agents (e.g. one's doctor) are not necessarily the major influences in respondent's decisions to join the Network, but perhaps the catalyst that builds on the smoker's exposure to BC in the media, the urging of family and friends, and so-forth. When respondents identified sources of influence in joining the network, they mentioned the following (in order of frequency): (a) something delivered to the home (ad in newspaper, flyer etc.); (b) pressure from friend or family member (who often takes the initiative to sign the respondent up); (c) BC information display and/or recruitment booth in a mall or at a local event such as the Olde-Tyme Family Picnic; and (d) referral from their doctor.

Many respondents were vague about their expectations of BC when they joined, reflecting a broader difficulty in identifying needs for assistance in quitting (this is discussed more fully in Chapter 8). It seems that generally respondents weren't sure what to expect but were willing to keep an open mind and hoped that BC could offer something new they had not yet tried that would help them quit and stay quit. For some people that meant BC 'just being there', whereas for others it meant concrete support, or in some cases even an acknowledged hope for a miracle

cure. An attempt to categorize these expectations generated a number of core themes, listed in Table 6.2, with several people displaying more than one simultaneously.

Many people indicated they really didn't expect much in particular, but just thought "what the heck, I might as well join", or "anything's worth a try". It is not clear whether respondents had difficulty remembering what their expectations were, or if there was a reluctance to admit high expectations (having been "taken"). But the nonchalant attitude displayed by many respondents raises the questions (a) as to their ability to define and act upon needs for assistance; (b) as to their level of commitment to quitting, or perhaps both. Many people knew very little about COMMIT but were curious what BC had to offer, so for them joining the Network was clearly a way of finding this out. For example, when asked what she thought she might get from being part of the Smokers' Network, Linda responded:

> I think what I thought at first was that I would find out some more about Commit, because *I wasn't really too familiar with what kind of things they might be able to offer* me, or what's out there... I think that's basically why I signed on was to try and see what else there was, you know, who was out there, what could be helpful... (Linda, 31, 496-502; emphasis added)

It seemed as though many people were looking for something 'new' that would help in the struggle to be free of smoking. While anything that might help was probably welcomed, respondents seemed quick to dismiss tips they had already tried as ones that "don't work" if they had had cause in the past to be unsatisfied with them (hadn't liked it or felt it was effective). These feelings seemed to coexist with the acknowledgment that perhaps 'one man's meat is another's poison', that what worked for one person might not for another.[1] Given this and the fact that many people had tried to quit several times prior to joining BC, disappointment would seem virtually inevitable. In fact, several smokers admitted to tacitly hoping for a magic pill to rid them of the addiction, having run out of ideas of their own. Consider the following passage from Pam, a 45 year old heavy smoker who had tried Life Signs on several occasions without lasting success:

> I didn't really give it a lot of thought. I thought I'd send off for it and see what turned up (pause)... I was looking for a miracle cure, actually. (Pam, 45, 296-301)

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[1] By and large, people based their appraisals of efficacy on personal experience and anecdotal evidence from others who might have shared their experiences (or hearsay impressions) with the respondent.

Jamie and Annette had much the same to say:

> ... I thought maybe, subconsciously.. you must think it's going to be a miracle thing, like COMMIT, you know: its from the hospital and the doctor... [but] you can send people all the stuff you want [referring to the cessation package BC sends to new members]... its just replacement, but if you want a cigarette, you want a cigarette, you know what I mean? (Jamie, 21, 254-269)

> When I went [to COMMIT] I was hopeful that they had something to offer. When I was there, [it was] nothing really I hadn't tried before. They hadn't any cure. I suppose I was looking for a cure. And there isn't any such thing.
> (Annette, 12, 570-583)

Much as the majority of respondents appeared to have a nonchalant or 'wait-and-see' attitude in terms of what to expect from BC, the act of joining presumably belies an interest in getting *something*, and the assumption that *something* will be forthcoming, sometimes in the form of fairly immediate and tangible help. There may also be an implicit expectation that BC can do for them what they have not been able to do for themselves.

> I think a lot of people know about it, they just don't have the right concept of what COMMIT is all about and if they do find out about it, its not what they expected. Like, I kept an open mind, but I know a lot of friends think that if they come to COMMIT, they are going to quit smoking because it is a quit smoking program. It's a little bit of a misconception, but whether it is [due to] word of mouth or whatever... I think that the program is an excellent program, because it obviously has to work that way: you have to take that first step yourself, which the program does.. A lot of people probably think that it is kind of like Life Signs: 'Yep, it is a program designed to [make you] quit smoking...'. That's like my [subliminal] tape: my tape is not designed to help you quit smoking, its [about] living without smoking.
> (Dave, 6, 1343-1356)

Respondents varied as to how severely they were affected with withdrawal symptoms. Some appeared not to be affected at all (sometimes much to their surprise), while others found the whole experience very disabling and frightening (disoriented, bitchy, etc.). As a result, some people were looking for tips on how to eliminate or weather unpleasant withdrawal symptoms that they may have experienced in the past.[2]

It is important to be mindful of the timing of smokers' joining BC, since it often coincided with a fresh attempt at cessation (such as for those that signed on during Quit and Win contests) that precipitated certain crises around maintaining

[2] Needs for assistance in overcoming withdrawal symptoms are discussed in greater detail in Chapter 8.

abstinence and avoiding relapse. In many cases, once the initial crisis of quitting was over (successfully or unsuccessfully resolved) that may have accompanied a quit attempt and included joining the Network, people's needs for assistance diminished in intensity. This means there could have been a rather narrow window of opportunity for BC to make a difference in these people's lives through intensive face-to-face support for those who may have needed that, as opposed to arms-length long-term support through more common Network mailings. Furthermore, the onus was on those requiring more intensive contact to initiate it by calling the hotline, but for reasons that are explored in greater depth in section 6.3.4 this seemed to have been harder to do than one would have supposed.

Regardless of what specific tips and techniques BC might have to offer, most respondents were keen to be treated with dignity and respect, to be understood. Overwhelmingly, respondents appeared to value BC just "being there" for them. As the following quote exemplifies, they want and appreciate support, but do not want anything "rammed down their throat":

> To me, I find [anti-smoking hype] more irritating than anything else. Not to say that Brantford COMMIT is doing a bad thing or [that] I think they're a bunch of losers or a bunch of hypocrites, because I don't believe that at all. I think that what they're doing is great, and if you can convince somebody not to smoke or if you can help somebody to quit smoking, all the power to you. And *if you can help me, that's just great, I love it.* And if you're willing to offer it to me... *But don't tell me, you know. And don't, don't run it down my throat, because I don't need it,* you know.
> (Rick, 38, 1041-1050)

Respondents were rarely asked directly during the interviews as to whether their expectations had been met by BC, given how vague many people were about their expectations in the first place. However, this can be inferred from other things said about BC during the interviews (general perceived level of support, interactions with BC, etc.). On that basis, 44 percent of the interview sample seem on the whole not to have had their expectations met, 11 percent had their expectations met, and 27 percent reported not really having had any expectations (with a further 18 percent as not coded).

6.3 SMOKERS' EXPERIENCES OF BC ACTIVITIES, RESOURCES AND SERVICES

Much of the contact members of the Smokers' Network had with BC was through specific activities and services made available to them such as the Quit and Win contests, a cessation resource package mailed to new members, a periodic newsletter, and a telephone hotline. Their experience of these services and resources provides insight into the relationship between Network members and BC, and an indication of the role BC might have played in people's attempts to quit smoking.

6.3.1 *Quit and Win contests*

Seven respondents had direct experience enrolling in a Quit and Win contest, where participants are asked to commit to remaining smoke-free for 30 days in exchange for the chance to win a substantial prize.[3] This seems to have been a popular way of quitting, given the success many respondents reported having had in the past with bets between friends and relatives as an incentive to quit. Such contests typically drew in 50 to 200 new Network members on each of several occasions each year. For those who were considering quitting, the Quit and Win contest probably provided an incentive to do it now (as opposed to in an unspecified future). Entry forms asked participants to sign to the effect that they would remain smoke-free for 30 days, and provide the names of three references with whom that could be verified, which adds an important element of commitment to the process. Darlene's comments illustrate this feeling:

> ...and said, "I'll do this for 30...". And I mean, you quit for 30 days, why bother starting again? You're through the worst of it, so why bother starting? And I think that helps, you know? If you sign on the dotted line, you tell people "I'm going to do this". I mean, you['ve] got to tell at least three people, because you['ve] got to warn them that COMMIT's going to phone them up and ask them "Have you seen her smoking?" So there's at least three people you have to tell. And you make the commitment. And it *is* a commitment. (Darlene, 23, 2227-2246)

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[3] Prizes varied in nature, including a $1000 shopping spree at Eatons, and a pair of airline tickets to Florida. The odds of winning were generally acknowledged to be much better than the provincial 6/49 lottery, and those who were successful at maintaining cessation after the 30 days were declared successful quitters and had their names published in the local BC newsletter.

Respondents were generally positive about the Quit and Win contests. However, one woman on welfare indicated that the airline tickets to Florida would do her little good since she would not have the money to do anything when she was down there, indicating that the type of prize might be important in who is attracted to participate.[4] Several others bemoaned the fact that they felt "dropped" after the contest was over and "never heard from Commit again" (though in some cases it seems to have been because they moved and failed to notify BC of the change of address).

> Yeah, when I went on that Quit and Win or whatever it was I found they were very helpful with all the stuff... [but] *I was disappointed after I stopped hearing from them.* It was almost as like after the contest was over and done with that um... I think that maybe I got two newsletters or whatever they sent out after that, but that was it (Jane, 3, 263-275; emphasis added)

> ..they *weren't as supportive as I was expecting, because I never got a follow-up,* they never knew whether I started or stopped. You know, even if they once a month or once every six months after a contest goes on like write to us people and just say how are you doing, have you still quit and if you have congratulations and if you haven't do you need more information do you need another kit do you need something... and just keep following up on the person. *I felt like it was dropped after the contest.* I was really... [trails off] (Jane, 3, 344-381; emphasis added)

Although there is no direct statistical evidence of the impact of such contests on cessation rates, several case studies of Quit and Win contests in other sites and programs show that up to 90 percent of enrollees attempt to stop smoking, 51 percent quit for the full 30 day period, and as many as 32 percent may still not be smoking 8 months later (Cummings et al 1990). Enrollees in Buffalo NY programs were more likely to be female, under 40 years old, and heavy smokers (ibid), while participants in the San Diego CA program were reportedly more likely to be self-confident, have positive outcome expectations, and lighter smokers (Elder et al 1991). Experience with such contests in the Minnesota Heart Health program corroborates that of BC insofar as enrollment seems to diminish in successive 30-day Quit and Win contests (Lando et al 1991). However, by running the contest over a more extended period using monthly draws for everyone who had remained smoke-free that month not only boosted enrollment but provided an incentive for ex-smokers to remain abstinent for successive 30-day periods, even using much more

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[4] Given the predominance of heavy smokers in low socio-economic groups, attention should be given to ensuring that prizes are relevant and meaningful to people in these groups. The added benefit of shopping sprees at local stores, given the depressed economy in Brantford, is being seen to support local business.

modest prizes (ibid). This might have been worth considering in the latter years of the BC trial when enrollment in the 30-day Quit and Win contests dropped off substantially.

6.3.2 Cessation package

When new members signed onto the Smokers' Network, they all received a package of cessation materials including pamphlets, buttons, pencils, a scratch pad and fridge magnet, chewing gum and so-forth. Unless they registered in person at the office, these were usually mailed to new members. For many, this was the first real contact from BC, and in many ways it set the tone of the relationship between them: a relationship mostly by correspondence, top-down and hands off, although given the context of how individuals expect to relate to organizations in modern society, no-one raised this as being particularly unusual or objectionable. As indicated earlier, the decision to contact BC and join the Smokers' Network is set within the context of each individual's "cessation trajectory", providing an immediate window of opportunity for BC to make a difference by their having reached out for help and expressed a willingness to try again. One may well ask how the timing of receiving the cessation package (or 'quitpak') in terms of people recently (re)committing themselves to (the idea of) quitting addressed their needs at the time. In a few cases, respondents indicated that by the time it arrived they had changed their minds or discovered they were no longer so keen on quitting.

> I remember thinking about how I couldn't wait to read the materials, but then I couldn't do it. I had to put it away until I was ready to quit. Well, its still put away. (Debbie, 41, 795-798)

But in the light of respondents' expectation of "nothing in particular", "something new", "help with withdrawal", "a program to make you quit", or "support, not nagging" (Table 6.2), what were their reactions to the cessation package? Many said they liked receiving, as some of them called it, a "care package" or "survival pack", which are in themselves revealing names meant to reflect the acknowledgment that someone cares and that the material was intended to ease the transition to becoming a non-smoker. Many also said they liked some of the "gimmicks" in the package such as a plug for their cigarette lighter and ideas like

putting an elastic on your cigarette, and the candies, gum or fridge magnet. One person said the literature on negative health consequences of smoking was just what she needed, while another said the affirmation that healing started soon after quitting was very important for her.

But on the whole responses were non-committal: "it was *ok*", "I *read* it...", "it was *interesting*...", or "it was good...". In particular, many respondents marveled and despaired at the sheer volume of the package, and to some the written material seemed wordy and repetitive. In fact, on the whole, respondents displayed a poor retention of the written materials, in some cases acknowledging that they had not read all of it. Some people had grabbed the "interesting" stuff (gimmicks mentioned above) and left the rest "to get back to sometime", having never in fact done so (having in some cases lost it in the interim or come across it later and thrown it out). This suggests either a lack of time or of motivation, or the feeling that reading the material seemed somehow tedious or unhelpful. In fact several respondents said they thought it was too "wordy" (Jamie, Ian), or that they doubted it was anything they had not seen, heard or tried a dozen times before (William, Annette).

> I think a lot of easy reading would be something - like, when I read them brochures, *I don't want nothing long and thick. You know, the average person don't want to read that kind of shit, right?* But if you put it short and sweet, "hey, this is what it's going to do to you", you know, I think there's more chance there.
> (Jamie, 21, 478-483; emphasis added)

There is evidently a delicate balance between providing people with plenty of support and a range of materials in the hope that some will be helpful to any one person, and making them feel swamped and reluctant to dive in. The approach taken in compiling the packages seems to have been to include whatever cessation pamphlets were available that might be useful (mainly those produced by Health and Welfare, the Lung Association, and the Cancer Society), with some inevitable overlap as a result.

Amongst interviewees, 14 had good things to say about the package and had made some use of it, while 14 were less complimentary in their evaluation of the package. Table 6.3 outlines some of the problems that respondents had with the cessation package. It is interesting that in the context of people wanting something

"new", that there was much they had already seen, heard or tried before. They sometimes felt they were being patronized. In fact the theme of "not stupid" was a recurring one throughout the interviews as people tried to demonstrate that they already *knew* about the risks of smoking and more or less how to go about quitting, but either were "not ready" or otherwise somehow unable to quit.

Sometimes the appearance of contradictory advice contained in the cessation package literature or disagreements on the part of respondents with the advice provided compromised the credibility of the material or was used to justify its being discredited or ignored. Vincent felt that more support and follow-up should accompany the cessation package in the weeks and months following its receipt:

> Yeah, the survival pack was great. Because it just makes you [feel like somebody?] But they should follow up on that, the second month or third month.. Because they're the critical times. Even the third month or the fourth month, I was ready to go back on the fourth.. Because you always get those urges to go back, eh? That's when you get to feel lonely. That's when you feel like you lost a friend. And that's when they should have [contacted us?] once in a while. Even a phone call, "how are you doing?" [Or] that literature pack again, a reminder. I went through the two months there, and that's when I needed something: right there, second or third month, eh. Like uh, second or third day are the toughest when you quit right? First day you, you figure its tough, you prepare yourself (but) "hey, that's not so bad, the first one". But then second or third when your mind slips away get you while you're weak and then boom, it gets you eh? And that's when they should follow up. Yes, if you want, ask for, maybe 10 dollars more or 20 dollars more, but that lets you. [do better]. Lets see, if you get 60 percent quitting now, with that little extra in the second or third month, you end up with 75 or 80 percent (quitting). (Vincent, 25, 753-780)

Some respondents read the materials and were all set to take action when intervening factors derailed their plans. For Doreen, the death of her mother shortly after she received the cessation package meant that in the emotionally charged days that followed she picked up the whole package and threw it in the garbage.

Several implications suggest themselves based on feedback from the interviews with Network members concerning the cessation package (Table 6.4). The notion of compiling a "care package" for new members to ease the transition to becoming a non-smoker was well received and worthwhile, but might also have benefited from some modification. In fact, it would be helpful if smokers themselves were consulted as to what would be desired in a "care package" accompanying membership. Given respondents' desire for finding out what other respondents had said in their interviews with the author, it might be useful to include one of several

inexpensive and readily available books that distill a lay smokers' perspective on overcoming nicotine addiction (e.g. Ferguson, 1988; Farquhar and Spiller, 1990; Anonymous, 1992; Casey, 1987), or at the least an annotated bibliography and indication of which local bookseller carried them. It seems worthwhile to have included various gadgets and gimmicks such as the scratch pad, fridge magnet, and candies, since these seem to have been the most memorable and appreciated by many respondents. However, the written material could have benefited from being revised and consolidated to reduce redundancy and volume. The production of a concise spiral-bound Brantford-oriented cessation reference manual with sections on health benefits of quitting (and health costs of continuing to smoke), physiological and psychological effects of nicotine and nicotine addiction, withdrawal symptoms, cessation methods (including brief introductions to acupuncture, hypnotherapy, laser, and other commercial treatments and products), local cessation resources and services (including self-help resources such as Nicotine Anonymous), and perhaps even a thumbnail sketch guide to major national, provincial and local policy initiatives could have been particularly worthwhile and would not have been particularly difficult to produce, given the volume of material currently available on each of these topics.

It is nonetheless also evident that no one format or series of materials will suit everyone. In fact, the following quote exemplifies the ambivalence that some respondents had about what kind cessation information would be of assistance to them, or more broadly speaking what would help them quit.

> I think people are sick of the literature. I mean, it's like anything else that's so good for you: if you're flogged with it often enough you just, you tend to not recognize it as much as you begin to resent it. Everybody's read the literature and seen the photographs of the black lung and such.. If I was an organization trying to get someone to quit smoking, well obviously that's going to be one of my propaganda tools is to make it apparent to someone just what's wrong with smoking and how it can detract from your life and your lifestyle and how socially unacceptable it is. That, I think, is something that's been done probably as effectively as it can be done. I think most everything that can be done has been done. I don't uh, I don't see too much.. Like Commit is the best non-smoking organization I've ever seen. I was amazed at the volume of the package that was sent to me. It's incredible all the little tools and gimmicks and candies and the straws and the toothpicks.. The one thing that sort of tickled me was where you take your cigarette lighter out and you put this little plastic plug in that has a non-smoking sign. That was somewhat of a motivator because you can look over every time you're in the car and you see that and you kind of think, "Oh, yeah" you know, "That's, that's who I am right now" if you don't go back to it. The COMMIT system works about as well as it's capable of working, you know. But as I said, maybe I need a support group or something. Maybe I need to go

> to a pub somewhere and have some gorgeous woman say to me, "Well no, I'm going to dance with you, because you smell like cigarette smoke" or something.. until you get to the point where you say "Well, yeah, I, you know, I do have to quit smoking". But as far as COMMIT goes no, it's probably the best non-smoking organization I've ever seen. I just, carry the guilt because I didn't follow it as thoroughly as I could, or I should have. I think what you have to do with the non-smoking situation is bash at it every day and I did it for - I quit for about a week and a half when I first started the COMMIT program, and then I had a cigarette the next day. Well, the day after that I didn't, I didn't try (Bob, 39, 677-723)

*6.3.3 **Brantford COMMIT newsletter***

Two or three times a year BC prepared and distributed a newsletter to members of its Smokers' Network and for public distribution at worksites, doctors' offices and other venues around town. It acted as a forum for announcing upcoming activities (such as Quit and Win contest, support group meetings, or cessation course), sharing stories and quit tips, and publishing the names of members who had successfully kicked the habit. For most Network members, this was the only form of regular contact they had with BC, and served as a constant (and many thought, useful) reminder of their membership in the Network and that BC was there for them (see Table 6.5). Carolyn and Mark said that these sustained mail-outs demonstrated a level of commitment from BC that was rare amongst organizations. Several respondents felt badly that they had not "kept up their end of the bargain" by following through on their expressed desire to quit. It became evident in reviewing the transcript material coded "newsletter" that for many respondents this "keeping up the awareness" function was the most important as far as the newsletter was concerned.

> It is nice to know that the help is always there... As I say you go along and you're smoking and you go on for a month or so and then all of a sudden there's something in the mail: COMMIT. "oh yeah" ...Once you see the commercial or you see something from COMMIT or ..and it jogs your memory that you should be quitting. You really should be. And as I say it does put something in your head.. But now all that has to happen is for something like that to happen and then I've already got something in my head that I'm ready to quit. And that joined up with that little thing from COMMIT or the ad on TV... starts the ball rolling. You need stuff like that, just to, just to remind you that you are smoking and you should quit.
> (Mark, 14, 742-762)

> I think it's interesting that Commit keeps sending me things even though I'm not doing anything (laughs) You know, like I'm not avidly participating, but there's still that outreach, and that's good, because it's still a reminder to me that I have thought about this, and it's not just somebody telling me I should do this.
> (Linda, 31, 525-529)

In terms of content, the big hit for some respondents was having one's name published in the newsletter as a successful quitter.

> I was so proud that I did [quit], I phoned Commit up because I wanted to tell somebody... I was so proud of myself that I had done it. I just had to tell somebody. I'm not sure whether I got literature through the mail or whether it was advertising or something... Yeah, it was this flyer that comes through and that was when I first seen it and I thought "gee". It said about if you know anybody quitting or anything like this... I said I don't belong to nothing or... but I'm so happy, I'm glad that I quit smoking and I haven't had a cigarette since January 8 of last year... I just, I felt so good about it, eh? I don't know why but I just had to tell somebody, you know, and which I did. And they need somebody to give testimony [at the support group meetings] that they quit, (laughs) that they made it you know. I thought about it but then I never have. (Tim, 9, passages abstracted from lines 313-371)

Also, its clear that the supportive tone established in the newsletter (and seen by members to be characteristic of the organization as a whole) was both vital and much appreciated (see also Chapter 9). It was probably also the most efficient venue for notifying members of upcoming events (and certainly one of the few permitted under NCI protocol restrictions).

However, its also clear that many times the newsletters did not get read by recipients. But receiving material that you originally asked for and that tugs at your conscience is problematic. Some respondents clearly felt ambivalent about the whole thing. Most of them hastened to explain why it was that the newsletters had gone unopened or unread.

> It probably helped. You know, cause I started getting this stuff coming in the mail, and you can't really think of this as junk mail. So you can't throw it out, so it sits there staring you in the face, you know. (Darlene, 23, 1186-1194)

> Sometimes it's really easy when you get the things in the mail, you just sort of throw it out, even though there may be lots of good stuff in there, you don't sit down and read it or you don't have time or you think you don't have time or you're running around doing something else so it sits there for two weeks and you don't look at it and then you start cleaning up and you start throwing these things out. Sometimes what might be more effective for me, is if there was a personal touch base thing where someone phoned once a month... (Linda, 31, 507-516)

> To be perfectly honest a lot of the time I'll open the COMMIT envelope and just set it aside because I'm not ready for this yet, or it's not going to work, or it's never going to work, depending on the mood I'm in when I open the envelope. A lot of their stuff is group stuff and I don't think I can do that. I noticed in the last bunch of brochures I got there were various techniques, but.. I just wish there was a sure way to quit. (Shaine, 13, 545-551)

> Well, you see, once you start smoking again you don't want to [read them].. You know, this is just.. kind of... reminding you that you're doing something you

> shouldn't, really. You're just not interested in COMMIT anymore once you're smoking... Well, [when it arrives] I'll read it.. and then it just goes in the garbage and I might think for a few minutes, but it doesn't make any impact, you know.
> (Anne, 1, 938-951)

For Darlene, joining COMMIT was synonymous with "putting oneself on the mailing list", suggesting the centrality of the newsletter to the relationship of BC to Network members. Vincent and Leslie felt that the mailings were too sporadic and constituted too low an intensity of intervention to really make a difference for them in their struggle with nicotine addiction.

Key informants interviewed within BC indicated that the newsletters were geared to those with a grade 8 education and that they tried to make it as uncluttered as possible. They admitted that while putting out a newsletter made the Board feel good, and response from the middle class has been enthusiastic, they really did not know how effective they were with lower SES target groups. As indicated above, the interviews with smokers themselves did not shed much light on this, since their comments pertained more to the symbolic act of receiving a newsletter than its contents per se.

6.3.4 Telephone hotline

Soon after its inception, BC established a hotline for smokers struggling with nicotine addiction. For Network members, this was theoretically their lifeline to BC, the only interactive medium of communication and way of initiating contact or asking for help after joining the Smokers' Network. Yet despite a generalized (if vague) awareness of its existence, few respondents had ever used the hotline. This is all the more surprising in light of complaints about the lack of support and statements made by some that they would prefer to be the ones to initiate contact from COMMIT. In other words, the hotline seemed like a good idea in theory but there was some reluctance to actually use it, even though many respondents had clearly experienced relapse crises (near or actual relapses) since joining the Network. Some respondents claimed not to have had the nerve to call, some not to have gotten around to it, and others to have lost the desire to quit in times of crisis.

> I was hoping to call... but then I never got around to calling. And then I'd just forgot about it and.. "you didn't quit, don't bother, well maybe you should" And when you called me I had just received a letter last night just before you called me too. And I was going to call then, and I was telling everybody in the office "I gotta phone, I gotta phone" And then I felt kind of embarrassed... (laughs) ..that I didn't quit... So... But I'm glad you did call... And that you're here (laughs). (Shauna, 23, 481-505)

Doreen's experience illustrates the impact that external events can have on people's ability and desire to make use of available resources, and the complexity and interconnectedness of the various factors that contribute to or hinder a successful quit attempt:

> Doreen: I think it's good you've got that where you can call up to talk to somebody... [the hotline]. Now that is great. That is great. That is an ideal thing, because that's just like people that are getting abused or have problems psychi- [stumbles on the pronunciation] - you know, to where they feel like committing suicide and they call the suicide hotline, whatever.
>
> Author: Yeah... Did you ever call that?
>
> Doreen: Your program? No. Because, see I just got into your program. I got into it in April I think it was. So I only had more or less the month of it, and in that month I had cut myself down to two cigarettes, so you know that I got the motivation, "I can do it!", right? And then my mom died and that, so I really didn't get a chance to do anything else.
>
> Author: Yeah,.. You didn't feel like calling then with.....?
>
> Doreen: Oh, no, I didn't. I just kept to myself more or less. It was, you know... - and I just looked at [my husband] and I went, *took the package and threw it in the garbage.* That's what I did. I had the pad all written up on how I was doing it and everything, so I threw it in the garbage. And he doesn't push me. Like if I quit, he'd quit. But I don't feel like he should have to, because that's got to be his want and it shouldn't be he quit because I had. Nobody should quit because they're made to quit, unless it's by doctor's orders, you know. I mean they shouldn't quit because society says quit. They should quit because they want to quit.. (Doreen, 42, 1586-1625)

Since respondents were not routinely asked why they did not make use of the hotline, it is difficult to interpret their reluctance to use the service even in times of perceived need. Is part of it, as Fassel (1990), Hendlin (1992) and Nakken (1988) suggest, that as a society we seem to value self-control and stoicism, consider it a sign of strength and fortitude to "go it alone", and are obsessed with perfection and image, which fuels the need for control that is at the heart of the addictive personality? Is the result that we have a cultural tendency to hide our vulnerabilities, and are reluctant to ask for help or admit we're stumped? If so, it is ironic that it also

takes a inner strength to acknowledge one's vulnerabilities, to reach out and draw on others when you need to.

In terms of what was available to those making use of the telephone hotline, a staff person who herself was a smoker trying to quit would usually answer the phone and provide information or counseling to callers. Since few respondents reported using the hotline, its difficult to evaluate the assistance provided in this manner. On the other hand, respondents were delighted to learn that smokers and ex-smokers were part of BC; that it wasn't "just a bunch of missionary anti-smoking zealots". It's noteworthy that this was not an anonymous peer counseling service for nicotine addicts in the way that most other crisis hotlines are run: it operated only during business hours and did not use trained volunteers to staff the lines. In fact, presumably many relapse crises would occur "after hours", and one of the focus groups had fun with the concept of what it would be like to phone up in crisis and get the answering machine at the other end.

Peter:	I'll call you if I feel I need some support. And they always gave me that feeling they would've been... there to answer the questions of the literature if you had quit, if you felt you needed a smoke, call this number and talk to somebody. They have that. I've never called. And I don't know if it's 24 hours a day or what.
Author:	I think there's an answering machine comes on after hours.
Peter:	So you get to talk to a machine?
Author:	Yeah. (laughter from others) And they return your calls during the day.
Shaine:	(laughing) "I'm going to have a cigarette. Help. Call me back tomorrow!"
Peter:	"If you got a touch tone phone, please press number 3 for this response" (laughing)
Shaine:	"Don't light that cigarette. If you want to light the cigarette, press 2" (more laughter)

(FG#2, 1160-1180)

It does not seem that the number or nature of calls were tracked by BC staff, but apparently the frequency of calls increased dramatically in the days following the release of each newsletter (Lorraine, K33, personal communication). These sorts of calls generally involved requests for further information or clarification, or people calling to say they had quit and their name should be in the newsletter. It therefore

seems that a minority of calls during the course of the intervention actually involved people actively seeking immediate help or verbal counseling in connection with relapse crises. Nonetheless, having a hotline available contributed to BC's image of "being there" for smokers. The staff person responsible for taking hotline calls also had many other administrative duties to perform and was therefore not always available to take calls or to be with people as long as she sensed they wanted to talk (Lorraine, K33, 881-919).

Among the few respondents who had used the hotline, Cybil was the only one to voice her disappointment with the experience, but her testimony points to how easily one "bad experience" can 'turn someone off' the entire project, and how expectations about the meaning of a "hotline" (i.e. trained professional counselors?) can be inadvertently created in a way that outstrip the resources available to BC.[5]

> Author: What did you think at that point when you were filling that [Network membership card] out you would get from the network?
>
> Cybil: I really thought I was going to do it, you know.
>
> Author: Yeah? What sort of help did you think would come from being on the network?
>
> Cybil: More than I received... More than I received. I thought I would receive some advice on how to get rid of the pain at least, but this woman was very.. (pause) She didn't help, she just made me feel worse, in actuality...and uh, I didn't like that.. part at all. This time I, when I did manage to stop, when I did stop it, I did not even contact them. (27, 347-370)

In fact, in as much as smokers' needs for more intensive and personalized support deserved careful consideration, the feasibility of what smokers seem to be proposing in terms of more intensive support has also to be questioned in light of what the community is able to commit to, financially and otherwise.

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[5] My suspicion is that someone other than the usual staff person answered the hotline when Cybil called, and found it difficult to deal with her pointed questions and demands for advice (perhaps attempting to do her best rather than refer the caller to more expert medical advice, as the staff person regularly responsible for the hotline reportedly would do under such circumstances).

6.3.5 Mandate to change social norms

As indicated in chapter 4, one of the core thrusts of COMMIT, operating through multiple channels, was to influence social norms and reduce the social acceptability of smoking in intervention communities. While smokers were aware of the changing climate (generally in terms of social acceptability and specifically in terms of taxation and legislative changes), respondents were rarely aware of BC's role in promoting these changes. This is to be expected, since their contact with BC, by and large, was limited to those specific activities and services provided to Network members, as detailed above and in Chapter 4.

Notwithstanding, their experiences and opinions of BC's efforts to shift social norms can be assessed indirectly in a number of ways. First, one can examine their reactions to the mandate in principle, and second in practice in terms of restrictions and sanctions as they perceive them. This includes not only legislative reform (the subject of Chapter 9) but also the activities of physicians, employers, schools, the media and other "intermediaries" targeted by COMMIT (see Chapter 7). Third, their perceptions of (changes in) the social acceptability of smoking can be considered (see Chapter 9), and their experiences within their own social networks (spouse, peers, family; Chapter 8).

As we shall see, the majority of respondents support in principle the notion of prevention and promoting cessation, but they took strong exception to what they perceived as the dictatorial, patronizing and stigmatizing ways in which this was being done. The recurrent themes of being "not stupid", "not children" and having to adapt to changes "all of a sudden" in their responses attest to feelings of being misunderstood and unfairly treated. In other words, *how* one does something is perhaps as important as *what* is being done. The unfortunate consequence seems to have been one of making "enemies" out of those who, in wishing themselves to quit and supporting those efforts in others, would seem to be natural (and important) allies in tobacco control. This is discussed more fully in the Chapter 9. But it raises the question as to whether respondents' positive feelings towards BC and its supportive nature would have been tempered by the knowledge of its activities in other spheres such as some of the work of the legislative sub-committee.

6.4 PERCEIVED OVERALL LEVEL OF SUPPORT

How then do these experiences of smokers with individual BC programs and services translate into perceived overall level of support? Respondents were divided in their appraisals of whether the support they had received was sufficient to constitute "making a difference" (for even the same levels of perceived support), but several common points of agreement nonetheless emerged (see Table 6.6). For these smokers, it was important that BC was a supportive organization (in terms of the tone of its interactions with smokers). There is much to be said for the mere existence of an organization that affirms and supports the efforts of smokers to rid themselves of their addiction, especially in a climate of increasing hostility towards smoking (or, as many perceived it, towards smok*ers*).

The supportive nature of BC was revealed to Network members in a number of ways, including the positive and supportive tone of articles in the newsletter, and the availability of services such as the hotline, quit and win contests, subsidized cessation courses even if many chose not to use them, and also the widely held belief that BC was doing its best, on behalf of smokers, to research and disseminate new methods in the initiation and maintenance of smoking cessation.

> Well, it did seem to me that Commit had made a survey of the whole matter and had a lot of barrels on the gun. There's all these things that you might try, which I appreciate and I subscribe to. But what works for one may not work for another. But anything's worth a try. (William, 11, 938-941)

Part of the support perceived by respondents also derived from the fact that they received material on a regular and ongoing basis.

> I got more than I expected I guess (laughs) actually. I wasn't expecting all these, you know, the gum and the stuff like that to help you quit, and I thought that was really good. I thought it was just kind of a hotline type thing, really. I didn't think it was very personal in the beginning, but when they start sending you things and stuff, then... I thought that was really good. (Carolyn, 30, 266-278)

For some people, the relationship with BC seemed to take on the nature of a contract in that they would pull their weight, as it were, in trying to quit, and that the volume of material they had been sent meant it was their turn to pitch in.

Bob: You folks are doing your job anyways. I just got the Commit letter. I feel guilty, too, about uh, all the work that you people put in and I can't uh, can't give you any positive results but uh... (coughs)

Author: Well it might be one of those things that just kind of adds up over time.

Bob: Well, you know, it's gotten to the point where I just I, I haven't got any excuses anymore... I do have to quit smoking. But uh, as far as Commit goes no, it's, it's probably the best non-smoking organization I've ever seen. I just, I, I carry the guilt because I don't uh, I didn't follow it as thoroughly as I could, or I should have. You know. (39, 538-547 and 715-719)

Doreen implied that being on a mailing list was not enough to make a difference for her, that she needed ("real"?) help:

When I joined I didn't know what to expect. I was in my doctor's office and we were talking about it and he handed me - and I had looked at my husband, I said, "Well, I'll give it a try." You know.. And uh, oh I read everything. Every article that you sent me, I read it. And like I said, I put some of it to use. But uh, I think I'm the type that I'm going to need help. (42, 1438-1444)

It is likely that a proportion of members join BC while in the contemplation phase, and never really feel ready to move to the next level.

[The cessation package] was good. Obviously nothing helped me to achieve my target... [she's still smoking]. I read the little news things they send out... [But] you see, I haven't really given them much of a chance. All I've asked is just for the material and I've been reading it when it came. I haven't gone to any meetings or anything. I knew there was a hotline - I've got it up on my fridge. (laughs) No, I haven't called in... I um.. I have been giving thought to joining the support group. I don't know if that would make a difference. Maybe that would give me that extra bit of strength in the evenings to stay away from... [cigarettes]
(Pam, 45, excerpts from 290-329)

This of course raises the question of what difference makes a difference, and what "making a difference" means. Judging from the interviews with Network members, it is not evident that the feeling of BC having made a difference is always contingent on their having been successful in quitting. However, it did seem related to whether people felt there were certain kinds of support that they did not receive but should have gotten.

Several respondents like Vincent wanted more support in the form of follow-up. Jessica spoke for many of the respondents in the following interchange when

she suggested more intensive support might be needed, while simultaneously asserting that she herself would have to be the one to do the quitting.

Jessica: [I thought I would get] Newsletters... Tips on how to quit. That's about it. I mean, most of the tips I know, you know, chew gum, hold a pencil or toothpick, you know, eat candy, go for a walk after dinner, I mean I know all that. I've known all that for years. It doesn't help me, because it doesn't always work. It's not always what you want to do. I don't know, I think that it's probably like any other addiction.... I think you need a self-help group. You need a buddy system...

Author: So, on the whole are you satisfied with what you've gotten from COMMIT?

Jessica: Well...

Author: - has it made a difference for you?

Jessica: No, not really, because I think probably if I'm going to do it, it's going to have to be a conscious step on my own and no-one can push me into it. So, I don't know. That's, it's really hard for me to say. (16, 677-719)

Like many other respondents who called for the establishment of a *peer* buddy system, Marilyn felt this might be the best next thing for her to try:

Marilyn: I don't know if it [the cessation package] came at the right time. I don't know if I was quitting - I mean, I think with myself it takes more than just getting a pack in the mail and saying "Okay, I'm going to start today and quit"...

Author: Do you remember what you were thinking you would get by joining the network?

Marilyn: No.

Author: When you joined up, like what your expectations were?

Marilyn: No.

Author: Are you happy with the level of support that you've gotten through COMMIT? Do you think there's something else that could be done?

Marilyn: Um. Myself, I guess, I would need more constant attention. I'm trying to think - I think it's about once a month or, or maybe even less that I receive something in the mail. I mean, I would need this once every couple of weeks just as a reminder that there is some support out there.. (pause)

Author: Yeah. Something in the mail or a phone call or whatever?

Marilyn: Phone calls, um, buddy systems. I can remember, I don't know if it was through the Lung Association or where it was when I quit and there was a lady that I could call whenever I wanted to and it was great, because as soon as you're feeling like you want one, you can call this person, they talk you down. (laughs) So...

Author: And she was going through the same thing at the same time?

Marilyn: She had quit. She had quit. Yeah. So, I can't remember how I was connected up with her, if it was a doctor that gave me her number or what it was. That was quite a while ago.

Author: If there was something like a Smoker's Anonymous group that met on several different days of the week or whatever, you can go pretty much whenever you wanted and there was a buddy system like that and so on, do you think that would be helpful?

Marilyn: Oh, definitely. Yes, definitely.
(32, 411-456)

In fact, 21 (47%) of respondents indicated a strong interest and willingness to participate in a buddy system or AA-style forum for nicotine addicts, which was the most often cited thing people felt might make a difference for them. On the other hand, uptake would likely be much smaller if a suitable program was available. In the fall of 1992 I placed calls to all of these people to let them know a Nicotine Anonymous group was forming in Brantford. I attended the first two months of the weekly meetings and not one of them came.[6] The implications of this apparent discrepancy between what is called for and what is used in terms of relying on lay perceptions of need in evaluation research generally, and in the Brantford COMMIT case more particularly, are discussed in Chapters 3 and 8 respectively.

6.5 IMPLICATIONS FOR ASSIST AND BRANT COMMIT

When one examines smokers' own experiences of the COMMIT intervention in Brantford, as we have done in this chapter, clear implications emerge in particular for how activities and services could be improved. This is particularly germane for those settings in which the COMMIT model continues largely intact: (a) the Brant COMMIT project now funded by the Ontario Ministry of Health in the Brantford region as a demonstration site for the provincial tobacco control strategy; and (b) the ASSIST projects gearing up throughout the United States, far more extensive in

[6] Based on recent communication with a Nicotine Anonymous member (summer 1993) it seems that the group has grown in size and popularity. It may be that some respondants have begun attending N.A. meetings in the interim, but seeing as I have not personally attended meetings to see for myself and there are strict rules on confidentiality and anonymity, I have not been able to ascertain their attendance.

reach and in resources than was COMMIT, and for which the COMMIT trial was to have been a testing ground.[7]

In summary, Table 6.7 shows some of the ways in which subsequent programs might attempt to build on or learn from the BC experience as told by smokers. The importance of maintaining an image - and practice - of being a supportive and non-judgmental organization dedicated to working towards cessation *with* and *for* smokers should not be underestimated. As indicated above, this message came out loud and clear: even with poor recall of the content of the cessation package and the newsletter amongst smokers, they were clear that one of the important aspects of BC for them was the notion of an organization that cared, that supported them in their struggle to be free of nicotine addiction, that "was there for them". It kept them aware of their own expressed desire to quit. Notwithstanding this, it was also clear that many smokers felt they needed more intensive or personalized assistance.[8] And as rates of smoking decline in North America, the proportion of smokers who are heavy smokers and may have tried many times before to quit continues to increase. This may challenge our faith in community interventions that rely on indirect trickle-down effects to translate into cessation in this group. It may therefore be necessary to make helping smokers quit and maintain cessation one of the prime directives of cessation organizations of this

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[7] In this context it is worrisome that there do not seem to be clear mechanisms for the 'transfer of wisdom' from COMMIT to ASSIST. Indeed, perhaps history is doomed to repeat itself in the way that Schwartz lamented in 1987 that the lessons from earlier multichannel community interventions had not been incorporated into the trials (like Stanford 5-city and Minnesota Heart Health) that were being conducted at the time. Likewise, the tendency in Brant COMMIT, given the (perhaps natural) predisposition of most "movers and shakers" in senior positions in smoking-related voluntary organizations to feel like they know what needs to be done, may be to ignore lessons learned from smokers and proceed with activities that excite them and make them feel good as middle-class volunteers. The fact that several very real opportunities to learn from smokers were not capitalized upon in the previous incarnation of BC (see Chapter 10), the adage of history being doomed to repeat itself seems even more likely. This of course raises larger issues of how wisdom is distilled and disseminated within (but especially between) these kinds of projects, even when the same sponsoring organization is involved (such as NCI with the COMMIT and ASSIST projects).

[8] While each of the activities in and of itself may not seem to have been sufficient to have a major impact on the majority of smokers on the Network, it may nevertheless be true that the cumulative and synergistic impact of several activities (as positted by NCI in designing the COMMIT trial) may be sufficient to tip the scales for smokers who have been seriously considering quitting. In some cases this is acknowledged even by smokers themselves (see quote page 122). However, the jury is still out as to whether that level of intervention is sufficient to sustain a quit rate fully 10 percentage points above the comparison community until results of the formal evaluation surveys are released sometime next year.

kind, and to tailor assistance to particular groups such as heavy smokers and disadvantaged groups.

Indeed, the lack of willingness to directly target low SES groups may have compromised the COMMIT intervention, particularly given the sort of relationship BC established with Network members. By sending a cessation package of written materials, and periodic newsletters, smokers who joined BC were implicitly being told that this cessation organization that had been created on their behalf expected them to enter into a relationship that for the most part required (or at least expected) them to be passive recipients of "knowledge from above". Does this allow COMMIT to fulfill its mandate of helping smokers with the very difficult task of quitting?

But even within its somewhat formalized relationship with smokers, there are a number of things that BC might have undertaken to overcome these limitations. In particular, there is always opportunity to involve smokers in decision-making, particularly as it affects the nature of assistance that might be offered to fellow smokers. That such opportunities in the past have not been seized upon may indicate a reluctance on the part of those in charge to listen to the wishes of the very populations they are meant to be serving.

What is not clear, however, is what constitutes the best forum for soliciting the input of smokers. It is likely that participation in a formalized task force setting with minutes and Roberts' Rules of Order is not a viable or comfortable option for many "average citizens", particularly when it puts a few isolated smokers who are already sensitive to being stigmatized into an environment in which (in terms of level of articulateness etc.) they are at a disadvantage. In fact, detailed analyses of how such meetings usually unfold indicate that lay participants are largely ignored, in a variety of subtle and not so subtle but often quite unconscious ways (Paap and Hanson 1982). Furthermore, given the background of many of the other volunteers (from tobacco control organizations), it would be hard for lay smoker participants to feel they had not betrayed their allegiances and gone to work with "the enemy". It may be that a parallel grassroots structure is most appropriate. This would be more informal in nature and perhaps more focused on self-help tasks (such as

management of the Smokers' Network or the hotline). Indeed, this notion of bringing smokers together to work on common problems (how to best make the Network work for them, or how to adapt to policy change) fits well with the spirit of self-help and the expressed desire of nearly half the respondents for a forum for peer support in their efforts to quit.

Even without adopting these more participatory structures (which to some extent were prohibited by the intervention protocol), there are several steps that BC could have taken in more effectively tailoring its resources to the needs of smokers in Brantford. The notion of reworking the cessation package into a more comprehensive and locally-oriented cessation reference manual has already been discussed. Even including some reference material produced by smokers for other smokers (Casey 1987; Krogh 1991; Ferguson 1990; Farquhar and Spiller 1990; Nicotine Anonymous 1992) would perhaps have been well received and more useful to the heavier smokers than a collection of somewhat superficial and redundant pamphlets from voluntary organizations and government sources. These materials would be less likely to be perceived as telling them things they already know (experienced as patronizing) and might be kept as ongoing reference and motivational materials for later quit attempts rather than misplaced or thrown out within days or weeks of being received.

Any steps that BC could have made towards implementing a more flexible, individualized support system for Network members would also have been laudable. If Network members were able to indicate on the sign-up card what sorts of assistance they would like (from a concise menu) and be able to call in to change that as their needs for assistance changed, then a better fit between BC resources and smokers' needs might have been achieved. This would also have been consistent with Prochaska and DiClemente's (1983) stages of change thesis. As it was, what BC had to offer was often not enough for those who had just decided to quit and perhaps too much for those who had just given up, with little room for smokers to have direct input into what was available for them. Of course this assumes that a more flexible individualized support system, perhaps using the right blend of volunteer and staff resources, would be economically feasible and would have an appreciably greater impact. Until this kind of more participatory intervention is tried

(even on a more modest scale than the COMMIT trial), we are unlikely to know what we might have been missing.

Finally, with respect to the Quit and Win contests and worksite challenges mounted by BC, it was suggested that extended contests and challenges with more support options built in might have increased the impact of these contests on the "delta" (outcome measures) of the trial.

Chapter 7 extends the analysis of smokers' experiences of Brantford COMMIT by examining the four channels of activity targeted by the intervention. Drawing upon interviews and focus groups with smokers and with key informants, the activities and impacts of the Health Care, Worksites and Organizations, Cessation Resources and Services, and Public Education Task Forces.

Table 6.1 Referral points for joining Smokers' Network according to interviewees

Referral medium	Interview	Network database
ad delivered to home	10	8
influence of friend, family	10	1
booth or display	8	10
other (info sessions, events)	4	4
doctor	2	9
own workplace challenge	0	4
Quit & Win	-	7
not known	10	1

Table 6.2 Expectations of Brantford COMMIT

Nothing in particular
Just see what they had to offer
That "extra something" to help you quit & stay quit
Something new
Help with withdrawal
Program that makes you quit
Support, not nagging

Table 6.3 Problems with the cessation package identified by respondents

Overwhelming volume of material
Not enough time to read it all
Too wordy
Nothing they hadn't read a dozen times before (i.e. we're not stupid)
Disagree with some of the advice ("things that don't work")
Should have more follow-up
Fine for 'early smokers', but more seasoned ones need more help

Table 6.4 Recommended changes to the cessation package based on feedback from Network members

Continue the practice of compiling "care packages" for new members
Consult smokers themselves about what to include
Provide annotated bibliography re people recovering from nicotine addiction
Continue to include helpful gadgets and gimmicks like the BC fridge magnet
Revamp & consolidate written materials into concise Brantford-oriented cessation reference manual

Table 6.5 Reactions to the BC newsletter

Positive

- good to have ongoing reminder of BC being there, of need to quit
- supportive tone vital and much appreciated
- publishing names of successful quitters a big hit
- probably best venue for notifying members of upcoming events

Negative

- they don't always get read due to time pressures or ambivalence about quitting
- interesting but far from sufficient to help me quit
- doesn't cater well to the less literate

Table 6.6 Did BC make a difference?

Yes, to the extent that:

- supportive organization is important
- proactive messages well-received
- being on the network reminds you of decision to quit

But...

- more intensive or "high-touch" component wanted by many
- it depends on what difference makes a difference: what does it mean and what about external events the enhance or cancel out support for cessation?

Table 6.7 What can Brant COMMIT do?

Continue to be supportive and non-judgmental

Make helping smokers quit and maintain cessation the prime directive

Consider targeting programs to disadvantaged groups

Involve smokers in decision-making (participation)

Bring smokers together to work on common problems (self-help)

Have current and former smokers staff the hotline

Produce a local, all-in-one guide to smoking cessation

Implement a flexible, individualized support system for Network members

Extend contests and challenges and build in more support options

CHAPTER SEVEN

A SMOKER'S PERSPECTIVE ON BRANTFORD COMMIT
PART II: INDIRECT EXPERIENCE OF BC THROUGH THE INTERVENTION CHANNELS

7.1 INTRODUCTION

As indicated in Chapter 4, a minimum of four task forces was established in each of the 11 intervention communities (Figure 4.1) to ensure that a broad range of activities were undertaken in each of these intermediary channels thought to influence social norms around smoking in general, and the efforts of (heavy) smokers to quit, in particular. The Task Forces were health care providers, worksites and organizations, public education, and cessation resources. In this section, smokers' experiences in each of these areas are explored, and this is compared with NCI's goals for each channel and with the perceptions of key informants involved in the intervention locally in Brantford. Since the majority of activities undertaken by BC in each of these channels was not directed at smokers per se (let alone heavy smokers), it was difficult to distinguish BC-initiated changes from those due to other organizations or various levels of government when talking with smokers in Brantford. Therefore, smokers were only asked in a general way what their interactions with doctors had been around their smoking, what their experiences had been with workplace restrictions, cessation messages in the media, and their use services provided by other tobacco control organizations (such as the Lung Association).

This chapter builds upon the analysis of activities directed at smokers on the Smokers' Network presented in Chapter 6, and in broadening the focus to the four intervention channels in the community, it paves the way for the next chapter, which examines BC in the context of the needs (articulated and implied) of smokers for

assistance, and for Chapter 9, which examines smokers' perceptions of a broader range of tobacco control activities.

7.2 HEALTH CARE PROVIDERS

The Health Care Providers Task Force was charged with two essential tasks as part of the standardized COMMIT intervention protocol: (a) to get physicians to intervene more consistently and effectively with their smoking patients; and (b) to ensure that all health care facilities (hospitals, doctors' offices, etc.) adopt smoke-free policies. This section explores the following issues: the rationale for this approach, a brief description of the intervention itself, and its impacts of the intervention based on mid-course survey research conducted by NCI and on interviews with key informants and with members of the Smokers' Network.

7.2.1 Physicians

The rationale for targeting physicians as intermediaries rests on two key assumptions. First, doctors have access to large numbers of smokers in a way that few other professionals do. On average 70 percent of Americans see their doctor each year (Ockene 1987a; 1987b; Ockene et al 1990-91), and without financial barriers to access to care these figures could be even higher in Canada. Second, the notion that doctors can intervene with patients who smoke in a way that has a meaningful impact on cessation is supported by a growing number of clinical trials in the United States (Cummings et al 1989; Kottke et al. 1988, Ockene 1987; and Secker-Walker et al. 1990), in the U.K. (Jamrozik et al. 1984) and in Canada (Wilson et al. 1988; Lindsay 1989).[1] The success rates in these trials are modest: typically between 3 and 15 percent - but as low as 1 percent or as high as 30 percent or more, depending on the intensity, duration and type of intervention, and whether quit attempts or long-term abstinence is used as outcome measure. However, the practical significance of these rates applied over the extensive population of current

[1] Smokers tend to over-report cessation by as much as 24 to 40 percent, based on evidence from one large UK study (Jamrozik et al. 1984). However, wide-scale biochemical validation of self-reports is very expensive. Therefore, many scientists prefer to design randomized controlled trials to assess the efficacy of physician interventions (e.g. Streiner, Norman and Munroe-Blum 1989), in which evaluation is based on quit rates achieved above and beyond those realized in the control group(s).

smokers in the United States (50 million: US Surgeon General 1989) and Canada (5.8 million: Pederson 1993) could make a significant impact on overall cessation rates. The resulting impact on mortality and morbidity attributable to smoking over time (over 27,000 deaths in 1986 in Canada and over 314,000 in the U.S. according to Wong and Arraiz 1990) could also be significant. Proponents of physician interventions (e.g. Davis 1988; Ockene 1987a; Ockene et al 1990-91) argue that, in addition to their frequent contact with both healthy and ill smokers, physicians are ideally placed to influence smokers to quit, because (a) they are among the most respected and trusted of all professionals (in a way that cajoling friends or family members may not be); and (b) perceived vulnerability to health threats is highest when patients see their doctors, and this represents an opportunity for intervention especially if the complaint can be related to their smoking.[2]

The need for a detailed intervention plan for physicians in the COMMIT trial reflects the fact that at the moment much of this potential goes unrealized. In two random state-wide surveys of Michigan adults, Anda et al. (1987) reported less than half (44 percent) of smokers indicating their physician had ever asked them to quit. Young males were the least likely to have been asked (30 percent), while those with certain smoking-related health problems were more likely. Based on surveys of physicians in the United States, Ockene (1987b) reported that although doctors feel a responsibility to help smokers, less than two thirds advise all smoking patients to quit. Baseline surveys for the COMMIT trial conducted by the U.S. National Cancer Institute indicated that only 39 percent of smokers had been told by stop smoking by either their doctor or their dentist in both intervention and control communities (Ockene et al. 1990-91). Several authors highlight the importance of getting physicians to intervene earlier with asymptomatic smokers, particularly those

[2] The assumptions that appear to underlie these statements include (a) that respect for physicians will mean their advice to quit will be recognized as sincere and legitimate (within the purview of their knowledge and concern), (b) that this respect coupled with the legitimacy of their claim to know the importance of cessation will mean the advice to quit is taken seriously, and (c) that this advice, having been considered legitimate and of some import, is then acted upon by the patient (compliance with advice). Of course, there is plenty of room in this probable chain of causation for patients to find reasons to discount the advice of physicians (due in part to how physicians approach the topic and partly to other factors in the doctor-patient relationship) or for motivational or environmental barriers to prevent compliance with physician dictates to quit. Some of these issues were raised by patients themselves during the course of the interviews (these are discussed below).

who present with multiple risk factors for CHD (Anda et al. 1987; Ockene 1987a; Ockene 1987b; Glynn and Manley 1989; Davis 1988; and others).

Barriers to physicians' efficacy in helping smokers quit exist at a number of levels. Efforts at motivating physicians to intervene are mitigated by restrictions on the time that can be spent with each patient, remuneration for counseling patients,[3] medical school emphasis on curative medicine rather than on prevention skills education, the low success rate that physicians perceive themselves to have with smokers, and a lack of information on the effectiveness of various cessation approaches (Anda et al. 1987; Ockene 1987a). Furthermore, the evidence suggests that of those who broach the topic, only a small proportion go beyond offering advice to making use of what's available to them, such as making referrals, handing out cessation self-help literature, getting patients to set a quit date and enter a cessation contract with them, arranging follow-up visits and so-forth (Ockene 1987a; Cummings et al. 1989; Wilson et al 1988; USNCI 1992). In COMMIT intervention communities for example, a 1989 survey revealed that while 67 percent of smokers reported having been asked if they smoked, only 19 percent received cessation literature, 12 percent were prescribed nicotine gum, 9 percent reported having been asked to set a quit date, 5 percent were referred to a stop-smoking program, and 4 percent were asked to return for a follow-up visit (Ockene et al. 1990-91).

Even if the physician does intervene, there are numerous factors in the patient's own life (degree of nicotine dependence, level of motivation, beliefs about the determinants of health, self-confidence, perceived self-efficacy and locus of control, presence or absence of a supportive environment at work, home and among peers) that contribute to or detract from their willingness and ability to follow through on the physician's advice. (Some of these factors are discussed in Chapter 8).

It is within this context that the U.S. National Cancer Institute built a series of mandated physician oriented intervention activities into the standardized protocol of

[3] In Brantford, physicians and COMMIT staff rallied together to successfully lobby the provincial Ministry of Health to develop a billing code that would reimburse physicians for time spent counseling patients to quit smoking.

the COMMIT trial, to be directed by the Health Care Task Force (HCTF) in each intervention community. Primary among them was comprehensive training for physicians to ensure that by the end of the intervention, 60 percent of smokers report being told to quit smoking and 25 percent report being asked to set a quit date (Ockene et al. 1990-91; see Table 4.3 for goals, impact objectives and intervention activities for the HCTF). The training program, to be also aimed at dentists, was supported by the implementation of office cueing systems, and was based on the "4 A" model of physician assistance (Table 7.1), based on the evidence that sustained, personalized interventions utilizing a number of resources are more effective than advice alone (Kottke et al. 1988; Jamrozik et al. 1984; Wilson et al 1988; Willms et al. 1990). Notable by its absence was any concerted program directed at nurses, despite their relatively high rates of smoking among health care professionals,[4] and the potential for delivering effective cessation interventions of their own in place of more costly physician interventions in some settings (Hollis et al 1991).

Mid-course surveys of physicians and smokers, as well as on interviews with key informants and members of the Smokers' Network, indicate that the HCTF met with mixed success in Brantford. COMMIT's evaluation surveys showed that while the number of smokers reporting that their doctors had told them to quit (in the past 12 months) had risen from 39 percent in 1989 to 43 percent by 1991 for all intervention sites combined, the figures in Brantford showed a decline over the same period from 38 to 35 percent (USNCI 1992). These figures are all considerably less than the anticipated 60 percent targeted by the intervention. The percentage of smokers reporting having been asked over the past 12 months by their physicians to

[4] Nurses are frequently closer to the patients than physicians and according to many smokers I interviewed, were often to be seen on the back balconies and terraces of the hospitals smoking with their patients (they have become, in a sense, allies against smoke-free policies in health care facilities). This added to the sense of separation of nurses from physicians that was reinforced in HCTF meetings, where key informants indicated that doctors sometimes had neither the time nor interest in taking (nor, in some ways the ability to take) leadership on smoking cessation issues, but were reluctant to accept the leadership of others. This suggests that the tendency to look to physicians for leadership in these matters may not always be appropriate. The physician/non-physician dichotomy in the HCTF was also reportedly reinforced by an unspoken but very tangible sexism in which female nurses could not easily take leadership roles in the activities of this TF. Incidentally, one of the few times this did occur was in the form of a worksite challenge between the Health Department and Social Services Department in Brantford that was meant to - but failed to - capture the interest of nurses in their own smoking cessation. My own interviews with nurses suggests that job-related stress together with pressures on women to carefully manage their emotions, and the tendency for nurses to be desensitized to the physical risks associated with smoking combine to make this a difficult group to "crack".

set a specific quit date also declined in Brantford from 10 percent in 1989 to 6 percent in 1991, both short of the 25 percent target set by NCI (*ibid*). Granted, these are mid-course figures and much could have changed between 1991 and 1993. However, given that key informants reported that the HCTF was quick to complete its protocol requirements in the early years of the trial, these figures do not give much cause for optimism.

Physicians themselves indicated in no uncertain terms that counseling patients to quit smoking was "a grinding sort of thing" and that consequently it was a hard sell to get colleagues to attend COMMIT training sessions. One physician who had been involved with COMMIT had several comments to make in this regard.

> It was interesting. Our role in trying to teach doctors, nurses, dentists and pharmacists is a difficult one, because the message is a pretty hard one to get across.. And to try and modify people's practice is a pretty difficult one... We managed to capture large groups of them at times using subterfuge to get them in a room, like using hospital coordinator staff meetings, so we could give them the message, when they came out on a voluntary group basis, we succeeded in fulfilling our mandate, but it was a little bit like pulling hens' teeth sometimes. And I can understand it, because if I'd not been [involved] myself, I might not have been quite as motivated to come out. It's a grinding sort of thing, to try and get patients to stop smoking, quite frankly. It's a difficult thing. And what the Health Care Providers' Task Force program wanted to do was fairly intensive, although they say it could be done in a short period of time, it involves a fair amount of work, trying to get patients to come back and see you and get them to talk about something that often they don't want to talk about.... And particularly since you don't have any magic bullet to give them, and say, "if you take this you can stop smoking". What you're saying is well, "you've got to decide that you're going to do it, and you know, I'll help you," but what we're trying to do is overcome a terrible addiction. Both physiological and psychological addictions... One of the toughest ones there is. I mean, the numbers are out there. They tell you that the best results maybe have 10 or 15 percent quit rate. That means an 85-90 percent failure rate. So no matter how good you are the vast majority of patients, according to statistics, are going to continue smoking... You like to see some higher success rate. But also that means you're going to be coming back at 90 percent of your patients who are going to get, quite frankly, sick and tired of listening to you carp on something that they don't want to do, or can't do... I think that the wise physician knows when to back off and just-- you know, you try and get the message in a couple of times and if it works, it works, and if it doesn't you might mention it again, but you simply can't go back on it. Because then if you do that, the patient will simply switch off, and they'll switch off for that, but they'll also switch off for other things. So, if you're trying to get them to do some other modification of their lifestyle or get them to do something, if you sort of shot your bolt at carping at them with something that they really don't want to hear about, they won't listen to you for anything [else]. So, you have to be very careful. But obviously from COMMIT's point of view, smoking is the thing, [but] there's a lot of other medical... issues out there that he or she has got to deal with on an ongoing basis. And smoking is a very important one, granted, it's uh, one of the biggest killers around. But in the whole care of the patient, it's only part of it. And so, you've got to balance your advice against the other things you're going to try and do for the patient in other matters. (K22, excerpts from 116-209)

In fact, this physician seemed to think the value-added of the level 2 (3 to 4 hour) training over the level 1 (20 to 30 minute training) was questionable:

> Well, I mean, the level 1 training where we spoke to them and gave them the overview and provided them with all of the material, most of the physicians got that. And got a sort of a repeat recently with that intensive training. We had a mandate that provided for x number of doctors-- I don't know if it was 20 or 30, which we did. Quite honestly, although those sessions went over well, I'm not sure how much additional information we got in giving them a three hour session as opposed to giving them a 20 or 30 minute session. We pretty well covered the essence of it in the short time, and it almost felt uncomfortable going back and saying, geez what am I really telling the docs in 3 hours? Cause their time-- I mean, we go out to hear speakers-- I've got two talks next week, one on the xxxxx (garbled) disease and one on diabetes. And you listen to these guys talk for about one hour, and you know, that's sort of the limit... you don't want to listen to people for 3 hours. And yet, we're asking them to come for 3 hours, and we give them a meal and we give them credits and all that stuff. But still, it was, I think-- in a sense, pretty thin content for 3 hours. But, I don't know how we would have done it differently. (K22, 616-634)

Other key informants seemed to be aware of this ambivalence. They spoke in terms of (a) acknowledging the time constraints and other factors that impinge on physicians' ability to counsel patients to stop smoking; (b) the difficulty that BC experienced in generating interest amongst local physicians for the NCI training, (c) feeling that the HCTF (partly by virtue of the black-and-whiteness of the protocol but largely due to lack of imagination or motivation) had failed to understand that the "protocol was a springboard" (K5, 346) (doing as much as possible in the available time, and more than just fulfilling contractual obligations). My impression from key informant interviews and participant observation, is that the 'performance' of the HCRF was probably discussed between various individuals, but that this was done mostly "in private" and not in a way that would bring it onto the formal agenda of the group meetings for overt discussion, so that it was probably never fully and publicly acknowledged and resolved. Several factors probably worked against these issues receiving early public airing and resolution. For one thing, the (at times delicate but unanimously agreed to be necessary) transfer of ownership from research institution to the 'community' must have meant that lines of responsibility for 'grabbing the bull by the horns' and resolving latent difficulties that were hindering the work of a task force were unclear. Second, there seems to have been a general reluctance to publicly be floundering, ambivalent or experiencing barely acknowledged but tangible disputes over turf or personality clashes. Third, the traditional independence, rank and respect of/for physicians that might have

dampened the comfort level of staff or others in intervening in the affairs of the HCTF. A fourth factor contributing to the mediocre performance of the Health Care Providers Task Force not being aired for more open public discussion might have been the lack of strong, visionary and powerful leadership within the HCTF committed to the spirit as well as the letter of the intervention protocol and committed to excellence (as opposed to competence) in the work of that Task Force.

Based on 45 interviews with members of the BC Smokers' Network, it would seem that their experiences with physicians are in keeping with what one would expect, given the opportunities, intervention activities and difficulties outlined above. Responses to inquiries about whether the doctor had ever said anything to them about their smoking seemed to elicit four kinds of responses: (a) "I don't go much to the doctor" (2 respondents); (b) "the doctor never said much (about it)" (16 respondents); (c) "sure, the doc mentions it once in a while" (7 respondents); and (d) "oh yeah, the doctor's always on at me about it" (10 respondents). Those who indicated that their doctor rarely if ever mentioned smoking seemed compelled to offer an explanation in defense of the doctor, which took several forms. Some smokers rationalized that either the doctor already knew they smoked (the implication being there was no need for the doctor to ask) or the doctor didn't know the respondent smoked (wouldn't have known to ask). Others argued that the doctor knew that they were not a "*heavy*" smoker, with the implication that the risks are not pronounced or urgent; i.e. not requiring of the doctor's attention right now. Some smokers also said that since they were not sick there was no cause for immediate alarm. A fourth rationalization was that the doctor knew better than to harp on about it, since that would turn smokers off or cause them to change doctors (c.f. similar physician's quote above). In a few cases, attention was drawn to the fact that their doctor him/herself smokes, with the implication that it really would be rather odd of the doctor to harp on about it. Some smokers thought that if the doctor did not have much to offer in the way of assistance there was not much point in bringing up the topic. In addition, some respondents felt that the doctor was probably too busy to bother with such things 'extra' to curative care.

For the 7 who reported that their physician asked them about smoking "only once in a while", it emerged that in many cases this was during a routine physical

exam (such as the annual checkup). It may be that some physicians see this as the most appropriate context for raising this issue (assessment of general health and its determinants) rather than in each patient visit (where other agendas may predominate). Amongst those who said their physician routinely broached the subject with them (10 respondents; 9 of whom were still smoking at the time of interview), the overwhelming majority felt that (a) the doctor had never really offered much help other than some verbal advice; and that (b) this verbal advice was often perceived to be patronizing since it dealt with the dangers of smoking and they were much more interested in dealing with the difficulties of quitting.[5] Consequently, the perception amongst many respondents was that physicians had little to offer them in the way of assistance.

> I talked to him [my doctor]. His wife smokes. "Well" he said "You know, there's really nothing you can do, except this gum". And he said his wife [had] tried to use it to quit smoking as well, but it's still hard and then he gave me.. what was it again? (pause) He gave me some kind of a pill to calm me down enough to get through the first week, because sometimes if you're more relaxed you won't like, you know... But I hated taking the pills. I felt like I was half sleeping all the time, you know. (Debbie, 41, 864-876)[6]

Some people had very clear ideas of what they wanted from the physician, though not all had verbalized them. What some of them would like is something new, a quick fix or perhaps even a magic pill or "cure", a way to deal with withdrawal symptoms, referral to a self-help group, or a device like the nicotine patch (which was introduced as the trial ended) which "puts nicotine in your system without hurting you" (Doreen, 42).

> I get withdrawal symptoms, like a heroine addict. I burn up, I get fever, I get blurry vision, I can't drive, I can't function like to answer phones, to dial, it's difficult, I have, I just can't do it and that's after four days. So instead of going through all the hell, I asked the doctor once to put me in the hospital. I said - he wanted me to quit - hospitalize me like as if I was on drugs [like a detox centre]. And he said "oh, we can't do that," and I said "well, then don't ask me to [quit] you know, because I can't." (Julia, 38b, 430-441)

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[5] In some cases when the physician wrote a prescription for nicotine gum, this was also discounted because respondents objected to the taste, not wanting to be doing a lot of chewing, or perceived the gum to be inefficacious in alleviating the urge to smoke. Respondents also said it was patronizing for the doctor to 'lecture' them about the dangers of smoking when they felt themselves to be well aware of these dangers. Respondents frequently insisted they were "not stupid" and "not children", to counter what they perceived to be the attitude of others towards them.

[6] Several women reported having been prescribed tranquilizers after seeing their doctors and having complained about the difficulties with quitting smoking.

> [My doctor has] asked if I smoke, like, when I go in for checkups, but he knows like, over a few years I've mentioned to him that I would like to quit, I ask what he suggests... it's just the Nicorette, never really any.. list of groups that you could go to. I don't know, maybe some doctors keep a list like that to give their patients (pause) Yeah, but he's said well, we'll give you this and you can come back and let me know how things are going and wished me good luck, which was nice, because you feel good. (Nellie, 15, 476-493)

> Oh, I haven't asked my doctor for, give me anything. He just suggested "put your cigarettes far away as possible forever and he'd put it in your trunk so if you want a cigarette you have to go all the way down the stairs, out the door now it's cold, you have to go to the trunk, you'd only take one, you leave them there, you come back in the house - enjoy your cigarette." He said then eventually you know, you'll cut down and you'll just say "ah, the heck with this!" (laughs) And he said "don't go the other way, don't bring it back into the house..." So um.. (talks to child) I wanted something else, you know, and *they say these doctors can help you quit, but what do they have? What? The gum?!* (laughs) You see, I don't know, I've been having a problem with my jaws. I can't close my back jaw there right now: it hurts my eardrum... I was just wondering whether or not they had anything from the doctor's office that would help, like to help you. I mean, I've 1 heard there's doctor's signs(?), but, but what do they have to offer besides the gum and just verbal.. How come they have a drug that they can stop you from drinking, but they don't have one that can stop you from smoking? (laughs) I bet you a lot of people would actually turn to that instead of cigarettes. Then it'd be something on your own, especially when they have enough problems with low self-esteem or something like that. But.. Because I know there is a medication that you can give somebody, you know, take a drink of beer or anything and they throw up. So, they won't drink anymore. I thought maybe that's what they have in the doctor's office, that there was some type of chemical balance that they put back in your body to stop this craving of nicotine... They should develop something like that. (laughs) (Shauna, 24, excerpted from 515-545 and 1088-1127; italics added)

To elaborate, many respondents were not keen on nicotine gum and were disappointed to learn that that is what their physicians had to offer. More recently, the availability of the nicotine patch has begun to change this situation, but its introduction in 1992 did not help the COMMIT trial, and in any case it would also have been available in the control community. Furthermore, patients are not keen on being lectured by their physicians, much as they might expect it.

> I remember, when I was in to see [the doctor] after I came out of the hospital [with heart trouble and breathing problems requiring use of a ventilator], I said, "I've been waiting for you to give me the quit smoking and lose weight lecture." And he said, "It would be good if you did." But he wasn't on my back, and... actually in some ways I appreciate it. I don't like people on my back. I am one of these people, the minute you start telling me I can't do something, I'm apt to get my back up and say, "Who do you think you are anyhow?" Uh, which is probably not a good idea (laughs). I tend to cling to my independence maybe a little bit too much, so if he had started getting on my back, I probably would have gone back to smoking if he started really hounding me about it. Um, he's certainly being very encouraging. He gave me a prescription for a mild sedative in case I needed it. (Darlene, 23, 703-771)

> Oh, I don't see him that often. I think the first time I was there he asked about my smoking and asked if I understood that smoking's not good for you. "You should try and quit... You should try and uh..." cut down on all my foods and stuff, loose a little weight. [talks to child] *I just let it go in one ear and out the other.* (pause) But uh... they're doing their job I guess, they're doing their job. As long as they keep mentioning... same as your advertising, they have to keep mentioning it. Just let you know that you should do something about it. I just haven't done anything about it yet. (Mark, 14, 826-848)

Sometimes the result of pestering patients about their smoking can be counterproductive if people react by smoking even more. In these cases the relationship between patient and physician seems strained by implicit power struggles.

> I think the more pressure that's put on people, the more they smoke. Because I know when they told me to quit smoking, I started smoking two packs a day. And my doctor finally figured that one out and don't say nothing to me. But he can tell I've cut down by the nicotine and he's always looked at my fingers. My fingers used to be all yellow. (Doreen, 42, 1277-1282)

Just being in the doctor's office (an anti-smoking environment) as a smoker ("who should know better") leaves some respondents feeling stigmatized, shamed and on the defensive. This is compounded by the way in which some physicians broach the topic (admonition as opposed to supportive empathy). To some people, this means they would rather not have to approach their doctor about it at all in order to get assistance.

> It's always been a puzzle to me: there are those different aids that your doctor can give you. There's the gum and different things that you can use, but you have to go through a sort of "I'm a bad person - can I have a prescription to help me with this?" And that's not a very pleasant feeling for most adults to go through, to have to go to their doctor and say, "Gee, I'd really like you to write me a prescription for Nicorette" or whatever. I think it should be something that should be more readily available. If it is an aid to help you kick the habit or deal with the addictive process that's going on in your body, it should be something that's a little more readily available. I don't know if Commit could do something with that or not, but... I think that the aids that are available to you should maybe be more available, not just through a medical profession where you get pooh-poohed upon anyway if you smoke. You have to go in and say "I've been bad", anyway. I think there's a, a feeling among smokers that if you go to something like that, you, you're sort of a bad - you know, you get that sort of "Oh, (tut-tut sound)". The nurses (tut-tut-tut sound) and the doctors you know, tsk tsk tsk because you're smoking and, and I think maybe that is the, there's still that stigma, which is unfortunate because you know, it's only within the last few years that smoking it has come to light that it has a lot of serious repercussions, not just for the smoker, and uh.. I think there is a tendency on the part of medical professionals or even just the general Joe on the street to treat the smoker maybe with less consideration than non-smokers to begin with.
> (Linda, 31, excerpts from 628-687)

This is compounded by the perception that doctors could never know how it feels to be a smoker and the difficulties involved in quitting.

> I find it frustrating to get my point across to him how difficult it really is, because he has never been a smoker himself. I don't know, maybe it's frustrating for him to try and treat smokers when he doesn't really know what they're feeling...
> (Marilyn, 32, 289-292)

On the other hand, two respondents indicated that if their doctor had been more unequivocal in his/her demands for them to smoke, they might have welcomed that and taken it seriously.

> ...life has been full of battles, I'm not ready to do another one, you know. It's something that I don't have to do. If the time ever came when my doctor said to me "you have to quit or..." then I would do it. But so far it hasn't come to that.
> (Jessica, 16, 735-739)

> Betsy: You know, he said "I'm not saying that you have to quit, I'm just suggesting". If he had have said, "Now you, you quit", I would have gone home and, and I wouldn't have smoked again. But he gave me the choice, so I'm still smoking.
>
> Author: Are you saying you think he should have told you flat out not to?
>
> Betsy: Yeah. Because I feel that it's not up to me to decide to quit. He said, "I'm just advising you should do." See, if he had of come straight out and said, "You quit smoking and I mean, *quit smoking*", you know, been firm, I'm positive I would have.
> (Betsy, FG2, 113-130)

Willms *et al.* (1991) suggest that patients evaluate the kind of support they receive from physicians when trying to quit, and that they are looking for balance in the relationship (negotiation, mutual respect, rapport), and emphasizing the personal (supportive tone, images of regeneration, promises of better health, encouragement and congratulations) over the interventionist (biomedical focus, short on time, emphasis on health risks, not understanding patient experience). Interventions for training physicians are beginning to make these process issues more central, so that they pay attention to not only what they say but how they do it, but this was not emphasized much in the COMMIT trial (Lindsay, personal communication).

It is likely that many physicians would prefer to be given a reliable biomedical 'solution' to smoking cessation than to be trained in effective communication skills. An earlier quote (page 143) suggested that some physicians (like many of their patients) were frustrated by their perceived inability to help

patients quit. Later in the conversation, the same physician (who had received NCI training) elaborated on his/her frustration over his/her perceived lack of teachable methods to offer patients.

> Physician: It's interesting: if you do surveys on doctors and surveys on patients, you often get different results. I think most doctors feel that they do give some counseling or some recommendation, but I think that there is a realization that we don't have that much to offer except advice. I mean, I spend a lot of time talking to patients about the risk of smoking, and it has some impact on some of them. I'm hoping that mine might not be an all or nothing thing. But I've often had patients come to tell me that their kids have been after them, you know, there's things at the worksite now where they can't smoke. And so I think it's a cumulative effect. And if I look upon it that way, I'm not so frustrated if I'm not successful. I think that it's going to have an impact down the road. They'll think about it again some day... And, you know, it's frustrating when you don't have that magic bullet that you can give them. We just don't have it. I mean, I'll sit down and talk 15 minutes to a patient and sort of really pour out what seems to me a very cogent argument. What you have to realize is that in the sum total of that patient's life, 15 minutes is not a very long time, even if it's an intensive 15 minutes. I can present him with all of the facts, and we can talk about the health risks and the benefits of giving up, and this, that and the other thing, and they'll listen to it, and that's fine. But I've only got him for 15 minutes... I mean, that's in addition to dealing with all the other problems the patient comes in to you [for]. He doesn't come in to you necessarily because he smokes. That may be just a peripheral issue. But if you spend 15 minutes and our intervention with Commit was talking about, you know, 5-7 minutes. Well, geez, you know the patient isn't even going to get their brain on track in that period of time. And then the other 23 hours and 45 minutes of the day, you know, they're exposed to their old bad habits and, you know, having an impact in that short a period of time it's-- you'd like to think you do, but it's going to be very minimal.
>
> Author: I guess, having it come from a physician would presumably help in any case.
>
> Physician: Well, they claim [that]. I think that's a critical mass factor. I think that if you have somebody who is ready to quit and the doctor says, "I really think you should quit" and looks them straight in the eye, hey yeah, there's where the 5 percent effect, just like they tell us. And if he tailors the message and expands it a little bit, he may go up another 2 or 3 percent. So, it has some impact, but the vast majority of them, no. (K22, excerpts from 217-295)

However, the same physician went on to say that one could never be sure when one in fact *had* made a difference with a patient.

> I mean, you sort of plant the seed. You'd be surprised actually, occasionally you'll get patients coming back to you, and you've made some comment to them... two years ago, and you see them two or three years later, and they'll come back and say, well, you know, since you told me or said this or said that, I stopped smoking . So it's, "gee" --... Because when they leave the, the office, you can't tell. The ones that say "oh doc, I'm going to throw away--" cigarettes away are usually the ones that will do it for a week. You can't tell, but some of the other ones that it obviously does work. So, I can't really tell what kind of an impact-- he [referring to a specific case the respondent had shared with me] wasn't-- you try to do it in a very supportive way. At least I do. I have a bit of an out because I'm an ex-smoker, and that helps. You can sympathize with them. If you can tell them they're not dummies, but they've got a very hard thing to try and give up. (K22, 492-511)

Despite this apparent corroboration between physician and patients regarding the difficulties of making a difference in the lives of patients, several other key informants involved in the COMMIT trial and this channel in particular, were adamant that we have the know-how, the necessary 'teachable methods' for doctors to make a difference (both the "what" and the "how").

7.2.2 Dentists

Rarely were dentists mentioned as having raised the topic of smoking, although respondents were not routinely asked in the interviews about dentists as they were about doctors. However, the following quote illustrates that credibility and legitimacy assumed to pertain to health care professionals may not have extended to dentists in the mind of some respondents.

> I know my dentist decided to give me a big lecture on my smoking and my general health style and that only made me worse. One of those cases of rebellion. With my family doctor its one thing [but] my dentist, it didn't impress me too much. For one thing, I'm afraid to go to the dentist anyway, like a lot of people. And.. you're practically strapped in a chair with a big rubber thing over your mouth and you can't talk back, you know (laughing) He wasn't very nice about it. He's a real health nut, though, anyway, and he prescribed I don't know how many different vitamins and stuff and, you know, I need so many grams of Vitamin C for every cigarette I smoke and Vitamin E and all this stuff. He's a real health fanatic, but... He just lectured me for a good half hour about smoking, drinking too much coffee, not enough exercise, bla bla. You know, talk about my *teeth.* (laughter) Its my teeth you're supposed to be worried about. I couldn't say anything, but - I don't know. I just.... And he wasn't understanding at all. I mean, he said "Your father died because he smoked. You should know better." Well, yeah, I know that. (laughs) I know I should know better. I know all the evils of smoking. But, I think it's understanding I need, not lectures. (Shaine, FG2, 142-173)

On the other hand, who is likely to say that they *need* lectures?

7.2.3 Restrictions on Smoking in Health Care Facilities

Although surveys indicate support in principle for restrictions on smoking in hospitals and doctors offices (Pederson *et al.* 1986; Pederson *et al.* 1992), in practice many respondents found the sight of nurses and patients smoking outside hospital doors in the dead of winter to be a pathetic spectacle. Pathetic not only in terms of the sadly addictive nature of tobacco that would make people go to these lengths, but also pathetic for what it says about the 'heartless' nature of 'militant anti-smokers' seemingly assumed to be behind such legislation, and their presumed lack

of willingness to compromise. In other words, these unfortunate, sick, and often vulnerable elderly people tend to often be the victims. The perception of the mythical uncompromising fanatic being behind legislative reform seemed fairly pervasive and perplexing to some respondents (see Chapter 9).[7]

7.3 WORKSITES AND ORGANIZATIONS

The primary objective of the BC Worksites and Organizations Task Force (WORF) was to accelerate rates of cessation within the work force. Rather than intervene directly in workplaces, the WOTF was mandated to convene a number of workplace visits (primarily with management) and policy consultations so as to (a) promote the adoption of more stringent workplace smoking policies; (b) encourage worksites to offer cessation resources and services; (c) foster a culture less tolerant of smoking amongst both management and labour (see Table 4.3). In this section I review briefly the reactions of smokers and the implications of their responses for the operation of the WOTF.

Respondents were asked about workplace policies (where applicable) and what the impact had been in terms of their own smoking. Because the bulk of these discussions did not implicate Brantford COMMIT directly (being an outgrowth of provincial and municipal legislation), this material is discussed in detail in Chapter 9, which examines smokers' perceptions of tobacco control strategies in general (including workplace and public place restrictions). It is evident that a majority of respondents support the principle of restrictions on smoking in the workplace as a courtesy to non-smoking coworkers, but they would much prefer that this took the form of designated areas rather than a total ban. While most respondents agreed that they smoked less during working hours when restrictions were in effect, they were divided as to whether they "made up for lost time" at breaks and after hours.

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[7] In one focus group respondents confessed to having never actually met such "fanatics". But since some respondents felt they had read about such people (or their alleged statements) in the media, it is they who are assumed to be behind much of the recent legislation restricting smoking in the workplace and in public places. It would be interesting to know what sort of class consciousness underlay these notions of the mythical health missionary, given that the "us versus them" dichotomy incorporates elements of class (education and income) as well as affiliation with government (not a popular prospect amongst this sample at the time of interview).

Furthermore, a socio-economic bias seems to characterized (a) the adoption and implementation of workplace policies (with white collar workers more likely to have restrictions and more stringent restrictions than blue collar workers), and (b) the social culture amongst workers, with blue collar employees more likely to be exposed to ridicule for trying to quit, and to be exposed to social environments outside of work that are supportive of smoking rather than cessation. Although there was general appreciation in theory of an SES gradient in smoking by BC volunteers on the WOTF, it does not appear that the practical ramifications (as discussed above and in Chapter 9) were either fully appraised or directly addressed except sporadically by intervention staff and volunteers.

The failure to adequately address socio-economic disparities in the workplace reflects a number of ongoing problems that plagued the intervention from the beginning. First, there was a somewhat naive hope, enshrined in the protocol, that trickle-down effects from community-wide activities obviated the need to target specific groups who might in fact have very different requirements. Second, the middle-class movers-and-shakers composition of the task forces seemed to encourage doing what they felt to be important (as "knowledgeable" community leaders) rather than consulting target groups. Third, in keeping with many other heart health interventions and community intervention trials, the use of an epidemiological and scientific, as opposed to sociological, perspective did little to encourage communities to give explicit attention to issues of power and disadvantage. Fourth, the WOTF had great difficulty in capturing the imagination (and participation) of labour in the intervention.

There were successes. According to Task Force members, after the first two years of turnover and awkward group dynamics, the WOTF "gelled" into a dedicated, creative, fun, close-knit group that spearheaded initiatives such as the video contest and smoke-free restaurant day (which generated considerable publicity), as well as making numerous workplace site visits and convening workplace cessation contests. But in hindsight it would appear that more emphasis was put on recruiting numbers to the Network than on follow-up support to maintain cessation, which seems to have resulted in an unnecessarily high rate of

relapse among workplace participants.[8] In effect, more emphasis seems to have been placed on workplace smoking policies than on behavioural interventions in the workplace. This is unfortunate, because studies show that while workplace restrictions are effective in getting employees to cut down, they must be combined with cessation resources and services to be successful in accelerating cessation rates amongst employees (Daughton *et al.* 1992; Gottlieb *et al.* 1990; Peterson *et al.* 1988; Sorensen, Glasgow and Corbett 1991).

While it can be demonstrated (in financial and other terms) that management ought to be concerned about the smoking status of their employees (Ryan and Zwerling 1992), there are significant barriers to be overcome. Sorensen, Glasgow and Corbett identify a number of these, and each was a factor in its own way in Brantford: (a) powerful individuals in management may themselves be smokers and resist cessation interventions or policy change; (b) the leadership may perceive the wider community culture as sympathetic to smokers (Brantford is in a tobacco farming area); (c) management may worry about the potential for aggravating labour-management relations (particularly if layoffs have recently occurred or other concessions have just been negotiated as a result of recessionary times, as was often the case during the BC intervention); and (d) there may be other competing priorities which appear to diminish the relative importance of smoking cessation in the workplace. In fact discussion in the literature does not appear to be widespread concerning the contextual features of workplaces that contribute to or hinder the adoption of workplace health promotion initiatives. Sorensen *et al.* (1992b) examine the potential role of employee advisory boards as vehicles for organizing workplace health promotion programs, but their treatment of organizational features is largely quantitative in nature. Gottlieb *et al.*(1992) and Glasgow *et al.* (1991) examine the implementation of restrictive worksite smoking policies and incentive programs across a number of worksites, but their treatment of the qualitative and contextual parameters of the individual worksites, such as work setting (size, weather,

[8] The drive for recruitment numbers and failure to provide adequate support to new and existing recruits was evident in other aspects of Brantford COMMIT, most notably with respect to the Smokers' Network. While it is true that protocol restrictions limited how intensively BC volunteers felt they could work with enrollees, and the whole nature of a trial (striving for a delta) tended to encourage this sort of behaviour, the lack of more intensive support was a source of disappointment for many enrollees (see Chapter 6).

ventilation), social environment (morale, smoking norms), and external environment (state and local legislation), is relatively superficial in that they list factors but provide little description or analysis of their specific impacts and the mechanisms by which these occur.

It is clear that the workplace, as a setting for health promotion interventions, is more than just a convenient receptacle for capturing misguided individuals or a captive audience for health education. Rather, it is a complex environment in which workplace smoking policies, job stress, interaction with peers, labour-management relations, economic outlook, and other factors converge to either hinder or support individual cessation efforts. Despite its many successes, by having to work "once removed" and through formal channels (mobilizing workplaces rather than intervening directly in them), limited by the uncooperativeness of labour, and dominated by middle-class movers and shakers who may not have had a natural predisposition to keep bringing socio-economic disparities to the forefront of task force deliberations, the WOTF could not have been expected to properly address this complexity of the work environment.

7.4 PUBLIC EDUCATION

The Public Education Task Force (PETF) was charged with media relations for the intervention and for promoting smoke-free norms in the community (see Table 4.3). It is difficult to evaluate these activities from the perspective of respondents from the Smokers' Network because they were not specifically targeted (except for the BC newsletter, discussed in Chapter 6) and because many other agencies (local, provincial and federal) are also active in tobacco control activities. Nonetheless, it is instructive to consider respondents' perceptions in three areas: (a) the profile of COMMIT in Brantford; (b) perceptions of prevention and cessation messages in the media; and (c) perceived changes in the social acceptability of smoking.

7.4.1 Profile of Brantford COMMIT in the community

During the majority of individual interviews, Respondents were asked "have you seen or heard much about COMMIT around town?". Of the 32 cases where this was discussed, 10 indicated that they had seen and heard a fair amount of BC around town, whereas 22 either said they had not or could only cite one example that they could recall (the latter case was true for 5 of the 22). Given that all respondents were members of Brantford COMMIT's Smokers' Network, these figures were a surprise. However, several caveats apply. What constitutes "a fair amount" for some people was probably "not much" in the minds of others. Alternatively, they may well have had multiple opportunities to hear and read of the intervention in the community but fail to recall specific instances of having done so. This might be especially true for those who were no longer actively interested in quitting (selective inattention).

> Maybe.. I think they've quieted down considerably this year, I don't know. Like I said, it could be myself... maybe I'm not interested in it no more (having quit) so I don't, you know, go looking for it or whatever. (Vincent 25, 703-707)

In addition, some people claimed not to be "media-type people" (to not watch television or read the paper much), and two of the respondents were elderly and did not get out much anymore. It is also possible that people are more attentive to BC at some stages in their 'cessation trajectory' than others.

On the other hand, there are several reasons to expect that people would *over-report* exposure to BC. Some respondents clearly did not distinguish between what they received in the mail as members of the Network and BC activity or publicity more in the public realm, so that regular mailings meant that "sure, I hear about COMMIT all the time". Nor can it be assumed that the ability of respondents to recognize the name and logo meant that they knew much about BC or what it had to offer, as evidenced by respondents reasons for joining the Network (see Chapter 6). In fact, people could say that BC had a profile in the community but not be able to recall any instances of hearing or reading about it

For those who said they had seen or heard plenty of COMMIT around town, the examples most often cited were ads or articles in the (local) newspaper,

billboards, and flyers. One person said that the "Yes You Can" t-shirts were popular in her fitness class at the Y, someone else that they saw the BC key chains everywhere they went, and two people mentioned having seen local cable television programming featuring BC.

Respondents made a number of suggestions about how the profile of BC and smoking cessation could be heightened in the community. Suggestions are useful in evaluations because they may be indicative of unmet felt needs or unrealized intervention possibilities. A number of those who said they hadn't seen or heard much of COMMIT around town suggested that BC place larger ads in the paper. Other suggestions to heighten the profile of BC included putting something on the buses, putting anti-smoking messages on rental VCR tapes, putting up posters showing a dirty lung full of cigarette butts, advertising in the way that consumer products do, and getting star athletic sponsors like Hulk Hogan or Wayne Gretsky to say "I couldn't do this if I smoked".

Key informants involved with the intervention felt that it had taken much longer than they anticipated to raise the profile (and, by extension, the credibility) of BC in the community, but that within the last year or two of the intervention this had occurred. Several key informants indicated that they really hadn't heard of COMMIT or known much about it before being recruited as volunteers or to positions in related organizations part-way into the intervention. Some frustration was expressed about BC being "Brantford's best kept secret" and people "not knowing what we've got here", and disappointment at the fact that BC's awareness was peaking just as the intervention was being phased out.

However, it's not clear how pervasive awareness of BC was through various sectors of Brantford society. The feeling amongst some key informants was that BC had not been "able to reach the number of low income, welfare, unemployment recipients.. that we should have..." (Kevin K31, 266-267), and that reliance on the print media biased coverage towards more literate segments of Brantford society.

7.4.2 Reactions to cessation and prevention messages in the media

Respondents were asked what they thought of some of the quit-smoking ads on television, and were often provided with examples of two ads that were playing at the time. One ad was for a commercial electronic cessation aid called the "Life Sign" computer, and featured an elderly lady on oxygen pleading with viewers to quit now before it was too late and they became like her. Only 2 of the 9 people that had seen this ad and commented upon it felt that it was motivating for them.

> I thought she got her point across really good and when she says "believe me... I smoked so many packages a day, this is what I am now" type of thing - it kind of made you think you know: if I keep smoking am I going to be like that when I'm older? It does make you think about what cigarettes can do to you. Sometimes when you are smoking you don't think of the health issues, you just smoke. But if there's reminders there all the time, reminding you this can happen, you think. And I think that everybody that's a smoker, they might not admit that they think about it, but I think it really - it hits a nerve there, and they start thinking about it. (Cheryl 7, 643-656)

While the majority acknowledged that these sorts of things "probably add up over time", they also maintained that scare tactics don't work, that these ads were exaggerations, that they just used actors anyway, or that they had heard that the gadget itself "didn't work".

> I used to say that commercial was full of crock, and I would just light up a smoke right away and blow it in the old lady's face, you know. I think it is annoying to people really, to see something like that. (Dave 6, 1734-1741)

Several people felt that seeing the sick old lady was not motivating because they had trouble identifying with her or thought they had plenty of time before they got to that point, and presumably felt they would quit before their health got that bad.

> There's the commercial with the old lady, okay, people our age, are not going to relate to that. That's an old lady, so I'm safe until I get older. Now if that was a person my age, a skinnier person that looks a little sick or something, that would hit more to me than looking at the old lady, because I know I have a few more years yet before I'm going to be her age, so who cares what happens right now. I'll worry about it when I... (pause) Oh, I see the sadness for this lady, because now she has to have oxygen. But I can't see myself as an old man... on oxygen. Right? And the old line, "oh I'll be dead before that" you know. I don't know who that's reaching, other than the elderly people that it's time for you to quit smoking. (Jamie 21, 1029-1040, 1054-1059)

> Like, the one they got there with the old lady on it That don't mean nothing, because it was... I'm goin' "well, she smoked for fifty, sixty years," right? They showed someone forty, forty-five, just a younger person, they'd get to more people. Well, that's just saying "well, uh, I can go out and smoke for fifty or sixty years and all I'm going to do is xxxxx (garbled) and I'm almost dead then anyways, so what's the difference? Because I could croak any time. (Bill 2, 600-623)

Marilyn described an ad she used to see that she felt ought to be run again. Judging from the reactions to the "old lady Life Signs" ad, it might be effective with this crowd too.

> I can remember the Cancer Association having a commercial on TV... something about "if you're not going to quit smoking at least make a contribution and we'll be here for you when you need us". That's something I think they should run regularly. It just really makes you stop and think. (Marilyn 32, 489-495)

The second television smoking cessation ad that was frequently discussed was one which featured a cartoon character dragging a larger than life cigarette chained to his leg. More respondents favoured this ad to the previous one, and said it symbolized how they felt about their addiction. But they were divided as to what they did with this feeling of guilt of being reminded that one should be quitting. Several respondents felt that while this ad was a good description of the problem, it contributed nothing to the solution.

> There again it reinforces the negative feelings you have about it, and it might make you think "oh, I've got to quit", but actually, it doesn't do it. You see, what you need is something that helps you. (Anne 1, 990-993)

> Sure, it's a chain and ball now.. so it's hooked right onto you, it's latched on. You've got the key, but there's no where to put it in. (Jamie 21, 534-536)

Several respondents said that these messages tend to fade from memory pretty quickly, but that perhaps they add up over time to contribute to your decision to quit somewhere down the line. In one of the focus groups, participants came to a consensus that there was nothing wrong with publicizing the risks of smoking[9] as long as it was not turned into a witch hunt, that it is still your own decision to smoke or to quit. There was strong support for anti-smoking messages in the media in terms of the hoped-for preventive impacts amongst children.

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[9] It was breathing problems, not cancer, that respondents found scary about the risks of smoking. As discussed in Chapter 8, most respondents adhered to concepts of fate (everything gives you cancer; there is nothing you can do about it; you have to die of something) and family (heredity) to describe the etiology and epidemiology of cancer.

7.4.3 Perceived changes in social acceptability of smoking

An overwhelming majority of respondents felt that there had been substantial changes in the social acceptability of smoking in a relatively short period of time. The frequent reference to changes "all of a sudden" is indicative of the fact that they felt they had to adapt to conditions that didn't exist when they began smoking.[10] The horizon of change, then, was a generation or less, but more than the 3 years of the COMMIT intervention in Brantford. These issues are discussed more fully in Chapter 9.

7.5 CESSATION RESOURCES AND SERVICES

The role of the Cessation Resources and Services Task Force (CRTF) was focused on increasing the awareness and use of smoking cessation activities and programs amongst smokers, and for improving the coordination of such services amongst voluntary organizations (see Table 4.3). Of the interview material collected from smokers, the most pertinent to this section relates to (a) their perceptions of self-help literature, cessation courses and support groups (the most common forms of assistance available); and (b) their impressions of other smoking-related organizations such as the Lung Association and Cancer Society.[11] Again, much of this is beyond the purview of BC alone, but has a bearing on the intervention nonetheless.

7.5.1 Smokers' perceptions of self-help literature, cessation courses, and support groups

Most respondents' comments on self-help literature on smoking cessation were oriented specifically towards the pamphlets and other materials (many originating with the Lung Association, Cancer Society, and Health and Welfare

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[10] Most smokers claimed that if there had been the sort of publicity about the dangers of smoking that there is today when they were growing up, that they would not have taken up the habit. They claimed that while the dangers might have been known in a general way, they were not publicized to the same degree that they are today, which suggests that a social environment that is not conducive to smoking may be more influential than abstract notions of possible health risk. In fact, a number of respondents said that as far as they were concerned, everything was bad for them.

[11] Issues of inter-agency coordination are dealt with more fully in Chapter 10.

Canada) contained in the "survival pack" issued by BC to new members of the Smokers' Network, which are reviewed in detail in Chapter 6. That respondents had few comments on written materials outside this context is perhaps interesting in itself, although Jim probably spoke for several others when he remarked that what he liked about the self-help literature was that it was informative without being judgmental the way many people often are.

Most respondents were asked if they had ever taken cessation courses such as those offered by the Lung Association, or whether they would ever consider doing so. BC often actively promoted the Lung Association's Countdown program within the Smokers' Network and in the community at large, frequently subsidizing the cost of the course for participants. As such, it represents one of the important venues at BC's disposal to turn recruits into actual quitters. Of the 31 cases in which it was discussed, only three respondents had ever taken a course before (one with Smoke-Enders and the other two the Lung Association's Countdown program). None had quit for more than 3 months using the program. Of the 28 who had not taken such a course, 7 said they would consider doing so (although often with caveats that suggested that in practice they probably would not participate), 11 rejected the idea outright, and 10 offered no further comment.

A systematic analysis of reactions revealed a number of perceived opportunities and barriers to participation, which have been summarized in Table 7.2. Although the smokers' support group organized by Brantford COMMIT was not frequently a topic of discussion, many of the same perceived opportunities and barriers to participation as listed here also applied. In fact, Brantford COMMIT staff frequently complained about low turnout for these Monday night sessions at the Y. It is unclear why BC had trouble attracting interest in this venue, given the apparent demand for a buddy support system voiced by the majority of respondents. Many of the barriers listed in Table 7.2 characterize the difference between wishing for an opportunity in theory, and taking advantage of those opportunities in practice.[12] Possible sources of discrepancy between what respondents say they want and what

[12] Because cessation courses already exist, people feel obliged to offer excuses for non-participation, in terms of why taking part was not seen as practical. When discussing the possibility of a buddy system, the emphasis was on why it would be a nice opportunity.

they actually make use of are discussed more fully in Chapter 8. My interviews with smokers suggest that those with more formal education have the greatest interest (belief) in participating in cessation courses, as well as the financial where-with-all to do so. This may be a venue that appeals more to the middle class than the working class, and/or it might also reflect the fact that the Lung Association usually (only) advertises its courses in the newspaper.

7.5.2 Smokers' perceptions of other smoking cessation related organizations

Respondents were not questioned directly about other organizations involved in tobacco control and smoking cessation, although the topic arose from time to time. But it is interesting in and of itself that the Lung Association or Cancer Society featured in the personal cessation trajectories of only a handful of respondents. Several smokers felt BC had a higher profile in Brantford and was more active in helping smokers than were the local branches of these other two organizations (a feeling that was shared amongst many key informants as well: see Chapter 10). One person suggested that these groups were not interested in making a serious contribution to the elimination of smoking, for fear of putting themselves out of a job.

> See, I don't think the Cancer Society's doing that much, eh? They say "oh, all the people are all against tobacco" and that. They're not really - ban it on television, radio. Well, that's not really doing anything, eh? You (have to?) hear it everywhere you go.
>
> Author: Can you make any sense of why these groups are not really doing what you're suggesting?
>
> Because they're really not... If everybody quit smoking, lower the cancer rate, they wouldn't need Cancer Society any more and that would put people out of work, so they're just doing the minimum just to do what they're supposed to do.
> (Bill 2, 715-719, 1145-1153)

Few respondents had first hand knowledge of - or experience with - provincial or federal tobacco control groups such as the smokers rights groups other than what they heard or read in the media, and in fact they were perplexed as to who exactly these more "militant" anti-smokers were (see Chapter 9).

7.6 CONCLUSION

In this chapter, I have presented a smoker's perspective on activities carried out by BC that fall under the rubric of the four intervention channels mandated by the intervention protocol: health care providers, worksites and organizations, public education, and cessation resources. This has been accomplished using interview and focus group material gathered from a sample of Smokers' Network members, supplemented with reference to a handful of key informant interviews. The picture of the intervention painted in this chapter is one of an organization (Brantford COMMIT) trying to create meaningful change in a number of key sectors of the community with relatively little time for community mobilization and in the face of considerable pockets of inertia (systemic, organizational, and personal in nature). An evaluation of these activities must be undertaken with the understanding that there are many other forces at work in each of these sectors of the community, some of which contribute to BC's success and others detract from it. It is evident that there is still much to be done in each area, and only a few issues have been identified here. Health care professionals need training in the *process* (not just content) of effective counseling (styles) that position them as partners in cessation, and they need to feel (and convey) that they have an effective and balanced program of action to offer. Worksites need to complement smoking policies with effective cessation resources, and to build participatory structures for tailoring them in particular to the needs of blue collar employees. Public education on the dangers of tobacco use needs to be complemented by the promotion of systems of support for smokers who are trying to quit, rather than stigmatizing addicted users. For although it was not the intention of BC to stigmatize tobacco users, and respondents generally felt COMMIT to be very supportive of their efforts to quit, their impression of tobacco control in its entirety is that it is patronizing and stigmatizing, and this is reinforced when punitive measures are not accompanied by resources and support devoted to cessation. Lastly, organizations in the business of designing and running smoking cessation programs need to more carefully consider how such programs are marketed and how to address perceived barriers to participation.

In building upon the analysis of activities directed at smokers on the Smokers' Network (Chapter 6), and in broadening the focus to the four intervention channels

in the community, this chapter paves the way for an examination of BC in the context of the needs (articulated and implied) of smokers for assistance (Chapter 8), and for Chapter 9, which examines smokers' perceptions of a broader range of tobacco control activities.

Table 7.1 Physicians Helping Patients Stop Smoking: A 4-Step Process

1. ASK patients about smoking at every opportunity
2. ADVISE them to stop
3. ASSIST patients by suggesting they set a quit date, by prescribing nicotine gum, by offering self-help literature, and by signing a contract with the patient
4. ARRANGE follow-up visits (at 1 to 2 weeks and 1 to 2 months after the quit date)

(Source: Glynn and Manley 1989).

Table 7.2 Opportunities and barriers to participation in cessation courses

Perceived opportunities

- a program that is an organized distillation of the best knowledge on how to quit
- hope for something new that they haven't tried that "works"
- support from the group; being accountable to others
- peer environment is more comfortable than confronting patronizing professionals
- provides non-smoking environment and positive social support that isn't available from own social network

Perceived barriers

- anxiety about sharing with a group of strangers; not a "group type person"
- hearsay about others who haven't been able to quit with such programs ("it doesn't work")
- if you don't really want to quit, a course can't do it for you (and, by implication, if you really want to quit maybe you can do it alone without a course?)
- reluctance to spend money on cessation
  - no guarantee it'll work (anticipate failure)
  - what are you really getting for your money ("bang for the buck"): nothing you don't already know?
- lack of time; only free in evening (courses often scheduled during afternoons)
- lack of transportation to attend meetings
- lack of awareness about availability, course content, and of opportunity for subsidization from BC

CHAPTER EIGHT

A SMOKER'S PERSPECTIVE ON BRANTFORD COMMIT
PART III: BRANTFORD COMMIT IN THE CONTEXT OF SMOKERS' NEEDS FOR ASSISTANCE

8.1 INTRODUCTION

The expectations and experiences of respondents in terms of services provided by Brantford COMMIT to members of the Smokers' Network were reviewed in Chapter 6. A broader range of activity was examined in Chapter 7 pertaining to the four intervention channels mandated by the protocol and extending to a wider community of smokers and non-smokers beyond the Network. In this chapter, a third component of a client-centred approach to evaluation is considered: smokers' needs for assistance with cessation, and how well BC met these needs. Rather than using program goals as the point of departure, a holistic perspective on smoker's needs, both expressed and implied through accounts of their own cessation trajectory stories, is taken. In this sense, the qualitative research with smokers functions as an interim needs assessment to contribute to more traditional process evaluation (c.f. Myers 1988), because it not only provides a context for evaluating the success of BC but it also helps identify different areas of potential activity for ASSIST and Brant COMMIT.

The rationale for considering the needs of smokers has been presented in chapters 1 and 5 and requires little further elaboration. The challenge is how to define and measure the somewhat vague and contested concept of need. In this chapter, the distinction has been made between direct and indirect measures of need (c.f. Thunhurst 1985). I shall refer to direct measures as those devoted to the

measurement of need specifically (felt, expressed and normative),[1] and to indirect measures as those needs that may be inferred from the statements of respondents who may not have perceived or intended such communication.

It should be emphasized that some needs will have been met by smokers themselves, through their social network, or by other organizations than Brantford COMMIT. Typically, the focus in a needs assessment is on unmet needs that are mutable and could be addressed by BC, with the recognition that some needs can not be presently met due to financial, technological or organizational limitations.[2] For this reason, needs are often operationally defined in terms of the ability to benefit from available services (Birch, Eyles and Poland 1990; Lord 1989). But this fosters two kinds of myopia in the gaze of needs assessment and evaluation research. First, limiting one's vision to needs mutable by existing services, while serving a certain immediate practical function, becomes self-serving insofar as services beget more services in service-defined needs assessments. As other non-service related needs become invisible, fresh creative thinking about how to address new types of unmet need in non-traditional ways is stifled. If we wish to make needs assessment and evaluation research empowering in purpose, process and outcome (as advocated in Chapters 2 and 3), then they need to be construed more broadly as "a political process for the organization, mobilization and consciousness-raising of groups and communities" (Marti-Costa and Serrano-Garcia 1983, 75) and therefore an integral part of community development (collective action towards a more just social order). In this context, it can be argued that needs assessment should consider

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[1] Bradshaw (1972) provides a typology of need that includes felt, normative and expressed need (direct measures). The lay person's self-perceived need for care represents felt need, itself a function of perceived symptom severity and personal experiences and values. To Bradshaw, expressed needs are those needs translated into demand for assistance, reflecting the impact of accessibility on self-perceived need. In this chapter, I use the term "expressed need" to refer to felt needs as articulated and conveyed by respondents during the interviews and focus groups, to distinguish them from needs implied by other statements made by respondents. The behavioural "acting out" of needs as help-seeking behaviour (Bradshaw's definition of "expressed" need) is considered in Chapter 6 (for example, use of the hotline) and Chapter 7 (for example, seeking the assistance of one's physician) and in this chapter (as help sought from sources outside BC) although not as a separate section.

[2] For example, some needs (such as for improved self-esteem) are genuine and vital but are difficult to properly address effectively via conventional institutional/organizational structures. Others, such as finding a 'cure' for addiction or nicotine dependence, have no current technological solution.

a broad spectrum of perceived needs and internal community resources rather than limiting itself to an assessment of needed services (ibid).

A second and related form of myopia engendered by traditional service-oriented needs assessment evaluations concerns not just *what* is considered a relevant need, but *who* is considered qualified to identify 'legitimate' needs. The traditional epidemiological approach to needs assessment is to constitute health-related needs as needs for health care to be identified through the study of illness distributions and patterns of risk factor distribution in 'populations'. This has typically been the domain of 'experts' and health care professionals based on 'scientific' research. While this may be appropriate in the context of infectious disease and other biomedical problems, it is unquestionably problematic when the root of the problem is mostly behavioural, environmental and perceptual. In these cases, where perceptions and context guiding human behaviour are the crux of the 'problem', situated actors are theoretically the best placed and best informed concerning needs for assistance. It makes little sense to design and deliver educational, behaviour modification or skills enhancement programs that do not address perceived needs of the client, because uptake and success rates will be disappointing.

Both of these shortcomings of traditional needs assessments (together with points made in chapters 2, 3 and 5) argue for going beyond traditional quantitative approaches to needs assessment (epidemiological and survey research) to the use of qualitative methods such as depth interviewing and focus groups., which are naturalistic, holistic, and acknowledge the subjectivity of human behaviour (Lord 1989; c.f. Patton 1990). While more time-consuming and expensive, qualitative research allows respondents to identify areas of concern and salient aspects of program delivery or needs that may not have been considered by researchers, which can then be used in the design of survey instruments (with enhanced validity), providing more reliable and generalizable data in larger samples (Taylor et al 1992).

Although this study draws on the claims, concerns and issues of multiple stakeholders (c.f. Lord 1989; Guba and Lincoln 1989), this chapter's focus on needs takes a consumer-oriented perspective (c.f. Scriven 1972; Fricke and Gill 1989).

Several dimensions of need are considered, beginning with an examination of the self-articulated needs of interview and focus group respondents who were members of the BC Smokers' Network, and proceeding to consider needs as implied (or inferable) (a) from their own accounts of their cessation trajectory and difficulties experienced along the way, and (b) from their commentary on available and proposed services and forms of assistance.[3] The implications for action, for the evaluation of BC, and for further research are considered in a concluding section of this chapter.

8.2 EXPRESSED NEEDS

During the course of individual interviews, respondents were asked what they felt would help them in their struggle to rid themselves of tobacco dependence. The question was phrased in a number of (similar) ways, as follows: "Are there any things that COMMIT or anyone else could do to help you?", "Do you think that you have any needs for assistance in terms of quitting?", or "Do you have a sense that there are other needs for assistance that you have that COMMIT could be meeting?".

It could be argued that joining the Smokers' Network represented an expression of a generalized need for assistance in quitting. Nonetheless, respondents had difficulty articulating specific needs for assistance, although they had plenty to say about specific issues like the use of fear tactics in health education, tobacco control legislation, support groups, various commercial cessation aids, and so-forth. (Potential sources of implied needs which are explored in section 8.3.) There are several plausible explanations for why respondents find it hard to articulate their own needs. The question implied that it was unmet needs that were being asked about. Since many respondents, particularly heavy smokers who had made multiple attempts to quit, will have already tried most of the things that they thought would "work", they would have been "at wits end" about what to do next. Also, a clear understanding of one's needs might be expected to have already led to action (including help-seeking) on those salient needs. The outcome of having

[3]Needs implied by what smokers think BC could be doing were explored in Chapters 6 and 7.

already taken action on self-defined needs is either that they were no longer smoking, or that the strategy they had adopted had 'failed' and they had returned to smoking. In many cases where a strategy was found to have 'failed', one might expect that having lost faith in its effectiveness, the smoker had removed it from his/her list of possible strategies or perceived needs for assistance when thinking about the next quit attempt.

Also, most of the time most people are not as goal-directed and systematic in managing their lives as one might be led to believe. Even if one were to assume a 'rational' decision-making process, a clear assessment of needs for assistance would appear to require (a) knowledge of the existence, efficacy and availability of a broad spectrum of cessation resources and techniques; and (b) knowledge about oneself and about human psychology regarding how best to get motivated and stay motivated in the application of these techniques to one's own cessation. In reality, knowledge is partial and variable, tradeoffs must be made between competing priorities, and decision-making processes rarely conform to traditional 'rational actor' models.

Examination of a substantive list of expressed needs generated by respondents predictably reveals that people want techniques that work and the willpower to carry them through. Where they differ is in what will work and what proportion of motivation versus technique guarantees success.[4] The relevant dimensions of support are listed in Table 8.1. The most often mentioned specific needs for assistance and opinions are summarized in Table 8.2. What is apparent from this table is the possible contradiction between the desire for peer support on the one hand, and on the other hand strong statements about the fact that external support and influences are ultimately of little use unless the individual him or herself truly wishes to quit and honestly applies him/herself to this end. The coexistence of these statements might suggest a understanding of the fact that individuals are ultimately responsible for their behaviour, and that external support makes the initiation and maintenance of behaviour change all the easier. However, few individuals shared

[4] The issue of motivation versus technique, often presented by respondents as a tradeoff rather than necessarily synergistic requirements for success, is revisited in greater detail in the next section, when implied motivational and technique needs are considered.

both opinions, so in fact the group was divided between the majority who professed an interest in mutual aid, and those who felt that they would have to come to it on their own accord, in spite of having joined BC presumably with the hope of external assistance.[5] This apparent divergent set of needs among respondents suggests the need to allow individuals to select from a menu of options for assistance so that assistance can be tailored to individual needs.

Many of the needs identified in Table 8.2 were areas in which BC was active, in terms of "being there for smokers" (not stigmatized), providing education on the risks of smoking ("scare tactics"), publicizing and subsidizing the integrated cessation course offered by the Lung Association (need for a "program"), and pursuing stricter tobacco control (legislative reform and enforcement) at the municipal level. But because much of the potential of the Smokers' Network for peer support amongst smokers was not realized (due in large measure to protocol restrictions), it is fair to conclude that one of the primary needs identified by respondents went unmet during the course of the trail.

But there may be a discrepancy between what people say they need and what is actually used when available, as was evident in the call amongst respondents for the establishment of support groups and a buddy system. While the concept of mutual aid was overwhelmingly popular, the fact remains that BC's own smokers support group was poorly attended throughout the trial, and that when advised of the opportunity to join a new local chapter of Nicotine Anonymous, none who had indicated an interest in such a program actually attended meetings in the months that followed.[6] There are a number of explanations for the discrepancy between what people say they want and what they do. They may have more pressing needs in their lives, so that needs around smoking cessation exist but go unmet. In fact, what a person says they want may be nothing more than preferred behaviour *if all else was equal.* In other words, expressed needs may ignore the costs associated with

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[5] The tendency was to see one as obviating the need for the other, in fairly black and white terms.

[6] I personally called all respondents to inform them of the opportunity to join N.A., and attended weekly meetings of the group for the first two months of operation in Brantford. None of the respondents attended a Nicontine Anonymous meeting during this time. (They were not advised that I would be there).

meeting them. Such costs might include constraints on time and mobility, and reluctance to reach out. In addition, needs may change significantly over time as a function of the perceived urgency of cessation and changes in the nature and sources of informal support in the person's social network.

The apparent discrepancy between expressed needs and those acted upon when the opportunity arises raises the question of how expressed needs should be used in the evaluation of health promotion interventions. As indicated in Chapter 3, there may be no straightforward answer. Rather than do away with client-centred evaluation altogether, one can (a) look at reasons why preferred behaviour might differ from intentions or eventual actions, and resolve apparent contradictions by subjecting them to closer scrutiny, and (b) discuss contradictions openly with respondents and attempt to better understand or resolve them collectively.[7] A critical-interpretive approach to needs assessments with target populations helps to explicate the contextuality and taken-for-granted aspects of preferred helping strategies.

8.3 LATENT NEEDS

People who have little to offer by way of opinion on their own needs for assistance nonetheless imply a range of needs by what they have to say on related topics, provided the identified needs are well grounded in the data.

There are several ways in which implied needs might be assessed (Table 8.3). Difficulties that respondents faced during previous quit attempts could be interpreted as needs for assistance to avoid or overcome these in their next quit attempt. Such needs typically encompass minimizing or coping with nicotine cravings and withdrawal, dealing with cessation relapse crises, other motivational or technique problems, and/or negative environmental factors. Other implied needs can

[7] This is what had been hoped for in the focus group, but in practice it was difficult to acheive. Part of the difficulty also revolved around not having sufficient time for a detailed analysis of interview transcripts before moving from interview to focus group stage. See Chapter 5 for more discussion of these issues.

be seen to arise from discussion of the perceived barriers to trying again, enlisting support for cessation amongst family, peers and coworkers, the nature and role of nicotine addiction, and what they report has or has not worked for themselves and others. Respondents talked about motivation, techniques and social support as categories of issues facing those who try to quit, so this seemed like a logical grounded typology for categorizing and discussing the implied needs listed in Table 8.4. (Respondents' ideas about what BC could be doing (another dimension of implied needs) were reviewed in Chapter 6 and 7).

It is evident that motivational needs are about "being ready" and "being determined" to quit as prerequisites for successfully initiating and maintaining cessation. But attempts to engage respondents in reflection and discussion about what constituted "being ready", how one gets "ready", and how one knows one is "ready", were not particularly fruitful. While many respondents identified motivation as a key factor in the success of initiating and maintaining cessation, few seemed equipped to identify strategies for boosting their own motivation. Smokers expressed a number of reasons for and against quitting (Tables 8.6 and 8.7). Much of the motivational self-help material designed for smokers emphasizes the reasons to quit (Table 8.5) rather than addressing reasons smokers may have to be reluctant or fearful to quit (Table 8.6).[8] These fears create ambivalence about "giving up the weed" and may distinguish preferred behaviour (surveys reporting a majority of smokers indicating they would *like* to quit) from behavioural intentions ("being ready" to quit despite the costs associated with doing so).

Technique-related needs seem to be about finding "things that work". As indicated in Chapter 6, many people admit to wanting something that will do the quitting for them, or make it easy. In Shelley's words, "people always want that easy quick fix" (26, 1223). By the same token, respondents were often quick to dismiss approaches that had "failed them" (or others) in the past as ones that "don't work". Whether these were nicotine gum, the Life Signs gadget, or laser therapy (the most commonly rejected techniques), the emphasis was clearly on personal experience

[8] The list of benefits of smoking and costs associated with cessation provided in Table 8.7 is very similar to what other qualitative and quantitative research has shown (c.f. Ferguson 1988).

and hearsay rather than research evidence. And while they expressed interest in what approaches had the highest success rates, they were also cognizant of the need to "be ready" and "determined" to quit. A technique was seen as insufficient to guarantee success alone. This is where the distinction between motivation and technique becomes blurred, particularly since many "techniques" actually refer to strategies for staying motivated and for dealing with nicotine cravings, triggers to smoke, and relapse crises.

A third theme in the list of implied needs (Table 8.4) is that of environmental factors conducive to or hindering cessation. Three environments are considered here: spousal, parental and peer smoking status.[9] (for coworker influences see Chapters 7 and 9). Each has the capacity to influence the smoker in his or her decision to quit and the outcome of those decisions.

Respondents revealed that spousal smoking status often has a significant effect on the initiation and maintenance of cessation. Spouses who used to smoke and have quit may exert (subtle or direct) pressure on the smoking partner to quit, or demand that smoking be curtailed in certain areas of the house. Some indicated that it was important that they had quit along with their partner as a joint venture, although the risk of relapse was much higher if the other person was the first to "fall off the wagon".

> When both of us quit at the same time, it's a lot easier. Because there's nobody sitting in front of you smoking, so you don't have the urge to take it so easily. (Carolyn, 30, 492-498)

However, the timing is not always right for both people to quit at the same time.

> I've tried to talk my husband into quitting together a number of times, you know, "let's do it together, it will be easier, we'll be able to support each other and that way one person won't be smoking while the other is trying to quit", you know, it will be easier - but um, no, he didn't want to (Jessica 16, 686-693)

[9] For discussion of the influence of coworkers, see Chapters 7 and 9 dealing with workplace restrictions.

Spouses who continue to smoke may or may not be supportive of cessation, and may find ways to sabotage their efforts, since the success of their partner would render their own smoking behaviour problematic.

Of the 34 respondents known to have a regular companion or spouse, nearly half had a spouse who smoked. Recent sample survey research indicates that 85 percent of current smokers in Canada have one or more other smokers in the household, whereas less than a quarter of households with smokers contain former smokers (Pederson 1993). Forty-nine percent of survey respondents (1990 Health Promotion Survey) who had quit smoking in the previous year indicated that "support from family and friends" was an important factor (ibid). Likewise, interview respondents in Brantford identified the presence of a smoking spouse to be a major obstacle to their own cessation. Even if smoking spouses were supportive of their efforts to quit, exposure to smoke and to temptation in the home were difficult for respondents to overcome.

> If I go someplace when I'm not smoking, and I do see somebody smoking, like I'm just all agitated, because I want a cigarette and I just don't stop thinking about having a cigarette. (Emily 20, 306-309)

> My husband's still smoking so there's an encouragement there or there's an influence there that is very difficult to break from.... sort of looking at my husband... like, "Hum. That, that looks kind of good." You know. ...that's what I find the most difficult when I'm home and he's smoking, I'd like to have a cigarette. I really like to have a cigarette and I find it very difficult not to want one and not to have one when it's so accessible. (Linda, FG1, 327-330, 471-373, 539-541)

> We tried to quit again in the summer... He started smoking and I didn't know he was doing it behind my back and... I found out he had cigarettes and so, of course, I had to have one, too. Monkey see, monkey do, I guess. (laughs) (Carolyn 30, 230, 243-253)

> My husband wasn't smoking then at the time either, and I remember one day.. one of us said "You know I would really like to have a cigarette" And we both had one, and we both started back. (Leslie 10, 84-87)

Amongst smokers whose spouses had quit or had never regularly smoked, many complained about being "nagged" or "harangued" about quitting. Compared to the experiences of those whose spouses discouraged cessation, "nagging" constitutes a form of support for quitting. However, this was also perceived negatively by many respondents, and relatively few reported feeling positively and appropriately supported and encouraged by their spouses to quit.

> It's something that has to come from yourself, that you really want to quit smoking, I think, for it to really work. And you know, like my husband, he's on my case all the time and I would say well, I know what you're telling me and with him just nattering at me all the time, it just sends me, because he is not telling me nothing that I don't know. (Emily 20, 254-259)

For smokers, "nagging" seemed to have the following identifiable qualities: (a) judgmental overtones (lack of respect as a person); (b) being told what you already know (e.g. smoking is bad for you); (c) lack of understanding of the "smoker's dilemma"[10] and hardships involved in quitting; (d) use of negative rather than positive reinforcement. In these cases, smoking became a source of tension in the relationship and was sometimes used to spite the other person, or as a sign of defiant independence, and was often discussed in terms of a lack of respect for the other. "Nagging" thus became counter-productive and embroiled in a more complex web of relationship issues that may not have been conducive to cessation. Darlene (who had recently quit) provided a particularly striking example of how smoking can play into or exacerbate other relationship tensions.

> I resented people bugging me about it, and people saying, "You have to quit.". I mean, "excuse me!" In fact, that's what started me (laughs) smoking again. It was two years I hadn't had any cigarettes. I was dating a person and we had this major argument. I have no idea what the argument was about, I can't remember, but I know I was screaming a lot at him. I'm a screamer (laughs). And... he smoked Vantage and he had a package in his shirt pocket and at one point I took the package out of his pocket and took a cigarette and he said, "What are you doing?" I said, "I need a cigarette. I have just about had it right up to my eyeballs, I need a cigarette." And he informed me he would not allow me to smoke. Well, I had been married to a man like that who was actually.. abusive. But this guy saw a woman has a position, and I saw red. And I just, no man is going to tell me what to do. And I just gave him the old... women's lib lecture, and like who do you think you are? This is my body. And then I made my first mistake. I smoked the cigarette and then started right back, smoking again. And it's taken, well, what, twelve years [to quit again]?
> (Darlene 12, 425-458)

Several couples argued about smoking during the interview, and the accusations, denials and comments suggested tension on this matter.

For those who were beginning a relationship with a non-smoker, spending time with that person provided a welcome restriction on smoking for those who were trying to quit.

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[10] Ferguson (1988) uses the term "smoker's dilemma" to refer to the competing desires and pressures to quit and not to quit.

> My boy friend doesn't smoke, his family doesn't smoke, none of his family smokes and I wouldn't dream of lighting up a cigarette anywhere near them. I think that is good: the more time I spend with him and the more time I spend with them the less I smoke (Shaine 13, 228-232)

However, it also could pose a problem in the relationship, at times threatening it.

> I don't know if my relationship with my boyfriend will last if I don't quit smoking, he hates it that much. I know he loves me, but he's getting really tired of this (laughs)... and I know my smoking affects that. If we both happen to have a free evening and I'm really dying for a cigarette I'll tell him I'm busy you know, don't come over till 9 o'clock or something like that because I want to sit and smoke for a while because I am so hyper, or that's what I tell myself. Almost any excuse to get rid of him (laughs). "Um, don't you have to go somewhere right now?" (laughs) Could you believe [what you do for] these things?! I mean, it's ridiculous. And [he/love?] should be the top of my list - it *is* the top of my list, my health is even not as important to me as my relationship to him, but damn do you think I'm doing any thing about it? (Shaine 13, 647-660)

On the other hand, the quitting spouses themselves began wondering if quitting was really worth it, or whether it was better to "die young than be a bitch".

> [My boyfriend has] gone through some awful times with me, or my, you know, quitting days. It's terrible. We never ever fight, but boy, right after New Year's when I decided I was going to make another stab at it - just horrendous battles. Only time we've ever had fights, that's when I try to quit smoking and it's nothing to do with him.... I'm not going to jeopardize my relationship scaring the poor guy away. Like, you're going to marry the biggest bitch in the world? (laughs) Excuse me, or I can have a smoky breath. (laughs) You have a choice. It doesn't seem like it's worth it. Even though I know it is. I know it is. But... at the time, boy... (Shaine FG2, 270-305)

Some partners were not prepared to put up with the irritability of a spouse who had just quit would sometimes demand that they start up again.

> 'Cause the last time [my wife] tried [to quit] she went for about two days and it was over the weekend and she was just irritating the hell out of me. I told her to start again. (laughter) Oh, yeah....she's a real terror when she quits (Ian 34, 118-124, 497)

> And my husband says, "My God, I'm going to go out and buy you a pack of cigarettes myself. You're such a bitch" (Cybil 27, 2351-2352)

> I don't want my husband to quit smoking. He don't smoke that much to begin with and two, he gets as miserable as an old bear when he don't get a cigarette, and that puts pressure on me, where I'm just saying "Here, take a cigarette", you know, "I'll smoke just for you to...[not feel like you have to quit]" (Doreen 42, 947-965)

When one partner quits and the other continues to smoke, arguments sometimes arise concerning where smoking will and will not be allowed in the home.

> Like, my husband now, he still smokes. When I first quit I made him go down in the basement and smoke, because it was too hard. But after three or four weeks, it didn't bother me anymore, so he kind of weaseled his way back up and started smoking them all over the place.... (Cheryl 7, 220-225)
>
> [My husband] doesn't really like me to smoke around the house. But, I will if I'm having a few drinks with someone and there are other people here I will.... Then he doesn't want to embarrass himself [by saying anything] (Liz 44, 94-104)
>
> I don't care if [visitors] smoke or not. My wife does, but I don't. Actually, I think it's kind of funny when somebody comes in and smokes and she starts yellin at 'em. (Dave FG1, 577-579)

It seemed that the man's wishes often prevailed, and at times this there was a definite, if subtle, show of disrespect accompanying the husband's dismissal of his partner's concerns and wishes. Although this was a small sample, it seemed that men were less likely to take seriously or accommodate the wishes of their wives than the women were of their husbands regarding smoking in the home. Women were more apt to refer to their husband's experiences (and to devote more time to them) than men did about their wives.

The second environmental factor affecting smoking is parental smoking status (c.f. Swan *et al.* 1990; Malkin and Allen 1980). A family history of tobacco-related illness also seems to affect the cessation efforts of children. Eighty percent of respondents had a father who (had) smoked, and 58 percent had a mother who did or had. Smoke-free family gatherings were mentioned on a number of occasions as being one of several reasons to quit. Twenty-four percent of respondents made direct and unprompted reference to tobacco-related illnesses in one or both parents. The stress associated with the death of a parent sometimes compromised cessation efforts in progress even when the parent died of lung cancer or emphysema. But in the long run, each personal experience of tobacco-related illness in ones immediate social network may increase the sense of immediacy of the potential health impacts of smoking.

Thirdly, peer influences are also significant factors in smoking cessation (Westman, Eden and Shirom 1985; Shiffman 1982). Venters *et al.* (1987) found that the friendship patterns of ex-smokers more closely resembled those of never-smokers than smokers (with respect to the smoking status of friends), suggesting the importance of social supports for cessation. Unfortunately, I was not able to get

an indication of the prevalence of smoking amongst friends for 17 respondents out of 45. But amongst the remainder, three quarters indicated that the most of their friends smoked. This would appear to represent an important source of social pressure to retain smoking, as one aspect of membership in the peer group. Given the need for acceptance and the importance of social support, many respondents indicated that if quitting meant giving up their smoking friends then perhaps it wasn't worth it. Those who seemed most prepared and motivated to quit were those whose coworkers and a significant proportion of family and friends were non-smokers, so that pressure to quit was felt *and* relatively smaller adjustments to one's social network were needed to accommodate the reality (and needs) of a new non-smoking identity. The influence of peer pressure is undoubtedly behind the rationale within the COMMIT trial for a focus on changing social norms about smoking, but the community-level focus assumed an even trickle-down across social groups and ignored the possibility of clustering of social environments supportive of smoking.

8.4 CONCLUSION

It is evident that needs for assistance are not easily defined, measured, or interpreted in terms of tangible program and service implications. The expressed needs summarized in Table 8.2 have implications for the maintenance and reform of service delivery and tobacco control initiatives, but also raise the issue of how to reconcile the discrepancy between what people say they want and what they actually use or find useful when available.

Since the majority of smokers profess a desire to quit, the primary obstacle to quitting for many smokers seems be "being ready" to take the first step. Some of this stems from an ambivalence to quitting, given the sorts of reasons not to quit referred to above (Table 8.6). However, it seems important that this notion of "being ready" be more thoroughly investigated.

Taken together, spousal, parental, coworker and peer smoking status and degree of support for cessation provide powerful and immediate environments conducive to or hindering individual attempts to quit. But do barriers to cessation in

these areas constitute needs for assistance? The intervention implications are not clear. One avenue to explore might be the production and dissemination of a brief orientation and resource package or pamphlet for non-smokers (friends, family, coworkers) about how to better understand smokers and help them in their efforts to quit.[11] Since smokers frequently felt misunderstood by non-smokers, this would probably meet with approval from both 'sides'.

In the next chapter, smokers' perceptions of tobacco control initiatives are considered. Measures such as restrictions on smoking in the workplace and in public, taxes, and advertising bans are posited by their proponents as crucial to fostering environments more conducive to smoking cessation and prevention. They also were central features of the provincial and federal smoking-related context within which the COMMIT trial operated in Brantford.

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[11] This has been done in the field of addictions of the families of alcoholics, upon which the Al-Anon program has been based. Appendix I in *The No-Nag, No-Guilt, Do-It-Your-Own-Way Guide to Quitting Smoking*, Ferguson (1988), entitled "How to Help a Health-Concerned Smoker", is based on interviews with 200 smokers in San Francisco and Austin Texas. In addition, he has produced a resource package for health educators and other health professionals entitled *Helping Smokers Get Ready to Quit: A New Approach to the Toughest Problem in Health Promotion.*

Table 8.1 Dimensions of support

How personal the contact is (reading material vs phone call or support group)
How intensive the contact is
Whether the initiative comes from themselves or not
Whether they already know the people involved

Table 8.2 Primary needs and opinions about needs for assistance as articulated by (29) respondents (in order of frequency mentioned)

Peer support (buddy system, AA-style meetings, support group)

"No-one can make you quit" (you're on your own, "its gotta come from inside", etc)

Scare tactics (think that "gross pictures", alarming statistics & prognoses might work)

To not be stigmatized (to be treated with dignity & respect)

Need a 'program' (clear and efficacious steps-to-success approach, undertaken individually or in groups)

Need help dealing with withdrawal

Need more stringent tobacco control

Table 8.3 Potential sources of latent needs for assistance among smokers

"People need..." type of statements

Taking the first step
- reasons to quit and fears about quitting

Enlisting support for cessation
- amongst family members, peers, coworkers

What smokers find most difficult about quitting
- cravings, withdrawal, weight gain etc.

Preventing slips (relapses)

What smokers say about nicotine addiction

What has or hasn't worked for them or others

Ideas about what Brantford COMMIT could or should be doing

Table 8.4 Dimensions of latent needs for assistance among smokers

Motivational needs
- taking the first step & maintaining vigilance
- reasons to quit
- reasons not to quit (fears &/or difficulties to be overcome)

Technique-related needs
- comments about what has or hasn't worked for them or others
- what they want in a cessation method

Environmental factors
- spousal smoking status
- prevalence of smoking amongst peer group
- parental smoking status and tobacco-related illness
- workplace environment

Table 8.5 Reasons to quit smoking given by respondents

My own health
- concerns over physical health effects revolved around emphysema and breathing problems
- cancer was not the major concern, since many people felt that link was tenuous and "everything gives you cancer"

Health of my children
- especially for children with manifest respiratory problems (cough, asthma, frequent colds). This was where the adverse effects of ETS were most widely accepted by otherwise skeptical smokers (versus coworkers or friends who may not be exposed to as much for as long, nor be (seen as) as vulnerable.
- setting a poor example for kids
- health of spouse was rarely cited as a reason to quit, if ever

Waste of money
- savings "going up in smoke"
- don't want to give the damned government any more money than I already do

Just sick of it, don't even like smoking anymore

Temporary cessation due to certain circumstances
- pregnancy
- illness
- in the company of certain non-smoking others (boss, prospective mates, relatives)

Social pressure to quit
- diminished social acceptability of smoking/smokers; stigmatization of smokers

Desire to regain control
- dependency as weakness
- hassles of smoking (given restrictions) highlight how much I'm a slave to the addiction

Smell on my clothes and stains on my skin
- these are sensory cues that brand you a "smoker" amongst strangers
- may be considered "dirty"
- raises gender issues since women socialized to be very conscious of personal appearance

Religious convictions
- e.g. Jehovah's Witness prohibitions on smoking

Fire hazard

Table 8.6 Reasons not to quit given by respondents

Lack of motivation (benefits of smoking as an excuse not to quit)
- "a bit of a statement" (rebelliousness, self-image)
- "a social thing" (hospitality, camaraderie; part of my social life)
- manage emotions (stress, anger, frustration, boredom; constraints on use of other stress management techniques: knowledge, time, social sanctions in some circles)
- part of my own identity and everything that I do (quitting makes daily routines & taken-for-granted actions problematic)
- "cigarette is my friend"; I would be lonely without it
- "I want to quit" versus "I wish I wanted to quit" (would *like* to, but minus costs)

Avoidance of unpleasantness, or causing more harm than good
- fear of physical discomfort associated with withdrawal
- "better to die than be a bitch" (fear of failure to manage emotions, especially amongst women, for whom social sanctions against displays of anger are stronger)
- fear of weight gain (especially amongst women)
- looked at prospectively, nothing about quitting seems especially enjoyable; link more pain than pleasure to quitting, and people basically avoid pain and seek pleasure (but note that those who have quit report tremendous pride, sense of accomplishment & self-esteem and well-being)

Postponement and procrastination
- quitting is "always in the back of my mind" (and staying there?)
- I know I'll quit "sometime" (unspecified future)
- circumstances aren't right at the moment; I'm "not ready"

Defeatist excuses
- self-doubts and fear of failure
- "I probably wouldn't last long": giving yourself an out ahead of time
- "I'm too addicted" and other self-defeating statements

Minimizing risks
- permissible transgression, my one vice (at least I'm not a drunk driver etc.)
- "everything gives you cancer anyway"
- "you gotta die sometime of something"
- I've probably done the worst damage to myself already (little harm in continuing to smoke + little benefit to be gained by quitting)

Why bother?
- there's more to life than health; sense that life is hard and you want to do what you can to have fun, to take what enjoyment you can from life
- you're here (on earth) for a good time, not a long time (sense that being healthy isn't much *fun*, and involves giving up things you enjoy; and is it worth it?)
- could be killed tomorrow by a bus or something (and all that effort and sacrifice would have been for nothing)
- preoccupation with your health is sickly: just get on with living

CHAPTER NINE

SMOKERS' PERSPECTIVES ON TOBACCO CONTROL

9.1 INTRODUCTION

In western societies (and in Canada in particular), the shift to smoke-free environments, the imposition of 'sin' taxes on cigarettes, age restrictions on access to tobacco and other forms of tobacco control have been relatively swift and pervasive, given that as recently as a decade ago smoking was generally condoned and even encouraged in many segments of society. This chapter draws upon interviews and focus groups conducted with smokers, using a critical-interpretive methodology (Chapter 2), (a) to provide a contextualized understanding of how smokers perceive tobacco control in principle and in practice, and (b) to suggest that tobacco control be considered a process as arising from a particular social order and set of human power relations.

This chapter begins with an examination of the rationale for tobacco control and the forms that it has taken in Canada to the present time. The rationale for developing an understanding of the smoker's experience of tobacco control is then considered. Although several substantive areas of tobacco control are explored in the study, the particular emphasis in this chapter is on the regulation of places where smoking is permitted. The chapter concludes by considering the implications of a qualitative lay smoker perspective for the practice of tobacco control in Canada.

9.2 TOBACCO CONTROL INITIATIVES IN CANADA: RATIONALE & PRACTICE

The general societal movement in favour of smoke-free environments seems to have been propelled by two factors in particular: (a) increasingly incontrovertible knowledge of the harmful effects of direct (and increasingly of sidestream) cigarette smoke, and (b) a growing emphasis on healthy public policy and community interventions in public health.

Tobacco is one of the few consumer products in western society that is both highly addictive and lethal when used as intended. Numerous epidemiological studies have established smoking as a risk factor for cancer (especially of the lung) and cardiovascular disease (USDHHS 1982), as well as a contributing factor to many other diseases and causes of death. The Surgeon General of the United States has declared that "cigarette smoking is the chief, single, avoidable cause of death in our society and the most important public health issue of our time" (USDHHS 1982). Cigarette smoking has also been identified as "the most important avoidable cause of death in Canada" (Wong and Arraiz 1990; c.f. Schabas 1991), and the promotion of smoking cessation features prominently in the public health objectives of both countries (Anderson and Mullner 1990; Ontario Ministry of Health 1989).

Concomitant with an increased awareness of the importance of individual lifestyle behaviours as determinants of population health has been a more general acknowledgment of the role of other factors outside the formal illness care system as generative of (or injurious to) the public health (e.g. Lalonde 1974; McKeown 1979; Ottawa Charter for Health Promotion 1986). Furthermore, environments have come to be seen not only to affect health directly through protection from or exposure to harmful chemicals or pathogens, but also as constitutive of human behaviour within the rubric of a general social learning model of individual action. Therefore, the focus of health promotion has shifted away from health education and towards healthy public policy and a focus on designing healthy communities and environments in which individual behaviour modification is socially sanctioned and supported (Hancock 1985; Milio 1986).

Growing awareness of the public health costs of smoking coupled with a shift to public policy and community interventions as agents of change have set the stage for tobacco control as presently constituted in western society, and in Canada in particular. Three broad action areas constitute the nature of tobacco control in Canada at the moment (Table 9.1). Prevention activities are directed primarily at young people. Mandated education on substance abuse in the school curriculum, coupled with a number of ongoing advertising campaigns in the public media comprise much of the educational component as undertaken by the state, bolstered by the activities of not-for-profit organizations such as the Lung Association and the Council for a Tobacco-Free Ontario. Federal restrictions on public advertising of tobacco products and age restrictions on legal access to these products are designed to reinforce educational efforts at prevention and to combine with these to create a social climate that is not supportive of smoking.

Cessation efforts are aimed at encouraging current smokers to quit. Cessation messages in the media, with individual counseling and group therapy, nicotine replacement therapy, and the provision of self-help materials are mainly carried out by voluntary organizations, with some state support and involvement. The primary means employed by the state to encourage cessation is the taxation of tobacco products. Since 1980, tax on tobacco has risen 109 percent in Canada (Pipe 1991). There has been an associated decline in prevalence during that time of 24.2 percent (Pipe 1991). Insofar as scientific research has shown the use of multiple strategies to be more effective than any single approach (Lichtenstein, Wallack and Pechacek 1990-91), a series of community intervention trials have been mounted to demonstrate the synergistic effects of employing multiple community-based strategies for smoking cessation (Thompson *et al.* 1991). The COMMIT trial is a case in point.

A third arena of tobacco control legislation involves the protection of others from exposure to second hand (or 'side stream') smoke, as evidence of the harmful effects of environmental tobacco smoke (ETS) has grown in recent years (Allen and Adler 1989). It is in this context that restrictions on smoking in public places have been enacted. Increasingly, the combination of these efforts is hailed as a vehicle for

shifting social norms in favour of non-smoking, as a multitude of pressures come to bear upon smokers.

9.3 THE VALUE OF A QUALITATIVE PERSPECTIVE ON TOBACCO CONTROL

While a number of health surveys have documented declines in the prevalence of smoking in North America, and concomitant changes in attitudes towards smoking and tobacco control measures, the bulk of these have been surveys, relying on tightly specified conceptual models such as attitude theory. These provide few opportunities for respondents to share their experiences more fully with researchers and to comment on the meanings these behaviours and environmental changes hold for them. Since socially derived and individually interpreted meanings are constitutive of behaviour in much more complex ways than posited by linear attitude theory models, it is unfortunate that there have been relatively few qualitative studies seeking the smoker's perspective. Amongst those of which the author is familiar, the majority seek to evaluate specific cessation interventions or assist smokers in the cessation process (e.g. Ferguson 1988; Willms *et al.* 1991), rather than examining the impacts of the shift to smoke-free environments on smokers themselves.

A detailed qualitative assessment of the impact of tobacco control initiatives on smokers could serve several vital functions. First, it would help us better understand the effects of tobacco control legislation on smokers. How are current smokers coping with the changing environment? What adjustments do they make in their life to accommodate the proliferating restrictions on their "freedom"? How has it changed their smoking behaviour (when, where, how much) and attitudes towards smoking (under what circumstances)? And given that 28 percent of the Canadian population continues to smoke despite growing public opposition to their habit (Pederson 1993), a qualitative study might help us better understand why so many continue to smoke.

A second reason to seek a more detailed lay smoker perspective is to be better appraised of some of the unanticipated and sometimes counter-intuitive consequences of tobacco control efforts. For example, restrictions on smoking in the workplace and in public spaces has mean a retreat into the home, where infants

and other family members are subjected to increased exposures to ETS. Also, as early adopters of innovation tend to be the white urban middle class (Ferrance 1990), the residual population of smokers is not only becoming more resistant to change (the most heavily addicted) but also cluster along socio-economic, and therefore geographic, lines. This creates a certain insularity of the residual smoking population who are most likely to have social networks populated by smokers and workplace environments that permit smoking on the job. They become harder to reach, and therefore require different strategies if they are to be effectively encouraged and assisted to quit. In some cases, this socio-geographic clustering has combined with negative reactions to what is perceived to be patronizing and unfair legislative reform to produce smoker's rights movements and a general solidification of opposition amongst the residual population of smokers. These are not things that most survey researchers think to include in traditional surveys, and without the opportunity for smokers to speak in a more open-ended fashion about legislative reform, they do not emerge.

A third reason for more careful study of the lay smoker's perspective on tobacco control lies in the opportunity to bring smokers on side in the fight against smoking. Insofar as 80 percent of smokers profess a desire to quit (Glynn and Cullen 1989), and as many as 40 percent of those intend to quit in the next 12 months (Pederson 1993), there seems to be a pool of at least 2.5 million (and as many as 5 or 6 million) smokers who are sympathetic (at least in principle) to the general aims of tobacco control in Canada. Creating a venue for "smokers against smokers" to be heard might be a credible and effective means of reaching the increasingly isolated residual pool of smokers referred to above. It is crucial that such a group contain a majority of current smokers, as opposed to former or never smokers, since these latter groups are often discounted by regular smokers as evangelical or lacking in understanding, whose credibility is compromised.

But in addition to mobilizing a forum for "smokers against smoking", systematic feedback on existing legislative reform could be used to help guide future developments in tobacco control to ensure that they are more meaningful, relevant and effective than at present (perhaps by being less inflammatory?). Qualitative research with smokers could also improve our understanding of how to assist

smokers in learning how to live with restrictions and to adapt to the changing tobacco control environment. This is particularly important since many smokers perceive themselves to be stigmatized and victimized by current tobacco control initiatives, which may compromise their willingness to comply or readiness to quit while under pressure.

9.4 RESTRICTIONS ON SMOKING IN THE WORKPLACE

Because many adults spend a significant proportion of their waking hours in places of employment, involuntary exposure to environmental tobacco smoke (ETS; also known as 'side stream' or 'second hand' smoke) has become an issue with many non-smokers. Legislation designed to protect employees from ETS has only been introduced relatively recently, and is patchy in its coverage. Its appearance seems to have been fueled by (a) the declining prevalence of smoking in Canadian society (smokers are now in the minority), (b) mounting evidence that suggest that ETS is not only noxious (unpleasant) for non-smokers, but also causes them bodily harm, and (c) the desire to entrench the health rights of citizens in law. In 1988 the federal Non-Smokers Health Act was introduced (which came into effect in 1990), banning smoking in federally regulated offices and airlines. Also in 1988, the Ontario provincial government passed Bill 194 that restricts smoking in Ontario government workplaces (many other provinces have adopted similar legislation). Provincial and federal legislation provides a minimum baseline standard and paves the way for more restrictive local action. In fact, many municipalities have developed (and continue to create) more restrictive local bylaws. But there continue to be concerns expressed in some municipalities about the possible lack of legal precedent or support for more stringent local tobacco control initiatives. Yet discrepancies in smoking policies exist not only at the provincial level and between municipalities but also between places of employment (e.g. government versus non-government) within municipalities.

A spectrum of possible policies from leniency to total bans thus present themselves for individual work sites, depending in part on their nature (e.g. government/non-government) and size (since larger work sites are more likely to have restrictions than smaller work sites: Fielding 1990; Glasgow, Sorensen and

Corbett 1992). A recent survey of 793 work sites (with more than 50 employees) in the 11 COMMIT intervention communities across North America revealed that 69 percent of work sites had written smoking policies, but that only 15 percent had instituted a complete ban on smoking in the workplace (Glasgow, Sorensen and Corbett 1992). Although the author is not aware of any recent comprehensive worksite surveys conducted in Canada, it is likely that a large number of workplaces have few if any restrictions on smoking because of their size or the nature of their operations. Smaller sample surveys and interviews with Brantford respondents suggest that many work sites restrict smoking to designated areas such as the cafeteria.

Proponents of workplace restrictions sometimes argue that they not only protect non-smokers from second-hand smoke but also accelerate the rates of cessation amongst smokers in work sites where restrictions are imposed. There is now considerable empirical evidence to suggest that workplace restrictions decrease amounts smoked at work, and that they may foster non-smoking norms and stimulate interest in cessation (Sorensen, Glasgow and Corbett 1990-91). However, a number of studies have failed to demonstrate significant reductions in employee smoking prevalence as a result of restrictions (Gottlieb *et al.* 1990; Daughton *et al.* 1992); although restrictions coupled with active workplace smoking cessation programs appear to be more successful (Sorensen, Glasgow and Corbett 1990-91; Glasgow *et al.* 1991).[1] Survey research suggests that a majority of smokers (as well as non-smokers) support the principle of some restrictions on smoking in the workplace as a matter of common courtesy to non-smoking colleagues (Millar 1988; Millar and Bisch 1989; Peterson *et al.* 1988; Pederson *et al.* 1986; Pederson

[1] Several caveats to these findings should be noted. First, contextual factors such as physical work setting (size, local weather, ventilation), social environment (morale, smoking norms), and external environment (state and local legislation) have a significant bearing on the nature of implementation and the reception of workplace restrictions (Gottlieb *et al.* 1992; see also Glasgow *et al.* 1991). Second, it is possible that while many smokers profess a desire to quit, in practice few are willing and ready to quit *now*. On the basis of a multiple worksite survey, Abrams and Biener (1992) have estimated that as few as 8 percent of smokers are currently ready to quit. Furthermore, it is evident that blue collar workers are less likely to be ready to quit than white collar workers, despite (or because of?) the preponderance of smokers in the former group (Abrams and Biener 1992; Brill *et al.* 1991). Third, due to "flawed research designs and/or analyses", including the failure to consider alternative explanations for their findings, many evaluation studies of workplace health promotion programs are poorly placed to make definitive statements concerning program effects (Conrad, Conrad and Walcott-McQuigg 1991).

et al. 1987). In fact even smoker' rights groups acknowledge this (Gillies 1992). However, respondents tended to prefer the establishment of designated areas as opposed to comprehensive bans on workplace smoking (Pederson *et al.* 1987; Gillies 1992; Gallup Canada 1992; USNCI 1992).

Although respondents were willing to take measures to prevent exposing non-smoking colleagues to ETS, they were divided on the subject of whether restrictions are successful in getting them to quit or to cut down the amount they smoke. Surveys in other populations have shown that only 15 to 20 percent of smokers think that further restrictions would make them try and quit (USNCI 1992, Pederson *et al.* 1992). In Brantford, respondents that voiced opinions in favour frequently did so with some reluctance, perhaps in part because of North Americans tend to be suspicious of government regulation of individual behaviour. Smokers may be reluctant to praise government regulation even when it contributes to their own professed goal of quitting smoking. Nonetheless, the feeling amongst this sample was predominantly that one could not help but smoke fewer cigarettes if smoking was limited to a handful of short breaks. In areas where workers are forced outside to smoke (workplace ban), the harsh winter climate in Canada is an added inconvenience that made some respondents question the sanity of their habit or of the legislators who put them there. Several respondents reported that in previous jobs where there were no restrictions they often had a cigarette lit even if it was mostly left to burn in the ashtray. Some respondents also said that when they were busy, they hardly noticed the time go by and sometimes missed a break and the opportunity to smoke. Conversely, those whose jobs were highly stressful or boring were less favourable in their evaluations and tended to find it harder to quit or go without.

> Well, it puts restrictions on you, because you can't smoke from the time you get there to your break and after you're going into lunch and then after lunch into your next break, so it definitely puts those kinds of restrictions. Last year I had a job where I could smoke at my desk... and I had another part-time job in a school, and it was out, it was public school, so there was no smoking area. So I went the whole morning without a cigarette and that was fine, I didn't have a problem with that. But then, in the afternoon when I could smoke at my desk, especially if it was pressured, or a lot of people would stop and drop in - and a lot of those people were smokers - then, yes I smoked a lot more in the afternoon. So.... I, I think, although sometimes it annoys me, I think that restricting areas.. is helpful. You know, it allows you to know that yes, you can do it. You can go without a cigarette and you'll survive and the world won't fall apart, you'll be okay. (Jessica 16, 119-134, 761-765)

Amongst those who acknowledged some impact of workplace restrictions on their own smoking behaviour, several indicated that while they resented the restrictions, they felt they were perhaps being done a favour. Several indicated they would welcome even more stringent regulations, and some of them had devised rules for themselves to limit their smoking at work as part of their own cessation strategies. Bob summarized perhaps better than most what many of the other smokers were thinking in this regard not just about workplace restrictions, but about restrictions in general:

> Oh, yeah, it has to help people cut down. I mean,... they're going to resent the hell out of it, but yeah, it'll help people cut down. I think it's a double-edged sword. As much as I hate the fact that it's being regulated to the point where it's really depriving people of their individual rights.. like I'm not political, but that gets me. That's the big brother syndrome.. I think those individual rights and freedoms being stepped on are unfortunate. Then again, I like the fact that people can take their children out and not expose them to second hand smoke. I like the fact that you can go into a restaurant and enjoy your meal without smoke wafting from - because I know I don't like that. I know when I'm eating I don't like second hand smoke. But, who knows, yeah, the medical costs, the health care costs of people smoking. I think it would be absolutely fabulous if Canada could be a total non-smoking, you know, as soon as you cross the border you're in a non-smoking environment. Like, that would be fabulous but you know, unfortunately it's not going to happen. I think the best thing that we can do is educate our kids and truly do what's being done: make it socially unacceptable. I really resent some of the extremes that people are going to, you know, wanting to take their co-worker to court, things like that. I think that's ridiculous, but then again, you know, that's just people. I mean, you're going to run into the jerks wherever you go. But the fact that it's restricted in the work place, I like that it's - well, I shouldn't say I like that it's happening, but I respect why it's happening. I just, I resent the way it's being done sometimes. I mean, the end result is good. There's no - I had absolutely no question of the fact that anytime you can stop a person from lighting up a cigarette, whether they resent the fact or not, you're doing them a favour, you know, and the people around them a favour. So yes, certainly it causes people to smoke less. People resent it and I'm not exactly sure I agree with the way it's being done but the results are... [good] (Bob 39, 907-950)

This is noteworthy in several respects. Firstly, the support of a smoker for the promotion of smoking cessation is in evidence and presents an opportunity for the idea of "smokers against smoking". Secondly, it demonstrates the contrast between support for the principle of tobacco control on the one hand and resentment over its practice on the other (see below). In fact there is some evidence to suggest that frustration over restrictions as experienced and perceived by those targeted by the legislation caused some people to voice evaluate negatively its impact on their own smoking behaviour. For example, some smokers (10 of the 45 interviewed) followed an acknowledgment that they smoked less during the day at work with a statement to the effect that they consequently smoked more during breaks or in the evening and

on weekends at home. Of these, the majority indicated that this resulted in "making up for lost time", with the implication that as far as their overall levels of smoking was concerned, the restrictions had been largely ineffective.

> No, it makes them smoke more. Oh yeah, definitely, because they get outside and it's [makes motion of puffing away in a frenzy] "how many cigarettes can I get in in my lunch hour?" or "how many cigarettes can I get in in my 15 minute break?" They're not thinking about eating, all they're thinking about is getting their smoking in. (Doreen 42, 1236-1248)

> I think in some cases it [workplace restriction] does [help smokers cut down or quit]. It'll cut them down, but then there's others like [my friend] Gina... She finds at work she's cut right down, hardly smokes at all. Puffs her brains out as soon as she leaves that place. She says she goes through a pack in an evening. She smokes more now than she did when she could smoke at work, because now she's just puffing away at night. As soon as she leaves, she says she can't believe how much she smokes. And it's all because before it was kind of spread out over the day, and when you can have something all the time, it's like having a dish of candy in front of you, you're not going to just eat and eat (because) it's always there. (Julia 38b, 841-852)

What is not clear is whether the perception of smoking more heavily during non-work hours can be taken as a reliable indication of whether in fact smoking during breaks and after hours was sufficient to regain "cigarettes lost" during working time.

A number of other reasons were volunteered for why the effectiveness of restrictions could be called into question (Table 2). The notion threading these together was "what good does it do?" (i.e. it does no good), and the examples offered were ones that showed restrictions (as they had encountered them) to be silly (easily thwarted, or meaningless in a factory environment), ineffective ("just make up for lost time"), or even counter-productive (doing more harm than good or causing other problems instead).

Several respondents indicated that restrictions in their workplace were laughable because they were "meaningless". Restrictions were seen to be "meaningless" in two ways: firstly by not being restrictions at all, or being seen to be easily thwarted, and secondly by being seen as trivial. Two respondents indicated that their workplace had instituted a policy that allowed smoking in the one or two square feet in which each worker stood on the assembly line. This meant that while the workplace legally conformed to provincial regulations (Bill 194) stating that

designated areas cannot exceed 25 percent of the floor space, in effect there were no restrictions at all: they were "a joke".

> There is not in the office, but.. you can smoke pretty well at will in the plant. [At one time] there wasn't any smoking in the workplace period, in the plant as well. Well, what happened was they just had a mutiny on their hands in the plant. The guys said "We're smoking! You know, what are you going to do? Fire all of us?" And so they eased off on the rule and said "well, okay in the plant if you're at your work station fine," and really the plant, I mean there is so much noise and smoke and welding fumes and machines starting up that, you know, and it's a big high, high building so... (Pat 19, 96-113)

For some respondents this was clearly a disappointment, given that they were looking for encouragement to quit.

> The last time I quit lasted maybe a couple of weeks or whatever, then I was right back at it. [smoking again].. But I wasn't smoking at work. I figured ..this new law was going to come in and they were going to just ban the smoking altogether, which wouldn't have bothered me one bit. But they didn't, and what they've done is these 'designated areas'. Now you can have a square foot in your own work area [where you're allowed to smoke]. Which as far as I am concerned is just like going back to the old ways as it was. (Mark 14, 58-78)

Restrictions were also seen to be compromised when service personnel were prevented from smoking in public areas of the workplace but free to smoke "backstage" in their own offices or shop floors (e.g. movie theatres). In addition, 5 respondents said they regularly smoked in the bathroom and thus more frequently than at breaks in formally designated areas.

A second way in which regulations were made to appear "meaningless" was to trivialize their importance. As in the preceding quotation, several factory workers marveled at the apparent irony of worrying about ETS while working under dangerous conditions or while being exposed to a variety of chemical agents and dust.

> Jim: Yeah, well they had their map of where you can smoke and you can't smoke here ... but where you can't smoke is empty spaces (laughs)
>
> Author: So nobody paid any attention?
>
> Jim: No. Well... even people who don't smoke it doesn't bother them because it's a pretty dirty place anyway so the cigarette smoke... it's not like *you're in an operating room or anything* so the cigarette smoke is *not going to matter a hill of beans in the factory.* (Jim 4, 301-311, emphasis added)

In this context, its noteworthy that research has shown workplace exposures to toxic agents and cigarette smoking to have synergistic effects that exceed the sum of their individual impacts on workers' health (Ferguson 1988; Tola 1982). These more complex understandings of etiology may not be part of the lay smoking-related folklore, at least among this group of tobacco users.

Another dimension of workplace restrictions perceived negatively by respondents involved apparent counterproductive effects: 'doing more harm than good', or 'solving one problem by creating others'. For example, one focus group talked about how they had heard that tests had shown air quality in many work sites had deteriorated since many had moved from designated areas to a complete ban, since there was less vigilance to change air filters without the visible threat of cigarette smoke. Several respondents also said they felt that the workplace would suffer as smokers being forced outside would mean more "down time", that less work would get done as smokers had to excuse themselves to smoke. Several also said that they felt that the sight of smokers huddled outside the front of office buildings looks unsightly and pathetic.

> ...look at the front steps of any federal building you walk into. It's strewn with employee's cigarette butts. It's ugly. It's awful. Tourists come to this country, and to me it looks like crap. They're seeing a side of our country that they never would have seen had it been left smokers in this room, non-smokers stay out. Plain and simple. You know, instead now they're saying to the smokers go outside, dirty our sidewalks. Now they're going to start complaining about the fact that filters aren't going to biodegrade or something (laughs) you know. I can just hear it, like that's going to be the next thing because they're going to get sick of seeing the smut outside the door, because who's going to have an ashtray outside? In the middle of winter and blowing wind... Then the employees are off work sick and they're saying "oh, it's because they smoke". Well, it's not because they smoke, it's because you won't allow them to smoke in a room. (Julia 38b, 1193-1207)

This also raises another element of the "counterproductive equation": that a complete ban on smoking in the workplace, as opposed to designated externally ventilated room, was seen by many respondents to be a regressive, unfair, failure to compromise on the part of a minority of 'anti-smoking zealots'. Perhaps arguments about worsening air quality and pollution in front of buildings arose out of anger at being "shoved outside". The majority felt that a fair compromise would be to establish separately ventilated designated areas rather than a complete ban, thereby

accommodating the wishes of both sides, or so the argument went. This notion of fairness appeared to be central to respondents' perceptions of tobacco control.

My research with smokers seemed to reveal two limitations of workplace smoking restrictions: firstly, that territorial limits do not appear to resolve social influences to smoke, and secondly that there are considerable socio-economic variations in workplace environments. It could be suggested, based on the testimony of this group, that restrictions are more effective in providing smoke-free environments for non-smokers than for smokers. That is, (a) smokers appear to band together and provide social support for maintaining the habit even when restrictions are in place; and (b) unlike many non-smokers, smokers appear to have plenty other occasions to encounter smoke-filled environments both inside and outside the workplace. Even in workplaces where smoking is banned completely, respondents spoke about a certain camaraderie that develops between smokers who, together, face adversity. Respondents recounted many stories of coworkers who they considered "partners in crime" for whom smoking was something they would "go off and do together". So if friends and closest coworkers tend to be smokers then that becomes the social milieu, and the immediate social norms ostensibly fostered under these circumstances are hardly conducive to the maintenance of cessation for smokers who do try and quit. This is significant, because nearly half of all smokers have tried to quit at one time or another (Gerstein and Levison 1983).

> Quite a few of [my coworkers] do [smoke]. Yeah. My people are the people that smoke, so, that's who I sit with my lunch and coffee breaks. So... (Carol 8, 233-236)

> I worked part-time as a waitress and almost all waitresses smoke, I noticed. It seems to be the kind of thing where you get a break and everybody's there puffing on a cigarette. So I think that contributed to [my] smoking, too. (Mary 22, 178-181)

In fact, 10 of the 45 respondents reported having felt pressure to continue smoking from coworkers. In some cases they had been actively discouraged from quitting , had been the object of humour for thinking that they could be successful, or had had bets laid on how soon they would "fall off the wagon" after having quit. For example, Tricia said her husband had trouble at work when he quit:

> Then he had to take the teasing at work, you know, because there a lot of people still smoking and then they'd have bets on who's going to start and... you know, they're sticking them under your nose all the time. But that's another thing that I can't stand, is... the people who "here, have one, have one". I think it's because they want the

> companions to do it with and it's so much more fun if everybody's doing it. (Tricia 18, 1325-1347)

It may be that even in the absence of overt pressure, some smokers feel the need to fit in with the majority in their social milieu. It appeared from their testimony, that other smokers were more likely to ridicule the efforts of peers to quit when in the presence of other smokers. Likewise, it seemed that non-smokers felt more comfortable making comments about smoking when they were in a majority and had restrictions on their side. In fact, one respondent suggested that employees keep a sort of informal "report card" of the smoking status of coworkers. It also seemed that some respondents did not want to be the last one to remain smoking

> I work in (this firm). There's me and three other people that work in the office. Well, one person just left, and that was one of the smokers, so...there's just me and another person in the office that smoke and the other two don't. And, you know, we always kid each other about it - now we got an extra smoker or now we're less one smoker or, you know, that type of thing. "Well, I'm going across the street for my nicotine", that type of thing. You're always kidding each other about that. So, every day it's brought up at some point (Rick 38, 274-287)

> ...at the time I was working at a different place and a whole bunch of the girls [*sic*] were going and getting it done [hypnosis] and everybody was quitting. And I think that maybe because they could do it I wasn't going to be the one who couldn't? (Leslie 10, 307-313)

> Yeah, because - well, I work in the hospital, in (such and such department). There's eight girls [*sic*] that work in there, two of us smoke. So it's like - when we go for break, we have to go outside, so when you get up from the table to go outside - you're getting comments. "When are you going to quit?" ..So it's like you've got to fight them off all the time and, "Leave me alone" so.. you know. [But] I can understand where they're coming from too, eh? (Debbie 41, 1074-1085)

> In our office, of about eight people... two out of eight [smoke]. Yeah, so it's always coming up. It's always throwing itself in your face or it's walking in to the office and there's a no smoking sign and walk into the washroom, you don't smoke in there.. uh.. its everywhere. (Peter FG2, 1275-1279)

It seems plausible, therefore, that interpersonal dynamics regarding smoking within work sites are more closely linked to the composition of one's immediate network of co-workers than to the type of formal restrictions in place. Certain types of employment such as trade jobs, drivers, jobs with high risks, stress or boredom may contain disproportionate numbers of both working class people and of smokers. These micro-environments that favour smoking have a distinct "socio-geography" that warrants closer attention, for these may also be the environments in which restrictions are less likely to be adopted or enforced. For example, 42 percent of

professional respondents and only 17.4 percent of the working class sample reported that smoking was prohibited in their place of work. Twenty-two percent reportedly had no restrictions (35 percent of the working class and 14 percent of professionals). Forty-six percent of the sample reported having designated areas. Complete bans seemed to be more common in government-owned or government-occupied workplaces including education and health care. And there seemed to be a clear distinction between office environments and the "shop floor" as well in terms of whether (and what kind of) restrictions have been adopted. While this sample is small, the trends are plausible and suggest a socio-economic gradient in (a) the application of workplace restrictions; and (b) the sorts of workplace environments that encourage or discourage smoking. These conclusions appear to be reinforced by survey research in the United States and Canada indicating that blue collar workers are less likely (a) to be employed in settings where smoking is restricted (Glasgow, Sorensen and Corbett 1992), or (b) to be influenced to quit as a result of legislation in that they are more heavily addicted, have greater difficulty adhering to restrictions, and live in a social environment that is more supportive of smoking (Abrams and Biener 1992; Brill *et al.* 1991). Furthermore, blue collar respondents in this study were more likely to encounter smoking in the home and in other non-work environments, perhaps further minimizing the impact of workplace restrictions. For those of working class background who held clerical positions in "middle class working environments" (Marilyn, Rick, Mary and Shelley), this seemed to present something of a dilemma:

> I find even in the professional world, in my professional work, I'm one of the very few smokers. Socially I'd say I'm surrounded by them, so...
>
> Author: (laughs) It almost gives you a bit of a schizophrenia or something?
>
> Yeah, oh yeah, it does, because often, too, people look at me and think I don't look like a smoker. And I don't know what smokers are supposed to look like, but... Because most of the time [coworkers] have known me for years and they'll never see me smoke. And then they'll see me and they think, "You smoke?" and I said "Oh yeah..". But, depends on where on I am... (Shelley 26, 845-862)

Respondents found different ways of coping with the changing environment and learning to live with the new restrictions, although they may never be very comfortable in smoke-free settings. In one focus group, for example, Shaine told the group what it was like for her as a smoking teacher in a smoke-free school.

Shaine: And for [smokers], in fact, it's pretty painful in some ways to go all day without smoking or to you know, have to rush out. Like I get five minutes between classes. I don't have time for a cigarette and then I'm not going to run outside to the smoking area where the students are (laughs) and hang out with them and swear and stuff. (laughter) But it makes it sometimes really difficult if stress is one of your reasons for smoking.

Peter: Can you not smoke in the staff room?

Shaine: No, we're not allowed to smoke in the building at all.

Blake: There's an area of the playground or something?

Peter: The playground! (laughter)

Jessica: In their high heels?! (more laughter)

Shaine: Yeah, well, we got a football field, yeah. (laughter) A couple of teachers hang out down in the boiler room. (more peels of laughter) And see it's so degrading, you know. It's so degrading.. Like I go out sometimes and sit in my car and I'm sitting in my car smoking a cigarette and kids are walking by, "Hi, kids" (makes embarrassed wave), you know, like it's just... It's ridiculous... and it becomes really stressful, because there's no [place to smoke], and you're told you can't have a cigarette you think about it more, and.. you become more and more uptight. (FG2, 1308-1358)

Despite the comic nature of their predicament, it must also be a painful one for many smokers. And while several admitted that the rising "nuisance factor" was accelerating their readiness to quit, others wondered what good it would do for those who were still too addicted to be able quit.

[The increasingly negative social evaluation of smoking] makes you feel bad, it makes you feel that you're doing something that's dirty and it does all them things, ...but what good is that? You know, that's like taking a two year old and telling him what a bad boy he is and what he's doing is naughty and this, that, but not showing him an alternative way of behaviour. It does all what it's set out to do, but.... I don't know, maybe some people have more will power than me or, I don't know, but, it does get the message across, there's no doubt about it. But then where do you go from there? You carry on smoking and feel bad because you're smoking.
(Anne 1, 1212-1227)

9.5 RESTRICTIONS ON SMOKING IN PUBLIC PLACES

Federal, provincial and municipal legislation in Canada has conspired to make a growing number of shopping malls, restaurants, airplanes, buses, trains and other "public environments" smoke-free or to limit smoking to designated areas of these establishments. Virtually all the smokers interviewed agreed with restrictions on

smoking in public and viewed it as a reasonable courtesy to non-smokers.[2] This is crucial because, in the absence of formal enforcement, sanctions are maintained primarily through interpersonal social relations and social norms.

Although human societies develop many context-specific 'rules of conduct', the apparent freedom of choice within a class of possible accepted behaviour blinds us to the constraints regarding the nature of the choice set in the first place (Goffman 1963a). Goffman (1959; 1963a; 1963b; 1971), who has written extensively about behaviour in public places, turned his attention, not to the perpetrators of 'inappropriate behaviour', but to the rules and social circles that are offended. He devoted himself to explicating the complex and implicit social order of moral norms regulating human behaviour, of which public order is a subset concerned with conduct in public. Goffman's work is useful in this context because it helps us identify the taken-for-granted ways in which social sanctions (not just formal legislation) govern the behaviour of smokers in public. The public realm can be defined as "those non-private sectors or areas of urban settlements in which individuals in co-presence tend to be personally unknown or only categorically known to one another" (Lofland 1989, 453). In contrast to earlier stereotypes of urban life as essentially cold and impersonal (or more properly, non-personal), it is in fact the case that the public realm is thoroughly social, and that some of the 'impersonal' feeling of big city life is precisely because of social (i.e. learned) codes of behaviour limiting and governing the nature of 'appropriate' interaction with 'strangers'.

The work of Blumer (1969) and Goffman suggests that a number of interactional principles govern public behaviour. One class of these pertain to the social etiquette of movement in the public realm, such as how to negotiate crowded streets, find a seat on a bus, and so-forth (Lofland 1989). Another class of interactional principles refers more directly to interpersonal social conduct, of which three are predominant: (a) civil inattention (somewhere between non-person treatment and staring: acknowledging the presence of others but not routinely

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[2] Although this could certainly be an artifactual result of volunteer bias in a small sample of self-selected smokers interested in quitting, survey research conducted by Pederson and colleagues (Pederson et al. 1986, 1987) in Ontario suggest that indeed the majority of smokers support the some form of restrictions on smoking in public places.

engaging them); (b) audience role (public life as theatre; see Goffman 1959); and (c) civility towards diversity (being civil towards what you would usually find offensive by not drawing undue attention to it or approaching the person directly) (Lofland 1989). These interactional principles conspire against people routinely drawing public attention to the fact that someone is smoking in a non-smoking area or that their cigarette smoke is bothering others, because people are reluctant to "make a scene" or to draw attention to themselves, and because it is not usual to approach strangers about their behaviour. However, the temporary suspension of these 'rules' is a powerful method of bringing the behaviour of 'offenders' into line (Goffman 1963a; 1963b). Staring, for example, is impolite and causes discomfort to the recipient. Likewise, sideways glances, body language, throat clearing, fake coughs, moving to another table and other actions can serve as non-verbal cues that one's (smoking) behaviour is inappropriate. Goffman's work suggests that these are some of the mechanisms by which changing norms about smoking in public could be communicated by non-smokers to those who violate social etiquette and legislated restrictions.

It has been suggested that "threats of shame, a self-imposed punishment, and threats of embarrassment, a socially imposed punishment, function much like threats of state-imposed legal sanctions to reduce the expected utility of illegal behaviour and, thus, to increase the likelihood of compliance with the law" (Grasmick, Bursik and Kinsey 1991, 233]. Anti-littering campaigns such as "Keep America Clean" (Grasmick, Bursik and Kinsey 1991) or anti-smoking educational programming can bolster social sanctions, increasing threats of shame or embarrassment. In fact, public opinion surveys suggest that 76 percent of Ontario residents would comply with more stringent regulations even though many were not in favour of them (Pederson *et al.* 1986).

The basis of many social interactional rules seems to be the minimization of "obtrusions" in terms of "a claimant press[ing] territorial demands into a wider sphere than others feel is his due, causing them to feel that they themselves could be seen as functioning intrusively, even though they feel that this is not the case" (Goffman 1971, 51). This is achieved by encroaching on the personal space of others, not just in direct physical terms, but also for example through sight, sound or

smell. Since territories of the self can be geographically fixed (home, private property), situational (use of office space and its layout, or appropriated public micro-spaces such as the park bench or picnic table), or transportable (so-called "personal space"), as an air-borne pollutant smoking has the potential to violate all three.

Goffman also observed that people in relationships do things that would violate personal boundaries if done with strangers, such that in fact the sharing of these things becomes a marker of intimacy. Perhaps the same could be said of cigarette smoking, in that spouses perhaps feel that they must put up with ETS as a 'natural' consequence of marriage to a degree that unrelated others usually would not. This hypothesis fits with the observation that we voluntarily take on greater risks than we would be comfortable having thrust upon us. Pursuing this line of reasoning might provided a clue as to why smoke in a bar is tolerated, where entry is voluntary and exposure expected as commensurate with the territory, whereas it is not generally as tolerated in malls or the workplace where one's presence is less voluntary and interaction assumed to be less intimate.

Complicating matters for the smoker is the fact that some interactional principles pertaining to behaviour in the public realm would appear to be in conflict with others. There are circumstances in which smoking may still be socially useful even though its acceptability in general is declining. For example, a cigarette or a light offered from or accepted by a stranger serves to break the ice and establish reciprocity and friendship through exchange as an extension of hospitality, and smoking has long been a symbol of identification in and of itself (status, rebelliousness, risk-taking, care free etc.) (Robbins and Kline 1991). Smoking may also contribute to social competence by helping one be more composed (management of negative emotions) or improving vigilance on the job (occupational role adaptation). And because of the need to appear to be actively going about ones business (social sanctions against loitering), having nothing to do or doing nothing may be socially frowned upon in our society, so that certain rules of disengagement apply for people who wish to withdraw momentarily from the bustle of activity (Goffman 1963a). Smoking seems to have had a history of being one of those

socially sanctioned excuses for inactivity and temporary withdrawal ("oh, she's not doing nothing, she's having a smoke").

This state of flux regarding what rules of public conduct apply to smokers and under what circumstances, has perhaps created confusion and uncertainty for smokers about "coming out" in public about their habit. People who smoke may therefore have to actively search for supportive environments to engage in the act of smoking (other smokers or places where smoking is permitted). This constant uncertainty may in turn become normalized as "par for the course" of living with social restrictions on one's behaviour.

> I've found that I've become more and more aware of non-smoking places now because I'm looking for a place to smoke. You know? (general agreement from the group) You walk into a place and of course, where's the sign? (laughter and talking) .... here or not? So yeah I've become more aware of that, whereas maybe three or four years ago it was not a big deal, whereas now ok, I look all the time. I have to know where I can smoke, where I'm going to sit... It becomes second nature.
> (Rick FG1, 810-817)

The situations that are conducive or discouraging of smoking would therefore appear to have a distinct geographic distribution as well as temporal and social distributions. The concept of "behaviour settings" (Fuhrer 1990) or "interactional settings" (Thrift 1983) as they apply to the individual's "life space" seems particularly appropriate to this discussion, since it distinguishes psychological from non-psychological aspects of behaviour settings as culturally constructed but individually mediated interactional and activity micro-environments with their own cultural codes of conduct (e.g. one behaves differently in a library than in a bar) infused with situational characteristics (e.g. being in a restaurant with work acquaintance versus with a lover) and temporal life cycle factors (organization of the 24 hour day, changes in the nature of a setting over time). This allows one (a) to close the "gap" between psychology, geography and sociology through careful specification of the parameters and roles of behaviour settings in terms of individually apprehended reality and the "foreign hull" of the ecological environment (the denotative geography and topography of the setting) (Fuhrer 1990); and thus (b) to identify behaviour settings in which smoking is more permissible or less (e.g. bars versus the maternity ward), and to chronicle (and account for) changes in the rule-structures guiding behaviour in public space to which participants must adapt.

Given the cultural history of private property rights, individualism and public responsibilities of citizenship in North America, it is to be expected that one of the primary distinctions governing the categorization of space for smokers could be that of public versus private space. It is perhaps expected that there are limits to permissible public behaviour but greater leeway about what one does 'in private'. With respect to public space, acknowledgment of the "reasonable" claims of non-smokers to smoke-free air, means that smokers may be faced with two alternatives. One alternative is to adopt the etiquette of the "considerate" smoker so as to minimize the effects on others. Smokers themselves have drafted such "guidelines for the courteous smoker" (Smokers' Freedom Society 1992), reflecting the need to be sensitive to the reduced social acceptability of smoking in Canada. The other option open to smokers is to gradually retreat from the public realm altogether. The respondents in this sample seemed to be overwhelmingly of the 'considerate' variety, but they seemed to feel that a retreat from the public realm was increasingly being required of them anyway, whether they liked it or not. Some spoke of a day when smoking, like sex, would be something that was done within the confines of your own home between consenting adults.

While anticipating further encroachments on their "rights" as smokers, some respondents felt the need to "draw the line" beyond which "government interference" would be intolerable to them. They felt that what they did in their own home (i.e. 'in private') was their own business. Yet these are the environments in which family members are probably the most heavily exposed to side stream smoke. As a result, the implication of smokers' protestations that their behaviour 'in private' concerns no-one but themselves is often untrue. Yet it is not clear how legislation could regulate smoking behaviour the home, except perhaps though the courts as people sue their parents for abuse due to ETS.

It is also ironic that while the home is a sanctuary for smokers, those who succeed in quitting may feel unable to control the smoking of others in their own home. The reluctance admitted to by some respondents to ask visiting friends not to smoke seemed to reflect a more generalized fear that their quitting would create a rift in their friendships. It seemed that such a rift could be made to occur in at least three

ways: (a) being more edgy or "bitchy" due to withdrawal symptoms associated with quitting; (b) feeling it is risky to ask friends who visit not to smoke; and (c) reluctance to encourage friends to quit for fear of appearing to "evangelize" to them. Yet it has been shown that ex-smokers must surround themselves with non-smokers if they are to successfully maintain abstinence (Ferguson 1988; Secker-Walker *et al.* 1990; Shiffman 1982), and studies indicate that the social network patterns of ex-smokers more closely approximates that of non-smokers than of smokers (Venters *et al.* 1987). Therefore the reluctance to alienate smoking friends creates both a dilemma and a danger for many smokers, in that it weakens their motivation to quit and maintain abstinence.

If the behavioural rules and norms governing smoking in public and private space seem convoluted, in a state of flux, and even contradictory, then those pertaining to the contested territory of privately owned but publicly used spaces are potentially even more problematic. There seemed to be less agreement amongst respondents about what constitutes a 'fair' compromise between smokers and non-smokers in places such as malls and small private companies, although, as a rule, designated areas were preferred to outright bans. This is supported by survey research in larger populations which suggests (a) there is greater support amongst smokers for bans on smoking in schools, and public transportation than in restaurants (Pederson *et al.* 1987) and (b) that a majority of both smokers and non-smokers consider the responsibility of designating non-smoking floor space in restaurants (and stores) to be the responsibility of owners/managers and their clientele (Pederson *et al.* 1986; Pederson *et al.* 1987) rather than government. The same polls show that people preferred legislation to come from local government than from provincial or federal authorities. Although no explanation was given for why this might be the case, it could be argued that people considered local government to be more accessible (less like 'big brother'). In fact, the role of local government *has* been increasing as both an object of and an agent of regulation in many areas of public policy, and this has contributed to uneven public policy development between municipalities (Goodwin, Duncan and Halford 1993), in tobacco control as in other issues.

9.5.1 The regulation of public behaviour: social class and the appropriation of public space

Restrictions on smoking can be seen as being consistent with - and an outgrowth of - a long history of regulation of public behaviour. There are legal (and social) sanctions prohibiting public nudity, loud noise, the use of skateboards, bylaws requiring one to keep dogs on a leash and so-forth that apply to public parks and other places. Insofar as public spaces are created and maintained in the interest of the public's welfare, then restrictions on noxious behaviour that might impede other people's enjoyment of those areas seems logical and in the interest of the public welfare. And since ETS can be shown to be deleterious to the health of non-smokers, restrictions are consistent with a history of public health legislation governing restaurant food quality and other aspects of commercial and private activity that might compromise the public's health. However, the result of these restrictions is that so-called 'less desirable' groups (vagrants, informal retailers, alcoholics, the elderly, and groups of teens) are often systematically excluded from public spaces. Sibley (1988) traces this to a more generic and long-standing trend towards the purification of (social) space, which involves the "rejection of difference and securing of boundaries to maintain homogeneity" (Sibley 1988, 409). He argues that the tendency towards social, economic and geographic segregation of social groups from one another feeds on itself, in that "distancing and a narrow range of encounters contribute to the stereotyping of 'others'" (Sibley 1988, 418). Furthermore, the purification of space is furthered in part by (a) the universal need to classify, and, following classification, to view that which doesn't fit adversely, and to develop rules to exclude those; (b) the practice of science, which abhors ambiguity and vagueness (thereby promoting classification); and (c) the tendency of geographers to deal in absolute boundaries and homogeneous spatial categories, so that "social practices which oppress groups seen as polluting or disorderly have rarely been challenged" (Sibley 1988, 416). Insofar as "nonconformity is more likely to be recognized in a purified than in a heterogeneous community" (Sibley 1988, 419), then the fact that the middle class and elites live in more purified (controlled, controllable, exclusionary) environments than the working class suggests that they have a lower tolerance for behaviours such as smoking which are less common amongst the elite. This may help explain some of the moral overtones that seem to flavour the anti-smoking movement at times. It also raises a

fundamental question about who controls public space and to what ends, and therefore the power relations implicated in - and social control overtones behind - the anti-smoking movement.[3]

The notion of control features prominently in the definition of health promotion, but there is a gap between rhetoric and practice in this case. Insofar as control can be defined as "the ability of an individual or group to gain access to, utilize, influence, gain ownership over, and attach meaning to a public space" (Francis 1990, 158), it is possible that marginalized groups, including smokers, have less and less control over (access to or meanings vested in) public space. There are those who would argue that perhaps in the case of smoking this is as it should be. But viewed in the context of social class and the appropriation of public space, perhaps it should give pause for thought. Lee (1972) has noted that middle-income people often have different norms and expectations about control of public space than lower income people. According to Lee, the middle class tends to view public spaces as not for the appropriation of any one group, and they rely on formalized modes of social control based upon notions of public morality bolstered by the law and its enforcers. Lower income groups, on the other hand, were found to view public space as regulated informally rather than through external agents such as the police (i.e. people watch out for themselves), and it being appropriate (even necessary) that each group have their own area to do their own thing in order to be comfortable. In addition, it is likely that groups of lower socio-economic status have fewer opportunities for recreational space, tend to rent apartments, and need public space for a variety of functions, since they do not have comfortable suburban homes with private yards to entertain friends, for example. Since these are the groups in which smoking is most prevalent, the result is that those most in 'need' of public areas to smoke are the ones hardest hit by the restrictions. Smokers who do not have a comfortable (physical or emotional) home life may need to make even more extensive use of public space. For example, ex-psychiatric patients (many of whom

[3] On the other hand, the tobacco industry has usually been quick to use similar libertarian arguments to justify their opposition to smoking restrictions. I do not wish to suggest that restrictions be removed or not enforced. However, also do not feel that fear about how the tobacco industry might 'have a field day' with a certain line of reasoning should prevent one from critically and reflexively examining some of the possible unintended consequences of professional practice. It is also notable that regulations target the behaviour of individuals, while publicly used spaces in the US, for example, continue to be available to the tobacco industry in the form of billboards.

smoke) must often vacate lodging homes during daytime hours, and in winter use regulated indoor public spaces available to them. It is noteworthy in this regard that some of the areas that have hitherto escaped regulation with respect to smoking are ones that are less frequented by middle class families: bars, dance halls, bingo halls, outdoor concerts and public parks. To return to an earlier point, these also appear to be the 'behaviour settings' in which smoking is the most permissible.

It is therefore conceivable that public places are manipulated by those with power to exclude (discriminate against) certain (primarily low SES) groups, even if this is not the conscious intention. "The attempt by an individual or group to affect, influence, or control people, phenomena, and relationships, by delimiting and asserting control over a geographic area" (Sack 1986, 19) is a definition of *territoriality* that seems a propos in this context. Territoriality involves specification of an area, communication of the restrictions (e.g. signage), and enforcement (or threat thereof), and in many societies it represents an institutionalization of human relations in space (Sack 1986). Sack maintains that the inherent tendency towards increasing categorization and depersonalization of public space is experienced as cold and impersonal at the micro level, and it focuses attention away from the exercise of power to the (spatial) objects of its control.

The work of Francis, Lee, Sack and Goffman collectively suggest that one of the results of tobacco control activities as presently constituted and deployed in space and time, is the intensification of existing inequalities at several levels. These inequalities are primarily socio-economic (and therefore also geographic), and pertain to the clustering of smokers (and of environments conducive to smoking) in economically and educationally disadvantaged groups, and geo-social irregularities in the application of healthy public policy between and within municipalities and between work sites of different types. This is more or less predicted by diffusion theory, which states that early adopters tend to be the urban middle class, with rural and lower SES groups being slower to adopt material and behavioural innovations (Rogers and Shoemaker 1983; Ferrance 1989).

However, tobacco control initiatives are not normally framed in social class terms or as requiring the targeting of particular social groups (more so for

educational initiatives than for legislative ones). The irony is that while disadvantaged groups are potentially disproportionately affected by tobacco control activities, they are not often explicitly targeted, and in fact irregularities in the adoption of restrictive legislation may historically have tended to favour the continuation of smoking in low SES groups. Herein lies a dilemma: one the one hand, the socio-geographic clustering of smoking seems to imply a need for explicit targeting for tobacco control to be effective, and yet on the other hand, the social control overtones involved in the exercise of power by the middle class to control the noxious (and self-damaging) behaviour of the working class and disadvantaged groups seems objectionable. It would seem unlikely, and perhaps ethically immoral, to suggest that the solution lies in suspending tobacco control efforts, but it is possible that part of the resolution of the dilemma lies in how smokers are involved in their own emancipation from addiction, in their fight against the tobacco industry, and in their concern to prevent others from going through the suffering that they have gone through. At the moment, there is some evidence to suggest that targeting smokers (as opposed to the industry) results in stigmatization (see below) and sets up a dynamic in which smokers feel compelled to defend an addiction which they truly wish to be rid of, so that much of the potential for real change and emancipation is lost by not enlisting smokers to work with health professionals in the achievement of mutual goals. The issue therefore one of how the issue is framed and how tobacco control is achieved, rather than whether or not smoking prevention and cessation are laudable (individual and societal) goals.

In closing this section, it should be noted that an awareness of the social and spatial inequities in the impacts of generic tobacco control legislation points to the need to view space, not as passive container, but as medium of social interaction (c.f. Thrift 1983; Sayer 1984), to study place as lived space in terms of who it is that's doing the living (Rodman 1992), and it argues for a reconstituted geography of health that puts *place* back into the experience (and production) of health and illness (Kearns 1993).

9.5.2 Smoking in public as a source of stigma

During the course of this research it became apparent that the testimony provided by respondents concerning tobacco control fell into several distinct groupings that could be symptomatic of three broad categories, or 'ideal types' (Shutz 1962) of smokers: the 'considerate' smoker, and the 'reluctant' smoker, and the 'adamant' smoker. The construction of ideal-types involves the creation of a 'grounded caricature' that unites a group of statements or experiences, with the understanding that in reality few people conform exactly to any ideal-type, but are nonetheless recognizable through them (or perhaps a combination of ideal-types where responses and behaviour are situationally mediated). They should make intuitive sense, capture the range of experience presented by respondents, and be recognizable by them. The testimony provided by this sample of smokers suggests that this might be the case for the typology described in this section. Each of the three ideal-types appear to be distinguishable in how they dealt with restrictions on smoking in public places and growing social pressure to quit.

The majority of the respondents might be classified as 'considerate' smokers, who appear to consider it only right that non-smokers not have to breathe his/her smoke. S/he would like to quit some day, and is willing to compromise in order to accommodate others. The sense among most respondents was generally that this was the new (and appropriate) norm amongst smokers. In the practice of daily living, deciding whether or not to smoke in particular settings was a function of how well they thought it would be received by those around them. In some cases this was seen to be relatively unproblematic.

> ..if they say "Don't smoke here" fine, I won't. I don't feel that's pressure on me as a smoker. [If] you don't want me to smoke, fine, I won't smoke. It's not a big deal. (Beckie 37, 803-806)

But in many cases deference was more than a sign of courtesy: smokers simply did not feel *comfortable* about lighting up around those who were did not smoke. There came a point at which it simply detracted from the enjoyment of smoking.

> I guess it depends on how comfortable I am with the person that I'm with. I had a boss who was absolutely adamantly against smoking and she had reached the point, I guess, where she had given me some respect for who I was... [to the point where] shortly before I left that job, she was quite [willing to] sit in the smoking area [when we go out to lunch together], but "no, it's okay Barb, like I could never enjoy a cigarette in your company, ever". It's like smoking in front of my father. No way.

> I'll just, I'll die with every puff. So.. if you know the person is accepting of it, and it's not offending them, then you're comfortable to do it. I guess that's true with a lot of the social things. (Jessica 16, 454-474)

A number of the smokers interviewed appeared to be what one might classify as 'reluctant smokers'. The ideal-typical 'reluctant smoker' seems to feel considerable social pressure to quit, feels guilty about smoking, and often hides the fact that s/he smokes. S/he participates in social networks at work and/or in their private lives in which non-smoking has become the norm and in which frequent verbal and non-verbal cues serve as potent reminders of the declining social acceptability of smoking. As a result, not only may they feel stigmatized as smokers, but to a greater extent than 'considerate' smokers" or 'adamant' smokers they have internalized this as guilt and self-blame. They have perhaps come to feel that smoking is a personal blemish, and their own behaviour has become a source of social "dis-ease", as exemplified in the following quotes.

> I try not to smoke as much any more when I am in other company because it is so unacceptable these days and they want to make you feel so *shitty*, so when I am out in a social situations I don't smoke nearly as much as I used to, especially at parties and people's homes or meetings (Shaine 13, 195-200)

> It's weird... if I'm sitting at a bench or something like that I won't have one.. because it's too open I just don't like ... I gets to the point where I'm too embarrassed to have a smoke ...because I just don't think it looks good. [Actually] I don't like anything about smoking. (Jane 3, 127-131, 143-144)

> I don't even think it [smoking] looks good. The same with the, the nicotine on the fingers, you know. I don't think it looks good. So, I'm not one to be walking down the street smoking either, you know. [Whereas] when I was a teenager, yeah [I would have] (Tricia 18, 370-379)

Changes in the perceived social acceptability of smoking contribute to the maintenance and enforcement of regulations through self-censorship of public behaviour, as illustrated in these quotations. They may also contribute to the creation of new regulations insofar as there is less resistance to (and, conversely, more support for) legislative controls.

Substantial changes in the social acceptability of smoking have occurred in less than one generation, accompanied by a 30 percent drop in the prevalence of smoking in Canada. Community interventions such as the COMMIT trial contain explicit directives regarding the acceleration of these "positive" social norms. But

human suffering occurs when smok*ers* and not just smok*ing* become stigmatized, which to some extent is an inevitable outcome of changing social norms (see discussion below). Smokers feel "caught between a rock and a hard place": shamed but too addicted to quit. This is what Ferguson (1988) refers to as the "smoker's dilemma".

> [People] smoke because they're addicted to it, not because they're cool, but [because] they're addicted to it (Vincent 25, 514-516)

> [The increasingly negative social evaluation of smoking] makes you feel bad, it makes you feel that you're doing something that's dirty ...but what good is that?... It does get the message across, there's no doubt about it, but then where do you go from there? You carry on smoking and feel bad because you're smoking.
> (Anne 1, 1212-1227)

The preceding discussion suggests that people who smoke may have become stigmatized by virtue of their addiction to a stigmatized habit (smoking). The feeling of being persecuted, misunderstood and unfairly treated seemed to colour some respondents' experience of public space and public life.

Goffman defines stigma as "an attribute that is deeply discrediting" (Goffman 1963b, 3) by virtue of the stereotypes developed about the meaning of that attribute. Social identity is forged in the context of powerful (if implicit) behavioural normative expectations. A person who is stigmatized becomes somehow tainted, weak, handicapped or not quite human, and shortcomings somehow are imputed that go beyond the original "defect". When smoking acquires stigma, non-smokers acquire and project the feeling of being "holier than thou" with respect to smokers.

> Oh, I think there's always that "I'm better than the Joneses" syndrome. "I'm a non-smoker so obviously that makes me smarter and more in control of my life than this person that smokes". I mean, you're always going to run into that group. As much as you can run into somebody who says, "Oh, I don't have a prejudiced bone in my body, but keep that smoker away from me!" You know... you can see the conflict there... (Bob 39, 1021-1029)

Goffman distinguishes stigma from (social) deviance by according the latter an element of free will or volition, a deliberate refusal to live by certain accepted "rules". In this manner it is possible that smokers are both stigmatized and deviant, insofar smoking is (rightly or wrongly) considered an individual volitional activity.

The assumption of choice and the exercise of free will underlying the blame implied in the stigmatization of smokers as social deviants rests on the idea of rational decision-making, which operates on logic rather than emotion, under conditions of full information (conditions of partial information and "utility maximizing functions" are another variant on this model). These assumptions have become cultural norms, but they are at odds with what we know about the effect of advertising and peer pressure on teens, and the role of addiction in maintaining self-destructive behaviour patterns. Smokers themselves have internalized society's tendency to blame the victim, and they often fail to see (or acknowledge) the wider social forces that constitute 5.8 million smokers in Canada (Pederson 1993) as being more than an accidental summation of individual free will. In our discussions about blame, Linda suggested that smokers contribute to their own stigmatization by denying their addiction, and therefore denying the *in*voluntary aspect of smoking.

> I think that all smokers know they're addicted. or they would just stop. You know you're addicted.. but it's, you, you sort of deny that you are, and that denial then sets you up for the stigma. (Linda 31, 747-753)

Goffman (1963b) points out how both 'normal' people and the stigmatized tend to arrange things to avoid chance encounters with one another. This social isolation heightens misunderstanding and reinforces the practice of stereotyping 'others', which then leads to further isolation in a self-perpetuating process. If this was also true of smokers, then it would suggest an insecurity in social interaction with non-smokers about whether their "defect" will be discovered, because it is never known just how one will be received and there is suspicion of what others 'really' think of you. Goffman (1963b) suggests that the results for stigmatized groups can be to instinctively approach others with distrustful shrinking and dread or hostile inflated bravado, and that as a result they are perceived as either too shamefaced (c.f. the "reluctant" smoker) or too aggressive (c.f. the "adamant" smoker). For smokers, sympathetic others who share his/her stigma may become "a circle of lament to which s/he can withdraw for moral support and the comfort of feeling at home, at ease, accepted as a (normal) person" (Goffman 1963b, 20). Thus stigma, together with restrictions on smoking outside the home, accelerates the retreat of smokers from the public realm and the solidification of geo-social ghettos (clusters) of smokers.

> I think also though you'll find a lot more closet smokers out there, because you do feel shame when you light up a cigarette, so you tend to hide. It may not make everyone quit, it just makes you more self-conscious, so you hide out with the rest of the lepers (laughs) and have your cigarette, you know. (Marilyn 32, 540-545)

"Going underground" means more than hiding the fact that you smoke from coworkers; it may mean a general retreat from public life to realms in which the smoker feels more comfortable.

> I feel uncomfortable.. when I'm surrounded by a lot of non-smokers. You know, you get that look like you're doing something dirty and terrible.. But in my own home I feel comfortable, [and] in my car. (Bob 39, 173-176)

> I don't know that [restrictions] will encourage them [to quit]. I think it'll force them to just not be at places where they can not smoke... because it isn't socially acceptable. I don't feel socially accepted to do it where there are [non-]smokers. I think that's why people *look* at you when you smoke. So I'm a real closet smoker, that's for sure. You don't like to be seen smoking lots of times.... But, with friends it's very different. And with smokers, maybe we sort of stick together and we'll smoke if we want to. (laughs) So, it's not a very nice way to look at things, but it is true. (Shelley 26, excerpts from 1002-1040)

Yet even the home or family environment can become hostile to smoking.

> I'm the only one left in my family [who smokes] so I always think I look like some kind of biker broad or something (laughter) when I go to a family thing cause there, no-one in the family smokes, just me... I feel like a disease every time I light up. (laughs) I tend not to, then, because nobody likes it and they all have little kids and they don't want me smoking around their kids and Auntie Shelley's just this awful thing that sits in a corner and smokes (laughs) and I'd rather not do it. (Shelley 26, 474-476, 497-501)

Smokers may react to social pressure by becoming angry or guilty (and often both).

> I mean, everyone makes a smoker feel guilty. I know I felt terribly guilty. When I smoked, I felt like I had the *plague*. You know, like I'm an unclean, unfit person, because I smoked. And that's a terrible feeling. And it's not fair to make a person feel like that. (Cybil 27, 1346-1354)

> I think they're going to have to back off, or they're going to have more people.. smoking underground ..you know. You can't make people feel guilty and bad about themselves. It's not a good thing and that's what the government and everyone is trying to do. "Oh, I know I shouldn't smoke, but...". [Its] ..guilt.... You've got to lay off and let people be grown-ups. I mean you're 45 years old and being told - I was virtually being told I was a bad person. Do you know what that does to you, really? That really makes you feel like hell. ..you know, that you're a bad person because you smoke. You're useless, you're worthless... that is a terrible feeling and a lot of people get it, and I hear so many people - like I work with two girls [*sic*] that smoke. Okay, they smoke, so what, big deal - but, "Oh, I know I really should quit, but..." you know, and, and *you can hear that guilt, it's just dripping.*
> (Cybil 27, 2192-2206, 2221-2240 emphasis added)

One wonders what quality of life improvements, if any, have occurred for these respondents as a result of tobacco control initiatives as they're currently conceived and implemented. Even for those like Cybil and Bev who have been successful in quitting, the resentment and bitterness at how one was treated lives on.

> I don't think I'm more tuned in [to the issues now that I've quit], just more relieved that I'm not on the, on the wrong side of the fence now. I remember before I quit smoking and how angry I was at the government for all this media and all this put down of people that smoked. I was just - I thought that we were people too, even if we had a habit we were still people, you know. (Bev 14b, 472-480)

These descriptions of internalized guilt appear typical of the 'reluctant' smoker. The angry responses appear more typical of a third group in the aforementioned typology of smokers, the 'adamant' smoker, who thinks that regulation and government "harassment" has "gone much too far". Respondents would also refer to the "confirmed", or "ardent" smoker as being defiant and rebellious. While few respondents identified themselves as 'adamant' smokers, the notion of their existence was frequently raised, suggesting the existence of an urban legend among smokers. In fact respondents who seemed resentful about their 'oppression' as smokers often alluded to a sense they had of a ground swell force of tenacious 'adamant' smokers that health professionals would have to contend with. Because of the current public disillusionment with government and politicians in much of North America, the smoker's rights proponents (including the tobacco industry's anti-tax campaigns) seemed to have also tapped into to a more generalized wave of anti-government sentiment. In practice, these categories are not watertight, but while respondents might appear to be an adamant smoker one moment and a reluctant smoker the next (e.g. Cybil, in the quotation above), most respondents seemed to classifiable as preponderantly of one type or the other.

9.5.3 Smokers' assessment of the non-smoking public

Respondents appeared to stereotype not only themselves but also the non-smoking public. Statements about non-smokers seemed to belie a latent classification of number of 'ideal typical' groups, including (a) 'normal' considerate ("reasonable") people, (b) evangelistic former smokers, and (c) a minority of "teetotalling" non-smoking zealots. On the whole, the non-smoking public was seen to mostly comprise normal considerate people who were prepared to accord

smokers "some basic human rights" and compromises (such as designated areas) as long as they were not exposed to much in the way of second hand smoke. The majority seemed to be perceived by most respondents to be reasonable and accommodating, but justified in their desire to avoid smoke-filled environments.

Many *former* smokers were seen to have become irritating "missionaries" in the service of non-smoking, despite the fact that they were seen as the only non-smoking group who could possibly really "understand" smokers.

> ...there are two kinds of [other] people. There are the people who have never smoked who don't understand it and there're the people who have quit and are still on cloud nine, they've still uh... They're zealots. No, they are (pause) It's true, you know, you see a guy who's been an out and outer all his life, he suddenly gets religion and my God, you can't live for him can you? Uh, and that happens. You know, a lot of smokers get like that. (William 11, 1660-1672)

A third group, "fanatical" non-smokers, who (from the perspective of some respondents) were not content with designated areas and wished to strip smokers of every human right and opportunity to smoke, were sometimes fingered as the vocal minority behind more restrictive legislative reform. But aside from isolated incidents involving strangers or reports in the media, many respondents were perplexed about exactly who these "militant anti-smokers" were. The implication in one focus group discussion was that, as a "fringe" group, they may not be representative of the public will. Alternatively, it may be that the 'ideal-typical' 'fanatical' non-smoker is rare in reality and that the pervasive nature of the concept itself constitutes an urban legend among smokers in the same way as the 'adamant' smokers.

> Shaine: Yeah, I don't, that's why I say, I just don't understand who they are. I just don't understand who they are. You can understand people who are truly concerned about health.. the health and welfare of their fellow beings, but I strongly doubt that all of these people..- like what do they want, publicity? Some sort of power thing? What, what do they want? I don't understand.
>
> Peter: I think it's more righteous.
>
> Shaine: Yeah, well, exactly, holier than thou, but, but...
>
> Peter: I, I don't, I don't run across people like, like that too much. You know, I don't know, I know what you mean, I uh...
>
> Shaine: But you do through the media. You know, you hear... Every time a news article, like you, you've just heard, you know. They're thinking of, of banning smoking in all of Toronto and, who's going to control that nonsense and crap that goes with it. And those.. lobbyists are making news. They're there. You might not meet them personally.

Peter: Yes, that's what I meant. I don't really meet them personally.

Shaine: Well, I don't know any personally, either.

Peter: No, not me...

Shaine: That's why I can't figure out who they are (laughter) Who are they? (Its) like Big Brother looking down on us and telling us when we can and when we can't, and where we can and where we can't. (FG2, 1423-1456)

The vocal minority were perceived by some respondents to have "incited others to riot" to create a psychological space in which people could pipe up and voice their disdain for smoking (or smok*ers*) in a way that would have been unheard of (a) five or ten years ago, (b) in other contexts (such as commenting on people's appearance or diet (or other behaviours), and (c) in other geographic areas. The implication from the same focus group discussion was that to some extent opposition to smoking was artificial, manufactured or exaggerated beyond the limits of conventional politeness and decency.

[to another focus group participant:] It's, it's funny when you say the bandwagon. It reminds me of how many people decide that because there is this thing happening, they can be rude about your smoking and stuff. And uh, and it's, I think I might have mentioned this to you, Blake, when I went to uh, Europe, with um, fifty teachers a few years ago and there was a smoking section on the plane and a couple of the teachers were smoking and a few others turned around and asked them not to smoke and they said, "We've got smoking seats. We got here early and got these seats." "Well, you know, you'd better not be smoking around me for the whole trip. There won't be any smoking on the bus, you know," and this sort of thing. We get to France and everybody smokes (laughs). It was great! (laughter) We'd be in the restaurant: there's no non-smoking section, nothing, and I'd pull out my cigarettes and just blow it in their faces. That's because they wouldn't have the nerve to tell any French person to stop smoking, but they thought that they could tell me because I was Canadian and they're, or Ontarian I suppose. You don't go to Quebec and tell people to put out their cigarettes, like, and, and I don't mean that because of any political thing. It's because Quebecers, people in Quebec smoke and there isn't a big smoke lobby, uh, smoking lobby, anti-smoking lobby there. And uh, I loved walking into a coffee shop in Quebec and it was like, whew, can't even see the doughnuts! It's great! (peels of laughter) Come on in with me, folks! And, and, and there's no way. But because of the, of this powerful lobby, people feel they can tell you that I have no right to smoke. That's what I mean by bandwagon, because these are people who probably sat for, you know, fifteen or twenty years with buddies in the staff room and the smoking never bothered them, until people said, "Smoking should bother you". "Oh, okay." (Shaine FG2, 1495-1526)

9.5.4 Typology of positive and negative reactions to tobacco control in general

The specific reactions respondents had to a variety of tobacco control initiatives (actual and proposed) are summarized in Table 9.3. The *types* of reactions they had, as categorizations and thematic abstractions of the material in Table 9.3, are summarized in Table 9.4.

As discussed in the context of workplace restrictions, the positive reactions of respondents to tobacco control generally assumed two forms. The first was that many smokers are "considerate" by nature and legislation merely enshrines this need to show consideration for non-smokers in law. Second, for this group of smokers who have voluntarily joined a Smokers' Network and expressed their desire to quit, there is qualified support for measures that give them extra incentive to quit, by raising the "nuisance factor". Reductions in the number of places one can smoke will inevitably result in many people smoking less than before. In fact, a 1990 national health promotion survey in Canada found that nearly 50 percent believed that restrictions have meant they are smoking less (Pederson 1993).

Several negative reactions typified the responses of many respondents when asked about tobacco control measures (see Table 9.4). Many felt misunderstood, unfairly treated, stigmatized, and even persecuted. This would appear to be a direct outcome of the changes in the social acceptability of smoking that have occurred in less than one generation. The notion of stigma, discussed above, was one of the most pervasive threading through their discussions on tobacco control.

9.6 IMPLICATIONS FOR TOBACCO CONTROL

In the opening section of this chapter it was suggested that a critical-interpretive analysis of smokers' perceptions of tobacco control could fulfill three functions: (a) improve our understanding of how smokers are reacting to (and coping with) trends towards smoke-free environments; (b) reveal unintended and/or iatrogenic consequences of tobacco control; and (c) illustrate, in a tentative way, how smokers might be encouraged to participate in tobacco control initiatives, so that

they may have a voice in shaping their destiny. These issues have been addressed in the examination of the reactions of 45 members of a Smokers' Network in Brantford Ontario to tobacco control, particularly restrictions on smoking in the workplace and in public places, and efforts to change social norms about smoking. The results of this research indicate a need to re-evaluate the *process* and *implementation* of tobacco control as it is presently constituted in Canada in terms of the broader quality of life of both smokers and non-smokers. Though few definitive 'solutions' were provided, several opportunities for working with smokers were identified, and tangible benefits of a more detailed qualitative understanding of the smoker's perspective on tobacco control were hopefully demonstrated.

It should be emphasized that an examination of the iatrogenic side effects of tobacco control does not necessarily imply that it is not a laudable goal. The evidence of health effects is clear enough and the moral arguments convincing. Furthermore, most smokers want to quit, they are supportive of the notion that non-smokers have a right to smoke-free air, and many support the principle (though not always the practice) of tobacco control. Rather, the issue is *how* it is right and proper that we go about tobacco control in a way that is respectful of others and of their right to ultimately determine their own behaviour, but also with the awareness that the tobacco industry and other social circumstances contribute to the coercive reproduction and maintenance of smoking in our society.

One implication would appear to be the need to pay attention to *how* one does things, and not merely to *what* one does. It may be that at times anti-tobacco advocates seem unnecessarily confrontational. In addition, it is often the field-level implementation, rather than the official policy or piece of legislation, that matters most, as evidenced by Julia's experience with a Ministry of Labour official.

> I think my worst encounter was - I had a man walk in from the Labour Board into [our] company and he said "put that out!" I said "who the hell are you?" He says, "I'm with the Labour Board, you can't smoke in here. There's no uh, [no] smoking signs". I says "we don't have any non-smoking signs in here." He says "you need smoking signs. Now put it out". He got on the phone, "bring me over two signs". By the time the guy got out from the plant we had signs up that had smoking, you know. It's like this guy has no right to tell someone else what to do in their business, in their company, their building, and so I think they've gone too far.
> (Julia 38b, 794-805)

Without hearing both sides of the story, it is difficult to determine how much of this conflict was attributable to Julia's own possible abrasiveness or to that of the official, or to verify the truthfulness of her account. Nonetheless, the perception remains, suggesting that the result of inadequate people management skills and lack of attention to process issues may well be a forging of resistance amongst the already-hard-to-reach. This has implications for discussions currently underway in many jurisdictions in Canada concerning how best to enforce existing legislation. When I raised the very real possibility (being discussed in some metropolitan areas) of employing people to issue tickets (fines) as a way of enforcing no-smoking areas, many smokers became very irate. On the other hand, respondents were overwhelmingly in favour of enforcement of restrictions on the access of minors to tobacco.

In questioning the gaze of a confrontational approach in tobacco control, we may find that there is be more to be gained by allying *with* smokers *against* the tobacco industry, perhaps using Freire-style conscientization methods (c.f. Collins 1977; Freire 1973; Freire 1990; Minkler and Cox 1980) that focus attention on the pushers rather than their victims.

> I think when you see legislation and when you see by-laws that are really pointedly against the smoker individually, not against tobacco, but against the smoker, that I think it's a sort of blind way of going at ..changing what's happening, because you're attempting to, I guess, manipulate the user, but not educate at the same time. You're just sort of hard-fisting it... I think they could target tobacco as a substance, same as you tackle alcohol as a substance. I mean... it's sort of the same how we traditionally used to view drunks. Fifty years ago they were scum; now they're treated as someone who has an illness. (Linda 31, 976-996)

Middle class professionals and other employees of the state in North America are not usually comfortable with this more activist role, because it means acknowledging and challenging fundamental power relations in society. Also, targeting the tobacco industry and the capitalist (free enterprise) underpinnings that sanction the production and sale of addictive and lethal consumer products seems a more formidable task than behaviour modification. This may explain the traditional popularity of the individual behaviourist approach in health promotion, but the differential efficacy of behaviour modification as compared with structural change may be more apparent than real, since our success with the former is frequently

over-rated (c.f. Norman 1986). Nonetheless, putting an emphasis on social justice back into health promotion would undoubtedly be a good thing. It might help us to be more sensitive to issues of power and the inadvertent overtones of social control present in tobacco control as its presently constituted. As educated middle class elite we tend to wax evangelical about the virtues and necessity of health promotion, which seems pronounced in the realm of tobacco control. But it may sound hollow to other social groups who do not have the same control over their lives, who do not live, work and play in environments that are as sanitized of environmental hazards (chemical, biological, psychological) as do we the middle class, and for whom other problems are often more pressing.

It seems at once self-evident but no less important to say that one should make the process of health promotion empowering for disadvantaged groups, amongst whom smoking is most prevalent. Without this, we risk violating a basic tenet of health promotion, which is to "enable others to take *control* over, and to improve, their health" (Epp 1986), for we manipulate rather than empower, and that surely does not make for a more tolerant and supportive society. But this seems at odds with the justification provided by tobacco control advocates who would have us believe that the means justify the ends. Attended to with integrity, health promotion as an approach or *process* should ideally foster critical, participatory, emancipatory education, be empowering, and build critical life skills that can be applied to other areas of people's lives. This implies helping people identify and slay their own dragons (of which smoking is one) rather than coercing them into adopting officially sanctioned behaviours. For example, some respondents had very clear personal development agendas that included smoking cessation, though not always as a top priority. Tricia was clear on the fact that she needed to work on self-esteem first, which would improve her confidence in her ability to quit smoking and therefore improve her chances of success. In the long term, I suggest that society (and health) might be better served by an approach that seeks to develop healthy *people* rather than simply healthy *behaviour*. The two are not necessarily mutually exclusive, but there are times when broader human welfare seems to play second fiddle to narrower professional behaviour modification agendas. To some extent, this is a result of an administrative compartmentalization of institutional responsibilities for the determinants of health, so that each organization works on its

own narrow agenda. But if the experience with 'healthy communities' is any indication, inter-sectoral cooperation and 'looking at the big picture' is possible. If qualitative research can contribute to making the practice of our trade, as generators of health policy and health promotion practice, more humane, then it will have amply served its purpose. That it would help us refocus our priorities to better serve the interests of disenfranchised groups would be even better.

Table 9.1 The major foci of tobacco control in Canada

Prevention
- education in schools, public media
- restrictions on advertising by tobacco companies
- age restrictions on access to tobacco (must be legal adult)
- attempts to change social norms about smoking

Cessation
- cessation messages in the media
- individual counseling and group therapy
- nicotine replacement therapy
- self-help materials and self-help groups
- taxation of tobacco products
- community intervention trials, community mobilization strategies (Ontario Tobacco Strategy)
- attempts to change social norms about smoking

Protection of non-smokers from exposure to second hand smoke
- restrictions on smoking in the workplace (e.g. Ontario Bill 194)
- restrictions on smoking on public transportation (air, bus, rail)
- attempts to change social norms about smoking

Table 9.2 Smokers' arguments for and against workplace smoking restrictions

For	Against
• reduced to smoking at breaks	• just make up for lost time later
• without restrictions always have one lit	• some designated areas a joke
• winter weather an added hassle	• people crowded out front looks cheap
• you hardly notice when busy	• why bother in a factory?
• some made own rules anyway	• air quality worse now smoking prohib
• resent it but really its doing you a favour	• ban is no compromise, goes too far
• some would even welcome more stringent regulations	• more employee "down time"

Table 9.3 Smokers' reactions to several tobacco control initiatives

ACCESS TO TOBACCO

Age restrictions: minors prohibited from purchasing tobacco products
- a "motherhood" issue: even the Smokers' Freedom Society is in favour
- shows how those who smoke would not endorse it or encourage others
- problem is its not enforced: the majority of retailers will sell to minors

Restricting points of sale for adults
- inconvenience not welcomed
- may mean have to pay more (many go to native reservation or have smuggled cigarettes delivered to their home)
- sympathy for retailers who would lose revenue
- not happy about prospect of greater government control

BAN ON ADVERTISING BY TOBACCO COMPANIES

No-one buys the industry's yarn about market share
- smokers recognize that real purpose being the purpose of advertising is getting new (primarily young) smokers to replace those who are quitting

Supportive of ban in principle, but wonder about its effectiveness, because of the following counteracting forces:
- in-store displays by retailers (at eye level, bound to be seen by kids)
- magazines & other media from the USA (which doesnt have similar restraints)
- sponsorship of the arts and of sports activities (ambivalence about this)
- role models who smoke
- forbidden fruit syndrome: makes it more appealing to rebellious teens

Reluctance to admit advertising affects you
- ban seen to be largely for the benefit of children than adults

TAXATION OF TOBACCO PRODUCTS

Widespread cynicism about government
- taxes in general are as unpopular as ever
- reluctance to admit taxes might be a good thing
- leads to contradiction that taxes don't work, but cost the reason I quit
- deplorable that despite considerable tax revenues, none earmarked to help smokers quit
- government more interested in going after victims than pushers

Considerable (published) evidence that its had an impact, but smokers also point to the following mitigating factors
- diminishing marginal returns
  (25 cent hike on $2 has more impact than 25 cent hike on $7)
- residual pool of smokers tend to be more heavily addicted, harder to reach
- ceiling beyond which contraband becomes too problematic
  (tax revenues may even decline, thefts increase)
- unfairly penalizes the economically disadvantaged
  (who tend to be the most heavily addicted but often the least able to pay; may take from food budget to satisfy the addiction)
- forbidden fruit syndrome ("if it costs that much, it must be good")

Table 9.3 Smokers' reactions to some tobacco control initiatives (continued)

EFFORTS TO SHIFT SOCIAL NORMS

Perceived social acceptability of smoking

- when we began smoking it was the natural thing to do, no warnings either
- social acceptability is rapidly diminishing... but varied socio-geography
- perceived as targeting smok*ers* as much as it does smok*ing*

Should society care?

- non-smokers' claims to smoke-free environments acceptable on grounds of noxiousness, but health impacts of ETS disputable
- elevated health care costs of smokers (but smokers pay considerable taxes)
- freeing smokers from unwanted addiction is a worthwhile endeavor
- protecting smokers from themselves was disputed as infringement of right to free choice (but note analogy of seat belt legislation)

Table 9.4 Dimensions of reaction to tobacco control

POSITIVE REACTIONS

Shows consideration for non-smokers who shouldn't have to be exposed to our smoke

Probably helps me cut down and even contributes to me quitting

NEGATIVE REACTIONS

It's my right, my choice
- my own business as long as I'm not hurting anyone else
  - rights commensurate with perceived risks to others
  - many smokers don't think ETS is particularly harmful (in *relative* terms)
- higher health care costs to society offset by taxes paid on tobacco
- competing rights and competing risks
  - fairness means treating all equal risks equally
  - other risks not spread evenly throughout society

Why get so excited anyway? (misplaced emphasis)
- it'll peter out anyway as smokers die off
  - just relax and let nature take its course
  - assumes changes in social norms come about naturally, rather than accelerated by advocates
- smokers are somewhat of a lost cause
  - try to help them anyway, but don't expect too much (effort better spent on prevention)

Tobacco control as it's presently constituted is unfair
- tobacco is addictive (addict as victim)
- change is "all of a sudden"
- tobacco is legal
- other things are more harmful but not dealt with as strictly

It won't work
- can't push anyone to quit
- digging heels in, making up for lost time
- will never eliminate smoking

Will do more harm than good
- forbidden fruit syndrome
- taxes just increase crime (break-ins, smuggling, tax evasion)
- thin edge of the wedge

Approach is patronizing
- we're "not stupid": already know the risks
- "you don't need lectures, you need help"
- not a child anymore
- focus on the positive rather than the negative

CHAPTER TEN

LESSONS IN COMMUNITY MOBILIZATION FOR SMOKING CESSATION: A BRANTFORD KEY INFORMANT PERSPECTIVE

10.1 INTRODUCTION

One limitation of a client-centred evaluation is that many aspects of organizational development and other "behind the scenes" events are not perceived by target groups and service clientele. To understand more fully the challenges experienced by intervention staff and volunteers in Brantford COMMIT, a number of key informant groups were consulted. In-depth interviews were conducted with a variety of individuals from each of four groups: (a) Brantford COMMIT staff, (b) intervention volunteers, (c) related organizations in the community (e.g. local chapter of the Lung Association), and (d) university-based members of the Ontario COMMIT Research Group (the research institution; see chapter 4). In addition, groups a, b, and d were asked to complete a short questionnaire scoring BC on 16 dimensions (see chapter 5), and a focus group of task force chairpersons was convened to discuss the trial following its completion. The material collected from key informants was taped, transcribed, coded and analyzed in much the same manner as for Smokers' Network members (see chapter 5 for more detailed description of methodology). However, with the key informant material, less emphasis was placed on generating 'thick description' or 'thick interpretation'. Rather, the testimony of key informants was used to generate a contextualized listing the claims, concerns and issues of a variety of potential stakeholders, as a basis for a fuller critique of the Brantford COMMIT trial. The key informant material provided

additional insights particularly into the process of community mobilization for smoking cessation.

This chapter has two main sections. The first deals with issues arising from the application of a standardized COMMIT intervention protocol in Brantford. The second section deals with organizational issues involved in implementing a new intervention within an established organizational fabric: in particular, the logistics of setting up and managing task forces, relationship issues and mediating personality and turf conflicts.

Because the flavour of evaluation is one of critique, it is perhaps inevitable that the focus of this chapter is on the limitations of the trial, and its strengths are mostly taken for granted except where specifically raised by respondents. Key informants were asked what they thought went well during the trial, though not what they liked about the trial. What they felt went well (such as the smoke-free restaurant day, the sting operations, the experience of working together) are reported in this chapter in a way that embeds them within a wider critique of the trial, rather than isolating positive aspects as a separate section of the chapter. Other successes were also reported in Chapters 6 and 7.

10.2 INTERVENTION PROTOCOL ISSUES

In this section, the merits and drawbacks of the COMMIT intervention protocol as described by key informants are discussed in terms of (a) the merits of a standardized protocol, and (b) the nature of the protocol to be implemented. Particular emphasis is placed upon (a) flexibility of the protocol to adapt to local conditions; (b) the nature of Brantford as context for the intervention; (c) changing environments versus targeting the intervention by socio-economic status and amount smoked; and (d) evaluation issues. Although there were other issues people raised in connection with the protocol (see Table 10.1), these four appear to be the most salient and needing of elaboration.

10.2.1 Implementing a standardized intervention protocol

As a multi-centre community intervention trial, COMMIT required the design and application of a standardized intervention protocol, together with specifiable implementation targets, to ensure comparable program delivery across all 11 intervention sites (see Thompson and Karimi 1988). This had the advantage, at least in theory, of ensuring that intervention communities would have access to the most recent and up-to-date knowledge about smoking cessation distilled from other trials such as MRFIT, Minnesota Heart Health and the Stanford 5-community projects, some of which were still ongoing when the COMMIT project was being designed (see chapter 4).

In hindsight, it could be argued that there was undue optimism about how quickly communities could be expected to mobilize, develop an effective organizational framework and draft detailed local action plans. Several respondents indicated that the protocol did not devote enough attention to building relationships of trust in the community, particularly between volunteers who often had not sat together on a regular basis before, but also to establishing credibility with other organizations (including city hall and the media). The schedule of mandated activities for Year 1 of the trial belied the implicit assumption that because everything was laid out in the protocol, communities could "hit the ground running". In fact, it seems that many communities had difficulty completing the mandated activities in the first year, although most subsequently caught up in years 2 and 3.[1] One researcher in particular identified community development skills training as a 'hole' in the protocol, which he felt "focused too much on getting the community mobilized rather than getting the community competent" (K10, 35-37). What was needed instead, he said, was "a more direct interactive community consultation model, where people who have a lot of experience doing community mobilization, helping organizations form and develop and change" (K10, 83-89) help communities through the initial community development process. Fortunately, the Field Director in Brantford was exceptional in her capacity to work with people, so

[1] Several researchers and COMMIT volunteers felt that too much emphasis on advance planning (drafting community smoking control plans and detailed annual action plans) left volunteers exhausted in the first year and without the satisfaction of having been able to do concrete things while initial enthusiasm was high, using initial successes to maintain morale and commitment.

much of this seemed to come "naturally" during the course of the trial.[2] But it is likely that more explicit attention to skills development and relationship-building would have been welcomed in intervention sites and might have paid off in terms of avoiding "hiccups" further down the road.

There were several other aspects of the protocol that interviewees found troubling. These are summarized in Table 10.1. One source of disappointment among many BC volunteers was that smoking prevention was considered by NCI to be secondary in importance to smoking cessation. There was a general feeling amongst many respondents that the emphasis on cessation largely to the *exclusion* of prevention activities was unfortunate, in that prevention effort directed at youth was important in its own right, as well as less controversial than efforts directed at cessation among adults.

> I don't think there's any question that [prevention] was an add on [in the protocol]. If you looked at the protocol development that's what happened when the Research Institutions and NCI. were discussing it. Somebody said, you know, "Well we have to deal with prevention in youth." And so they finally included it. But it was a last minute thing. Clearly the target was to reduce smoking in heavy smokers. Well that's a hard thing to do. It's going to create conflict and [prevention] was an easy way for people to deal with [the issue]. Nobody's going to really be openly antagonistic towards prevention in smoking in youth. Even [in the surveys] nearly 100% of smokers said that they were supportive of that. So that was the easy one, and I think you're right it led us to deal with those easy issues rather than deal with the difficult ones of actually getting those people out there to stop. (K4, FG 2156-2179)

> [We were] ...looking for success, for security and [prevention] was the way to go before you take that next leap [into cessation and tobacco control activities] (K9, FG 2183-2184)

The inability to significantly alter the protocol except in terms of implementation details created resentment in some circles. Researchers attached to the project who believed in the merits of a community-based approach must have anticipated this, because at the beginning of the trial they tended to under-emphasize the need for adherence to the protocol when discussing the project with members of the Brantford community. But their actions seem to have created some confusion as community volunteers recruited to work on COMMIT in Brantford struggled to

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[2] Perhaps one could argue that abstract manuals or ad hoc training seminars are no substitute for the natural talent of being "a people person". In other words, there may be limits to how much of this can be learned, at least in an academic sense or on relatively short notice.

clarify their own roles and responsibilities vis a vis NCI, the research institution, and the trial.

> I struggled with the waffling, the unfocused target at the very beginning when we were so concerned about not targeting smokers we wanted to work towards "healthy life style for all"... Looking back I found that really in a way threw us off track for a good year and half. If we had sort of bit the bullet and handled the protocol right off the bat and said, "Okay, we'll just do what we have to do", we would have done a learning process of what the protocol was all about, got our objectives and then the last half of the program would have been ready to be creative... But when we sort of.. got off on this global concept of trying to help everybody be wonderful, ..for me personally that threw me off for a little while until we figured out that we had to get these things done and *then* we can get creative. (K6, FG 687-712)

Careful consideration was given to providing leeway for communities to adapt the program to local conditions, but the scientific demands of a controlled trial meant that community involvement in the design process was minimal. For some organizations, the perception of a well-funded pre-established program being parachuted into the community was a barrier to enthusiastic participation because activities were seen to have encroached upon what they felt were traditionally their own areas of turf in the community (see discussion in section 10.3.3).

These reactions indicate the compromise that had to be struck in the protocol between maximizing the intervention and preserving the 'scientific integrity' of the trial in terms of comparability across intervention sites. The compromise that was required, however, had some unfortunate consequences for COMMIT volunteers in each site. Chief among these was the requirement that communities (and researchers) be 'blinded' to their progress on key outcome variables (such as cessation and prevalence rates) for the entire four-year intervention period. As several researchers and community volunteers pointed out, this runs counter to what is known about the importance of feedback in maintaining volunteer commitment and enthusiasm, particularly over a 4 year period in a complex trial such as COMMIT project.

> People need the feedback and the protocol specifically denies that for the purposes of pure.. science. So you've got a Catch 22. In order to mobilize the community you need the information, the information will be withheld because it affects the science.... You know, so you've got. a real problem I mean, people become volunteers because they believe there's some social redeeming quality to the participation. If somebody specifically and intentionally denies you the warm fuzzies, how long do you stay? And see and that's where we also go from academic theory which tends to be a longer term horizon, to people who, down on the streets. They may need a faster payback.

> They're looking for [some] kind of cause-effect and they're looking not exactly instantaneous, but PDQ. If all of a sudden you say, "Hey, we're going to force you to work for six, seven years here and God knows what the outcome is going to be..." (K5, 1166-1205)

> I think there were two things about the design that worked against achieving the delta. The first was the failure to provide communities with feedback about quit rates along the way. I think that was lethal. We thought that from the beginning, and if you look at anybody's model of self-control, it says that what you want to do is monitor your performance and use the feedback you're getting to set goals and, and to direct and re-direct your activity, so that if people are on-track and succeeding they need to know that, so they redouble their efforts, it's energizing... And if they're not succeeding, they need to know that, so that they can take a look at their strategic approach. I think that that was a terribly... bad decision to blind communities. It's like trying to teach people to drive a car while they're blindfolded. I mean it, it'd be absurd to attempt that...
> (K11, 305-324)

The COMMIT experience is in stark contrast to that of other community organizations like the United Way who chronicle progress towards their funding campaign goals with barometer-like public signs. If BC had been able to do something similar, public signs could have advertised the number of quitters to date and number needed for the trial to be successful, perhaps in competition with another 'twin city' intervention site. However, experimental design of the trial precluded intervention approaches that might 'contaminate' the comparison communities. On the other hand, 'blinding' communities sets up an artificial situation because future community interventions (diffusion stage) likely *would* have access to outcome data on a more regular basis.

Some information on intermediate objectives pertaining to attitude and behaviour change in the community was fed back to communities mid-stream (1989 and 1991 evaluation and channel-specific surveys). But the results of the end point surveys of cessation amongst cohorts of heavy smokers (the most crucial to the trial) remained hidden. Furthermore, the first round of surveys were conducted early in the trial when the Task Forces had not had much time to make an impact in the community, so the results showed that little impact had been made in the earlier phase of the trial. Yet the lag between data collection and its dissemination meant that the data arrived late in the trial when they could have a rather small impact on intervention design or practice (respondent K15, 410-414). The perception amongst many key informants was that insufficient feedback on quit rates amongst heavy

smokers may have compromised the effectiveness of the trial. What was called for in many cases was not centralized survey research, but much simpler local qualitative feedback from specific target groups (especially heavy smokers of low socio-economic status) about what would really 'turn them on' to quitting, as well as feedback about what BC had to offer. This sort of local data collection was not encouraged by NCI, nor was it actively pursued locally. In discussing the issue of ongoing monitoring and feedback, one researcher in particular noted that the lack of interim feedback combined with a focus on protocol-driven activity resulted in people losing sight of the "big picture" or the ultimate objectives of the trial, concentrating instead on protocol delivery objectives.

> How do you keep the volunteers involved in something like this? Well, as a psychologist, the first thing you probably would say is you've got to have rewards along the way. And one of the rewards is, you know, positive feedback that you're doing something, you're accomplishing something. At the moment it's "can we check off that box on the protocol with respect to this mandated activity?" and so that's where sort of everything is focused. [And]... writing reports and so forth is taking up an enormous amount of activity and talents and what not that they may be having very little impact and may [even] be counter-productive. But how are people to know this in advance? I don't know. This is pretty clear to me now, but it wasn't clear to me at the beginning. I would have been absolutely... 110 percent behind the idea of a protocol with mandated activities at the beginning. I couldn't have figured out how we could even get a project started without such a thing let alone have it be science. I mean, so, it had to be that way. But in retrospect it's clear that this sort of project by mandated activities is a little bit like management by objectives with a quantitative measure of the objectives, and... in our case checking off the activity with sort of narrow blinders on. (K12, 1550-1588)

While consistent with the aims of the COMMIT project as a standardized intervention trial, "management by objectives" may not have resulted in enough of the creative brainstorming in individual sites that might have maximized intervention impact. But the fear amongst the researchers was that community-level comparability would be compromised by different mid-course corrections in each site. On the other hand, it could be argued that the scientific requirements of the trial diminished its chances of success.[3]

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[3] Several alternative scenarios suggest themselves as ones that might have allowed for mid-course corrections without compromising the scientific integrity of the trial. The ideal, perhaps, might have been to ensure that lessons from each site were centrally collated and integrated into trial-wide protocol modifications midstream, although this would have been a mammoth task. NCI did encourage communities to learn from each others' experiences through the CEMS computer messaging service and through periodic centralized meetings, although of course protocol requirements remained unaltered. A second potential strategy for introducing "controlled flexibility" into the protocol might have been to structure it more as a menu of intervention options than a rigidly pre-specified activity plan. The protocol could have been fairly specific at first and loosened up over time into a menu of options as communities gained more confidence in managing the trial. Some leeway might even have been given for a few innovative deviations from

One respondents suggested that another way to maximize learning about what is most effective in accelerating smoking cessation would have been to using an additional intervention site in which feedback was used very differently.

> [You could have had] a twelfth site [where] say you put an ad in the local paper saying you've got a quarter million dollars if you're interested in becoming part of this, the only caveat is we're going to measure the number of smokers in the community now, we're going to give you this money... and we expect you to have changed this or we're going to take all your first male childs. (laughs) And you left it at that.... I wouldn't have minded a crack at that one... You'd have the Lung Association saying, "Gee, give me thirty thousand. Here's what I could do." You know, there'd be a different kind of dynamic. It'd be like a zero-based budgeting approach... [But instead] as a manager, the Commit project had none of the traditional productivity efficiency and effective measures that any company would have.... Now that we've said that that's the number of people [we have to get], do we care what range of strategies there are? You know, my sense is... we [would have] managed it with data information totally differently than the protocol. There's no doubt in my mind... (K5, excerpts from 1439-1572)

In fact, several volunteers recruited to the Brantford program felt that having an impact in Brantford was more important than making NCI happy or preserving the scientific integrity of the trial. Not being 'allowed' to do what it took to be successful in Brantford, and not being fully supported in this in terms of feedback, for example, created consternation and even resentment amongst some volunteers.

> I think the fear was that [surveys and feedback] would affect the natural evolution of what was happening with Commit. And I think that there were some of us that would say, "So what? Let it happen! We, we're hungry for survey information. We're hungry for it." And if we had had it, we may have responded a little differently and it would have been for the better of the project.... Some of the protocol stuff with not being able to survey and that kind of stuff.. stinks... there's no benefit in my mind. In fact, it's done more harm.. (K7, 1515-1527)

> We got frustrated because we couldn't get results to say, "How is it working?" And so our response to that was, "Well we know.. that we need to target the heavy smokers and we've got the information to say what their profile is so where are we going to reach?" And we started to do some things that were a little bit different near the end, but that was really because.. we got finished with most of the protocol stuff and started to think on our own.. (K4, FG 2329-2336)

Several other respondents made allusions to the fact that some of the most exciting work and greatest impacts were achieved by working outside the protocol. It was

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the protocol by individual sites, under the condition that they be fully and carefully documented in a standardized manner. However, to make informed choices along the way, communities would have to be able to monitor their progress towards mandated objectives, and the design of the COMMIT trial did not usually permit this.

evident from the testimony provided by BC volunteers that although they might have been grateful to have the protocol as a starting block, they also felt that protocol requirements stifled their creativity in dealing with smoking control in Brantford.

> In the whole 4 years we really didn't have the opportunity to evaluate the impact and then take it in a direction that was best for the community and for the target group we were looking at. That when we started to look at.. doing a little more with the Network people.. we either didn't have the information to make good judgements or we were told, "Well that's not really part of the protocol. You can go beyond but you have to do all these other things first." And so it started to restrict people... We had lots of creative ideas but.. they quite often sat out there and didn't get developed because we got drawn back to the things that were required to be done. And I think that for me that was the overwhelming difficulty with the whole thing. Although... the really exciting thing for me was the potential for a very large impact on people.. we didn't seem to be able to follow that through. We didn't have the opportunity to do that. (K4, FG 31-57)

It was clear from the testimony of BC volunteers that the impression they had of the protocol stifling creativity derived in large measure from restrictions dictated by NCI that prevented them from doing things in the community that as volunteers they were particularly keen about, such as working more intensively with members of the Smokers' Network (see chapter 6). The flexibility of the protocol (or lack thereof) to address the local needs in Brantford thus became an enduring problem in some people's minds, although several respondents felt there were degrees of freedom as to how the implementation of the protocol could be localized.

> ...if you were really wanting to talk about... mobilization and empowerment, organization renewal, you would do the exact opposite of what Commit did. You would not stroke a bunch of volunteers and then give them the holy bible and then say live it. You would take a bunch of people, and you would take them through sections or concepts of the holy bible and at the end of it bring it all together [so] they felt that they had had a chance in tailoring what the final product was. And that's what the Commit protocol didn't do. Because they [said], "here it is, here's the money, we're going to be looking over your shoulder, you're accountable for every quarter, get on with it. (K5, 543-563)

For some people, the inability to have significant input into the protocol design created a crisis of ownership that left them feeling that they were doing someone else's idea of an intervention. The respondent quoted above went on to say that he felt that this ultimately had a significant impact on the cohesiveness of the group, and may have been an important factor in the reluctance to take risks and in the jurisdictional disputes that frequently plagued the Task Forces (see section 10.3.3).

> There was no culture, there was no sense of teamness or group dynamics, there was no sense of affirmation of community... We have to have something that glues this group together more than just somebody waving a bunch of money, somebody waving a recipe book, because as soon as shit happens, you're going to say, "Keep your money. Keep your recipe book. I'm going to go back over here, because I'm having more fun, I feel I'm making a greater participation and I don't have to... deal with all the b.s. that you guys are bringing to this table. (K5, 563-565, 691-697)

But although volunteers were at first very cautious about violating the protocol, as time progressed they gained confidence and took more risks.

> When we found of ways to work with the protocol, to create interpretations which allowed us to still achieve the basic thrust of the protocol, but allow some nuance of the program delivery to be more culturally or community sensitive, we tended... to be a little more excited about it, so we went from protophobic to sort of... (protophilic) (K5, 513-535)

In fact, one researcher suggested that "if you have a creative group, you think of creative ways around the protocol" (respondent K13). While this was true of some Task Forces, it was not for others, who did not see the protocol as a springboard, but instead did just what was required to get the task done. The protocol became an end in itself (tunnel vision). This was the case for the Health Care Task Force, which quickly accomplished its 'tasks' and took little initiative to go beyond this later in the trial when other Task Forces were being more active and creative.

The danger of a standardized protocol is that some things get done, not because they are particularly effective, but because they are mandated in the protocol. Referring to the experience of trying to mobilize social and religious organizations around smoking issues, one respondent offered the following comments:

> ...a lot of energy was frittered away doing things that everybody knew weren't going to make a difference, just in order to fulfill our contractual obligations. And that's not to say that they were done in a cynical way. I think that people honestly made an attempt to do the very best job they could and to live up, not only to their letter, but to the spirit of the intervention. But when push comes to shove... If we're a bunch of entrepreneurs who had our own money on the line and we were told that we sink or swim based on our ability to get people to stop smoking and we can do whatever we choose, we would have done it a lot differently. And I think if you're thinking in that way, you're much more likely to spend your time and energy doing things that are going to make the difference. (K11, 334-353)

It also seemed that a focus on *doing* as per protocol requirements tended to obscure the need or time for reflection, so that being caught up in fulfilling

contractual obligations meant not seeing the big picture. When things seemed fragmented the resultant lack of clarity had an impact on the participation and enthusiasm of volunteers. The implication is that perhaps the protocol was "overly elaborated" in terms of limited leeway, burden of reporting and planning procedures, and inappropriate requirements for some communities.

Several examples of the failure of the protocol to be "in keeping with the local culture" were cited by respondents. In particular, the United States origin of the protocol contributed to the 'foreign-ness' of its feel for Brantford residents. The emphasis on physicians to the exclusion of nurses or public health officials in the protocol was seen as inappropriate for a Canadian context. Restrictions on working with members of the Smokers' Network were also deemed less appropriate in Canada than in the US, where concern with individual rights (as opposed to the collectivity) is perhaps stronger. Certainly, the tobacco control environment, in terms of federal and provincial legislation, was more conducive to cessation in Brantford than in other COMMIT intervention sites (see Chapter 9). This might make it harder for Brantford to reach its delta because Peterborough (which had to be 'beaten' by 10 percentage points) shared the same provincial and federal context, and much of the COMMIT trial was aimed at mobilizing intervention sites towards generating some of the conditions locally that Brantford and Peterborough already shared by virtue of being in Ontario Canada.

10.2.3 Brantford's defeatism, reluctance to ruffle feathers or be controversial

One of the characteristics perceived to be separating Brantford from the remainder of the intervention sites and highlighting the lack of fit of the protocol with "local culture" was the assumption of a willingness to be confrontational. The perceived 'cautious' nature of Brantford society was identified by the majority of researchers and BC volunteers as having been a problem throughout the trial, though diminishing over time. The nature, as well as the source, of this reluctance deserves careful investigation, because it is a fundamental barrier to community mobilization for health facing not only smoking cessation interventions but probably also a wide

range of community health promotion issues and healthy community movements more generally in communities across Canada.

Based on the testimony of a cross-section of key informants (residents and non-residents), it seems that the generalized reluctance to cause friction in Brantford society manifested itself in a number of ways. These included providing excuses for not getting involved, a lack of willingness to take a public stand on an issue that you are privately known to support, a lack of willingness to tackle issues publicly that get discussed in private, defeatism and negativism, and a degree of pessimism. Several key informants said that they had observed these local tendencies in other contexts than smoking cessation.

> I think that there's a tendency in Brantford for people to be nice to one another and to not address the issues even though there may be very severe negative things coming out of what's happening in the community, people will not address it. They'll talk about it in circles behind peoples' backs to people that they know really well but when they get into a situation where they must deal with the issue, they won't deal with it. They keep pushing it to the background and putting other things forward. I've never experienced it in any other community that I've been in with such intensity.... Confrontation is just not [seen as] acceptable... (K4, FG 254-270)

One of the manifestations of this desire to avoid conflict was the tendency to become preoccupied with process issues as a way of avoiding action on a controversial issue.

> You have to deal so much with the process that you can't get at the issue. I think it slows things down tremendously. I just see it over and over again in things that I'm involved in the community. People are willing to sit around a table and spend hours and hours of time talking about how they're going to go about this and how they're going to do it without offending anyone and they never - well I can't say never, but it takes a long time to get to some action to deal with the issue. And sometimes the issue will just go away and then for some people, they've achieved what they wanted: not to deal with the issue. 'Cause it's going to upset people. (K4, 302-317)

> I think this is all unconscious by the way, I don't think people deliberately sit down and plot to defuse action on the issue. I think it's a defensive mechanism that they use so that they don't have to ruffle feathers and deal with conflict.
> (K4, FG 766-769)

As in all groups, there were a few individuals in the trial who were outcome-oriented and not much interested in "getting hung up on the process", though sometimes they effectively "hung" themselves in the process.[4] Fortunately, the majority of

[4] There had apparently been several instances in which people had taken a bold stance or gone out on a limb and effectively backed themselves into a corner. They had been tremendously effective, in some cases, at getting action on certain issues, but had done so in a way that had alienated some people and that ultimately led to their own resignation.

volunteers were dedicated to making an impact and were also sensitive to process issues. Several respondents indicated that in their minds, framing the COMMIT trial as pro-health rather than anti-smoking or anti-farmers was critical to the success of the trial (in terms of building credibility, forging the necessary alliances etc.).

Nonetheless, the fact that people in Brantford often go to considerable lengths to avoid controversy and confrontation is known but taken for granted and rarely raised for explicit discussion. The reluctance to ruffle feathers was epitomized in a handful of powerful stories that key informants related during the course of our discussions together (individually and as a group). These are listed in Table 10.2.

The sting operation referred to in Table 10.2 involved recruiting 16 year olds to buy cigarettes in retail outlets, and tracking how many stores actually sold to under-age children (the majority did). Not only did this activity initially raise concern among BC volunteers, but when it did go forward as a proposal outside of BC, the chief of police and the mayor refused to publicly endorse it.

> I think that we found ourselves from the very beginning dealing with people whose principle investment was in making sure that some things that didn't change, and things which they would agree to change, were things which are already on the approved list of polite upper middle class Brantford society. The most dramatic example was when we designed a sting operation which was an invitation for people to do something illegal and then point out to them and the community that they had done something illegal, and deliberately to create a fuss by doing that, with the idea being that the fuss was going to be productive. Well, there were a number of people with whom we had to work, who wanted anything but a fuss,. One very intelligent, very decent, very committed woman said in conversation that she wanted above all to avoid doing anything which might be related as - this was her word: "radical". Some of us come out of a traditional where "radical" was something of a compliment, and she's certainly not of that tradition And adopting the mobilization style that we adopted... as an administrative kind of process, suggests that there is a view in the community [of COMMIT] as a kind of apparatus which functions more or less according to the sorts of rules to which we've all become socialized in major institutions and corporations and civil service or in educational institutions etc. [as being *not* 'radical']. (K13, 186-224)

A credit to the volunteers, staff and the encouragement of several researchers, the sting operation went ahead anyway and was repeated several years in a row. This activity was an important learning experience for the volunteers in particular and a milestone in their readiness to take greater risks in the community thereafter, particularly given the favourable reaction of the local press. It also provided

ammunition to push ahead for municipal legislative reform regarding access of minors to tobacco.

Another manifestation of Brantford's conflict avoidance that saw movement during the course of the trial was the personal willingness of BC volunteers to say anything in situations involving smokers in their own daily lives.

> We've had session after session [with the Board] where we said, "Well, what do you do when you walk into an arena and there's somebody standing underneath a no smoking sign, smoking." And most people said, "Well, I guess I move down to some place further away." You know, and, I mean, on a board that is dealing with the smoking issue, they weren't prepared to deal with it on a personal level. And so everything that came through on a board level was very, very soft and distant. You know: safe, because nobody's willing to risk, nobody's willing to take that step to challenge and to perhaps upset or to run into some conflict on it. And so we have to work hard at that. (K4, 502-519)

Taking risks was a learning process for volunteers that was accelerated by a number of pivotal events, including (but not limited to) the following: (a) experience with the sting operations, as mentioned above; (b) encouragement at an annual meeting in year 2 or 3 from a "radical" researcher to "proceed boldly"; (c) a central meeting of all the intervention sites in San Francisco in which volunteers could see first-hand the battles other sites had waged; and (d) the flurry of letters to the editor in the local paper following the smoke-free restaurant day, showing that controversy can be productive and generate free publicity. Much of the movement in volunteers' willingness to take risks occurred relatively late in the trial, which once again indicates the importance of having skills development early in the trial. It also raises questions about whether (and how) important developments such as these are picked up by the evaluation methods used by NCI. It is important that these experiences inform future community health promotion interventions, since they seem to be so fundamental to successful community mobilization for health (see also section 10.2.4).

While Brantford is unlikely to be the only place in North America facing this sort of conservatism, there are a number of reasons why it may be an anomaly amongst the COMMIT intervention sites. For one thing, there is a long history of tobacco farming in the area, although it is not the only intervention site to have to contend with public sympathy towards a societally threatened local tobacco farming

constituency, particularly in times of recession and when farmers of all types are facing hardship.[5] One key informant suggested that a history of economic hardship in Brantford (with the departure of Massey Ferguson in particular) has generated a cautiousness, cynicism and defeatism. Another reason to "watch your step" in Brantford is that, it seems, virtually everyone is related to or knows everyone else. One volunteer complained that since the same elite group rub shoulders at all the community events and gatherings, people accumulate a wealth of unspoken knowledge and grievances. Within this context, people who have to live and retire in Brantford are understandably more cautious about what they say and do than 'free spirits' such as nonresident researchers.[6]

> When I first got to the community one of the comments that was made to me is, "You don't say anything to anybody that's derogatory because you never know whose brother-in-law, sister-in-law.." You know, you say something and all of a sudden you find out that they're related to somebody that you were saying something about and "Oh, ghees, no." And you're dead. You get cut right out of the whole system in the community if you make very many of those mistakes. It makes it very difficult to change things because there is that networking in the community. (K4, FG 272-286)

> These [cautious ones] are the same individuals who, when its no longer called Commit, will continue to hold the roles in this community. I can remember saying we had to be careful. ..The lifelong residents here who have their own retail ventures or are in the service clubs, want to be happily retired people here ..and they don't want to rock the boat. They would like to achieve change, but they don't want it to be at the expense of their comfort. (K16, 502-521)

In addition, many volunteers felt constrained by their employers in taking a public stand against smoking in their involvements with Brantford COMMIT.

> I've tried to stick my neck out, but my job doesn't permit it. I've been told that I'm not allowed to do certain things because of my reception: it's not me the individual, it's me the person with this agency, and that people might perceive that I'm speaking on behalf of what appointees to our council have said... [Maybe some] people can come in and be hatchet people and achieve the change and leave [but] they don't have to still make them[selves] acceptable to community members afterwards. (K16, 522-533)

> I wasn't there leading the band at a smoke-free tobacco banner, because I have an investment in my job and if I wave that banner or I become a voice in the community for Commit - and I always said that I would not be a voice in the community for Commit - I run the risk of losing potential revenue fundraising-wise and I can't do

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[5] In hindsight it would seem that the threat of opposition from the farming community never materialized to the extent anticipated, although some of this can certainly be traced to BC's careful attempts to keep the issue a pro-health one rather than anti-tobacco or anti-farmer (K1).

[6] This raises some interesting issues about the applicability of health promotion literature written with an implicit big-city bias to small towns.

> that. Then my job is affected and part of this area is tobacco country and... we don't push the tobacco issue. [That way] we can [do other things] in the community.. and still have the support of the community. If I go in there with the T word, forget it, [my agency is] written off. So I can't afford to voice... So.. all along I knew that my name could never be attached to a letter to the editor or I couldn't go on the TV, on the Commit show thing that they did, because of our wider audience. I'd get into a lot of hot, hot water if I did that. (K7, 732-767)

This "wearing of several hats" was a somewhat inevitable consequence of drawing from influential "movers and shakers" in the community for membership in BC Task Forces and Community Board. It was suggested by one researcher that if one is interested in altering the natural course of a community's development, perhaps the wrong people to turn to for assistance are those who, by virtue of their nodal positions in the community, have a degree of vested interest in the status quo.[7] Insofar as the politicization of health is inherent in a true community development approach (Labonte 1989; c.f. Alinsky 1971), the role of professionals and their relationship to 'the community' should be carefully considered in the design of community health promotion interventions.

The research in Brantford also suggested that 'political leadership' is sometimes an oxymoron. If "being a *leader* means that you have to swim upstream every now and then" (BC volunteer K5, 277) and *politics* is about damage control and pleasing who you can, then how wise is it to look to those who survive by inter-organizational political savvy to take leadership on issues such as community smoking cessation? This is a crucial dilemma in community mobilization for health. Insofar as political good will and the support of some movers and shakers is needed for institutional or legislative progress in community health promotion and local healthy public policy to be made, perhaps it is a moot question. But at the very least, it should be acknowledged that those involved will have their limits and will be making tradeoffs because of other roles in the community.

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[7] It's interesting in this regard that many of the people complaining the loudest about the cautious nature of Brantford residents and the difficulty in getting things done were not native Brantfordians, but relatively recent arrivals in positions that required working with others to achieve change. It's not that native Brantford residents were oblivious to the dynamics in their community, or that it hadn't worked against them at times, but they were less likely to see it as remarkable. In other words, they took it for granted as the way communities operate. It is noteworthy perhaps to mention also (a) that early community analysis showed Peterborough movers and shakers in public health to be more willing to take risks than in Brantford, and (b) that perception was that US sites were more aggressive than BC (generally by nature, as well as in the context of the COMMIT trial).

10.2.3 Concepts of community, social class, and the merits of targeting

The preceding discussion, highlighting issues of community culture, the influence of key personalities, and local history, leads to larger questions about the role of place and definitions of community in community-oriented health promotion. This is particularly relevant, given that the notion of community features prominently (if implicitly) in recent definitions of health and health promotion which emphasize factors outside the medical care system as constitutive of health. This notion of community as container, setting and context is implicit in emerging 'determinants of health' paradigms (Evans and Stoddart 1990; CIAR 1991) and socio-ecological models of health (e.g. White 1981), but is treated as generic community largely disembodied of (explicit reference to) place (c.f. Kearns 1993). What, then, is meant by 'community' as a setting for the production of health and as a setting for mobilization towards improved health and quality of life?

> In spite of constant usage, community remains an untidy, confusing, and difficult term. This is no wonder when it has become a cliché and a rallying cry; an analytic concept and a sociological sample; a geographic location and an emotional state. The result is that no one is sure what is meant by such vague phrases as world community, the academic community, the black community, the church community, or community sentiment. (Scherer 1972, 1)

Given the liberal uses of the terms 'community development' or 'community health promotion' in the new health promotion, these terms might also be added to Scherer's list of indeterminate concepts. As social entities, communities are not visible artifacts like chairs, and are therefore subject to a wide range of sometimes competing but usually partial and complementary definitions and interpretations. Although many different perspectives on community can be identified[8] (e.g. Table 10.3), the tendency in the literature has been to move away from assumptions of community 'togetherness' or consensus based on physical co-location and homogeneity. Instead, there are 'communities of limited liability' (e.g. Janowitz 1952), which recognize that place and local issues assume different meanings and degrees of importance amongst residents, who may band together on specific issues

[8] Phillips and LeGates (1981) have identified 90 different definitions of community used in sociology.

or to ward off specifiable external threats (c.f. Alinsky 1971), and that there may be multiple communities of interest (Ashton 1988; Reitzes and Rietzes 1982). The differences between 'old' and 'new' concepts of community can thus be summarized as in Table 10.4.

In my research, key informants were not routinely questioned about their own concepts of community. Nonetheless several issues bearing on the notion of 'community' emerged in the interviews and focus group that deserve mention. For example, several BC volunteers said they had been uncomfortable with the fact that COMMIT targeted the city of Brantford rather than Brant county, since their own organizations had a county-wide mandate. It seems that few volunteers had had much cause for reflection on the meaning of community, although several did suggest that segments of the community (such as Labour and heavy smokers) had not been adequately represented in the organizational structure of Brantford COMMIT. On the whole, however, it was not their habit, as movers and shakers, to be overly concerned with the middle-class nature of the volunteer pool. Even the researchers were inclined to take pride in the shift to community ownership of the project while also acknowledging that there might be multiple "communities" in Brantford that were not represented in the group in whom ownership had been vested. This raises the crucial issue of who is fit to properly represent 'the community' and what 'community-based' health promotion really is; an issue that is revisited below in the context of social class.

Is it unwise to seek closure on the concept of community, asks Scherer (1972), if that freezes our learning about it, or if it is a phenomenon too vast and varied to fit into a single noun and common definition? Recent discussion about the apparent loss of community and revival of concept of neighbourhood "as the politically correct scale to address urban problems" (Smith 1984) suggests a quality of relationship is implied in the concept, despite (or perhaps because of) the increasing placelessness of modern life (Relph 1976) and decreasing social ties to neighbourhood. Typically, the term implies shared interests (association) or characteristics based on geographical proximity (Green and Raeburn 1990; Labonte 1987; Ontario Prevention Clearinghouse 1992). Perhaps what we are witnessing is a romanticization of the notion of community as refuge from the pace, scale and

ravages of modernity, where community is posited as togetherness, the opposite of the alienation of modern (wo)man (Scherer 1972; c.f. Labonte 1989; McKnight 1985). But to what extent can we cling to an implicit morality of togetherness while rejecting or ignoring the parochialism and intolerance that is also part of the community experience? In so doing, issues of power and class are masked, and community becomes an ideal-type, preferred view, or fairy tale of the elite. This is perhaps why the concept of community should not remain indeterminate as long as its use by professionals steers us away from vital questions about inequality and social justice.

> It is easy to forget how often history provides instances in which community has been used to suppress conflict and prevent change (Scherer 1972, 5).

What does this discussion imply for a 'community' intervention such as COMMIT? Neither the COMMIT protocol (Thompson and Karimi 1988) nor recent publications concerning the trial (e.g. Lichtenstein *et al* 1990-91; Thompson *et al* 1990-91) make explicit reference to theoretical underpinnings. If one examines NCI's rationale for adopting a community approach (Table 10.4) in conjunction with recent work on community health promotion and other recent community risk factor intervention trials, several implicit theoretical perspectives can be posited to have informed the design of the COMMIT protocol. The contributed papers in Neil Bracht's (1990) seminal book *Health Promotion at the Community Level* justify the emphasis on community in terms of (a) increased recognition of the importance of contextual factors influencing human behaviour, and (b) the emerging political correctness of community participation in health promotion. Both of these appear to resonate with the rhetoric of the "new" health promotion as described in Chapter 2, and with the growing fiscal crisis within health care systems in North America. In their paper on social change theory in community interventions in Bracht's book, Thompson and Kinne (1990) assemble a meta-theoretical framework for community health promotion by gluing together theories at various scales such as social learning theory (Bandura 1977; Perry, Baranowski and Parcel 1990), organizational change theory, and concepts of community change (in terms of organizational coalition-building). But there is no critical understanding of relationships between scales or of hierarchical power relations inherent in communities as places. Instead, their model implies an elite community mobilization and professional inter-

organizational networking agenda. Significantly, disadvantaged groups are not explicitly represented in these authors' notions of community or community-based health promotion, even though it is well known, for example, that 'problematic' life style behaviours (such as smoking) are clustered predominantly within socio-economically disadvantaged groups. Green and Raeburn (1990) posit community as an ideal intervention point by virtue of its presumed mediating function between individuals and systems. But as a proposed compromise between structuralism and individual behaviour modification, we should be asking whether the focus on community is merely a convenient spatial half-way point. Neither the concept of community nor community health promotion as described in Bracht's (1990) book, for example, are predicated upon (a) a thorough critical analysis of how structure and agency interact (c.f. Giddens 1984; Chouinard 1992), which, despite its relevance, has received much less attention in health promotion than in sociology (see Chapter 2); or (b) on a focus on community having been demonstrated as the most effective *lever* for social change, particularly for social change that ameliorates the plight of disadvantaged groups (c.f. Alinsky 1971), where concepts of communities of limited liability (Janowitz 1967; Reitzes and Reitzes 1982) and community development approaches in health (Bregha 1971; Hoffman and Dupont 1992; Labonte 1987; Minkler 1990; Ontario Prevention Clearinghouse 1992a) seem more appropriate. Griffiths and Adams (1991) in particular note that the shift to community in public health has not been accompanied by the proper acknowledgment of how adverse conditions like poverty, unemployment and poor housing are associated with smoking, or else this is mentioned but rarely acted upon.

Several fundamental questions with respect to the COMMIT trial are suggested by the observation that social inequalities are often not addressed in smoking cessation interventions: (a) the appropriateness of the decision not to target heavy smokers, who are predominantly of lower socio-economic standing; and (b) whether social class (and therefore issues of power and empowerment) should have been more explicit, and thus (c) the advisability of community development approaches (as opposed to community mobilization) as modus operandi for the trial. While the arguments in favour of building a smoking cessation trial around community-wide interventions seem sound, it is nevertheless odd that predicating

outcome evaluation on quit rates amongst a cohort of heavy smokers would not be accompanied by a battery of activities targeted particularly to heavy smokers in each community. Yet this is what occurred in the COMMIT trial. It seems more remarkable when one considers that social learning theory (Bandura 1977; Becker 1990; Perry, Baranowski and Parcel 1990), social marketing approaches (Novelli 1990; Ontario Ministry of Health 1992b) and community mobilization manuals (e.g. Ontario Ministry of Health 1992a; Dignan and Carr 1987) are explicit about the need to target programming to particular audiences.[9] Several of the large community risk factor reduction trials underway when COMMIT was coming into being (such as the Minnesota Heart Health project) also provided plenty of opportunities for intensive individual intervention as well as changing public policy and social norms, and were explicit in the theories guiding intervention design. Since there is no explicit reference to theory in much of the COMMIT literature, one might assume that the trial's architects hoped that trickle-down effects from community-level activities would be sufficient to motivate the most heavily addicted segment of the smoking population to quit and remain smoke-free in sufficient numbers to make the trial a success (i.e. 10 percentage points above natural background levels as measured in the control community). Another interpretation, offered by one respondent, was that COMMIT assumed too much in terms of the ability of existing organizations (such as the Lung Association) to proactively take up the slack and do the intensive one-on-one work with smokers effectively required in this trial.

Amongst the key informants that I interviewed (both researchers and BC volunteers), there was fairly universal skepticism about the wisdom of having not targeted heavy smokers more explicitly, not only in terms of information campaigns but also in the work of each Task Force and in working more intensively with new recruits to the Smokers' Network.

> To me, it was stupid... I think we could have done a lot more with [smokers]. I think the Smokers' Network could have been a very aggressively managed opportunity to get face-to-face and help people. [The protocol] just never did that. It relied on information dissemination rather than direct aid. If you want to change attitudes and

[9] In their review of the application of these approaches Hyndman *et al.* (1992) show that targeting has occurred in smoking cessation programs in the US and Canada that have applied these theoretical constructs.

> behaviour, you work face-to-face with people. The research is very clear on this. Changing social norms as.. arms length.. communication is misconstrued. I think that we could have... still.. focus[ed] on changing social norms, but we'd have much more of a high touch component too. (K10, excerpts from 100-119, 224-235)

The need for supplementing environmental supports with direct one-on-one interventions is well supported in the behaviour modification literature (e.g. Hyndman *et al.* 1992; Donati 1988). While it is plausible that environmental supports for behaviour change (social norms, social policy) are important factors in behaviour change in populations, the COMMIT protocol designers seemed to have assumed that it was also both a necessary *and sufficient* condition in any particular heavy smoker. Rather, it would seem that positive social norms might be conducive but not sufficient to induce change in highly addicted smokers. Models of human behaviour such as the Theory of Reasoned Action (Ajzen and Fishbein 1980), and Social Learning Theory (Bandura 1977), suggest that perceived norms are only part - albeit a potentially important part - of behavioural decision-making. And in both models, a clear distinction is made between generalized attitudes and social norms versus behaviour-and-setting-specific attitudes and norms in terms of their ability to predict (and thus influence) behaviour (Sutton 1989; Rimer 1990; Carter 1990; Becker 1990; Perry, Baranowski and Parcel 1990).

> ...we know that the evidence is fairly slender to support the relationship between... changes in general attitudes and changes in specific behaviours. And that's even within the same group of individuals. Now what we're saying is that changes in general attitudes in the community at large... can... affect change in behaviours in a very specific sub-group and that's a fairly tenuous proposition, especially within the four year term that we're limited to in the trial. (K15, 78-88)

Nor should it be assumed that changing community social norms necessarily results in a change in social norms within peer subgroups of heavy smokers. It seems more likely that changes at the macro social level must be reflected at the micro social level to have a significant impact on behaviour. Insofar as social norms conducive to cessation have occurred first amongst the urban middle class (c.f. Ferrance 1990), it may be necessary to target 'harder-to-reach' groups. Otherwise generalized efforts directed at changing 'community' social norms may result in greater acceleration of anti-smoking sentiments amongst the well-to-do and the alienation of heavy smokers, which may in some ways be even counter-productive. (This relates to comments made in Chapter 9 regarding tobacco control.)

A very different tack for NCI to have taken, suggested one researcher, might have been to encourage knowledge development around how best to reach (i.e. target) heavy smokers.

> I don't know of anybody who's really demonstrated how you work with these hard to reach groups. It would have been very interesting if the protocol had said, "Listen, here's a special need. We need knowledge development in this area. We need ideas. We need some experience." And set up, I was going to say competitions, but it's not quite the right word, but maybe it is not a bad word. If there was an understanding that each community was to think for six months about this and bring their ideas to the table and exchange ideas and test things out, so that it was on the agenda in a different way from activities where we knew more. That would have been a very interesting approach, I think. (K11, 798-814)

One of the results of the lack of encouragement in the protocol to target activities was that BC volunteers felt they were "working in the dark" with respect to what heavy smokers wanted or needed. Since targeting was not encouraged, little or no information on specific target groups was provided to intervention communities.

> There were no heavy smokers on the Board, and we have yet to get one of the target group participating in the governance of the project. So that the Board is totally unable to really understand the psyche, the decision making and priorities of the very target group that its trying to access. (K5, 946-950)

The failure to recruit heavy smokers, the working class, and members of disadvantaged groups onto the Community Board and Task Forces was partly intentional, insofar as the recruitment of "movers and shakers" at the outset of the trial in each community was mandated (c.f. Best 1988). This was no doubt a strategic decision, given the limited time allowed for projects to get up and running and the need for a core of volunteers that would lend credibility to the project and be effective in getting things done.

Despite the lack of representation from low income heavy smokers in the formal organization structure of BC, the Task Forces and Community Board had begun to see the importance of targeting and had come up with some innovative ideas in the final year of the trial, some of which were implemented. The "You Deserve A Break" day for low income women and neighbourhood cessation programs meant taking the programs to the people rather than waiting for them to come to you, and volunteers judged these to have been very successful. It is possible

that with time more of these sorts of targeted activities might have been undertaken. But it is hard to see how it could have been accelerated earlier in the trial given the orientation of the protocol as arbiter of the contractual obligations of each site.

Several initiatives were made to get the smokers' input, including (a) early community forums in May 1988 and (b) informal chats with a local priest, a representative from the local chapter of Alcoholics Anonymous (which subsequently split into smoking and smoke-free meeting groups). In the latter case, financial strain, a desperation to quit, and cigarettes as part of the smoker's identity, culture and way of life were some of the ideas that seemed to have emerged, but it is not clear whether and how these were acted upon. Apparently notes were taken at the early community forums but they do not appear to have had much impact on subsequent intervention implementation. Partly this could be attributed to timing, in that the first year involved volunteers and staff getting up to speed on protocol requirements. A year later, when the material might have been usefully reintroduced, it seems to have been forgotten. Perhaps the community forums or focus groups could have been done repeatedly as a way of monitoring the pulse of the community.

Instead, an unfortunate by-product of a lack of direct contact with heavy smokers was the tendency among key informants to stereotype them in condescending and patronizing terms. One staff member who smoked reported that snide comments about "stupid smokers" made by researchers and volunteers made her very uncomfortable. There is an interesting parallel here with the testimony of smokers who said that they often felt stigmatized and called upon to defend themselves as "not stupid" (see Chapters 6 to 9).

> Amongst the staff and the volunteers, there was a general attitude of... I guess ignorance about smokers and, and that, you know, smokers are all the low socio-economic group and they wear jeans and bomber jackets and have a butt hanging out of their mouth all the time. I mean, I'm not wealthy but I guess I'm a little more educated smoker than... the ones they were describing and it made me feel kind of um... (pause) I didn't really like the way it made me feel. It made me feel a little insecure .. you know... some of the things they would say about smokers and here I was a smoker and I was sitting there listening... Sometimes it used to get me a little upset.... "Stupid smokers" was mentioned a few times.. There was a few other things like... jokes about the lack of money that they have and yet they're spending it on that and... just generally uninformed or maybe had a bad picture of what smokers were like (K40, 90-115)

There is an irony here, in that they had the opportunity with this staff person to check out some of their preconceptions and bounce ideas off her. One would have thought that volunteers and researchers would have welcomed this opportunity, given that so little other information was available about 'what makes smokers tick'. However, this does not often seem to have been the case.

> I used to suggest places like, "Let's, let's put our posters in a laundromat." Or, "Let's put our posters - let's go to the bank, you know, and, and, let's go to the bank on cheque day and let's set up a little booth and see who comes over. You know, that's when they realize how little money they have and how many places it has to go... And I'd get all excited with all my ideas, but I wasn't the one running the show, kind of thing. Sometimes people just like it to be their own idea. You know. It's as simple as that. You know, their egos or whatever. For whatever reason, it's like, you know, "Oh, oh, the stupid smoker has suggested something." This is the feeling that I got. Lots of times my suggestions were just ignored. I mean, literally ignored. Like, I thought, "Geez, you know. Didn't anybody hear me, or...?" It was like I'd never said nothing. But after a while I learned what meetings I could speak in and what meetings I couldn't, and I didn't speak in the ones that I couldn't.
> (K40, excerpts from 241-291)

Her feeling was that having 'movers and shakers' who smoked on the Board and Task Forces would have given them credibility with the others that as a clerical staff person she felt she did not have, and that this might have encouraged more understanding of smokers.

On the other hand, a case could be made for also having more 'grassroots' (less socio-economically privileged) smokers involved in program design and delivery, given the disproportionate number of smokers in lower socio-economic groups. There has been greater recognition lately of the need to target such groups (for example the The Victoria Declaration on Heart Health 1992). Programs in Canada that have targeted smoking cessation programs at low-income women, for example, have succeeded in generating 6-month quit rates of 25 percent among this traditionally hard-to-reach population (Ontario Prevention Clearinghouse 1992b). The question for COMMIT is how this could best have been incorporated in the protocol design and implementation. The preferred option (expressed by a number of key informants) of having direct grassroots representation on the Board and Task Forces would have been difficult on several grounds. As one volunteer said, the difficulties associated with training lay leaders (although worth it in the long run) would have been considerable.

> How do you take a person who, every time you wanted to ask for something, he's always having to say please and thank you and ask for time off and then all of a sudden say, "we're going to put you on this Board and we're going to throw you in with the mayor, and... doing press conferences, an you have to be able to write...." Well, that's very intimidating.... Its very hard to say, you know, "you're John Q. Amorphous public, I want to make a leader out of you". (K5, 996-1002, 1020-1021)

In addition, the formal administrative *modus operandi* of the project in terms of Roberts Rules of Order would have been a foreign operating environment for "grass roots" elements.

Another strategy for including these perspectives could have been to pursue a bottom-up community development strategy with disadvantaged groups, but this would probably have made for an 'untidy' process from NCI's point of view and might have been threatening for Brantford volunteers. Because the parameters of the intervention were already set, NCI would probably not have been well predisposed to having "lowly" smokers commenting on the scientific merit (and likely efficacy) of the protocol. Once again this begs the question of who is fit to properly represent "the community" and what "community-based" health promotion really is. But also the issue is whether (and if so, how) the competing agenda of scientific versus community needs in the trial might have been reconciled by finding ways to support and creatively evaluate community development approaches to smoking cessation.

10.2.4 Evaluation issues: how to capture the wisdom?

Three issues are considered in this section that have a bearing on the COMMIT evaluation protocol: (a) the likelihood that BC will be shown to have achieved its "delta"; (b) the appropriateness of the formal evaluation methods employed by NCI for measuring protocol adherence, intervention delivery and receipt, and impact with respect to project outcome objectives; and (c) other types of "wisdom" from the trial that might not be captured in the mandated evaluation protocol.

The primary outcome goal of the COMMIT intervention was for cessation rates among heavy smokers in intervention communities to have been elevated to 10 percentage points above those found in the comparison communities. Twenty-one of

the 40 key informants interviewed who were most familiar with the COMMIT trial were asked to complete a brief questionnaire at the beginning of the interview. As indicated in Chapter 5, each of the 16 questions asked respondents to rank one dimension of BC's performance on a 7-point Likert scale. One question asked respondents to indicate the likelihood in their minds that Brantford COMMIT would be able to achieve this outcome goal with respect to Peterborough (the comparison community). On the whole, responses ranged from "not very likely" for researchers (N=7), to "somewhat likely" for BC volunteers (N=12), with an overall average score of 4.8 (1 being poor and 7 excellent). The lukewarm evaluation was based on a realistic appraisal of the aforementioned limitations of the protocol in terms of its impact on BC's ability to effect substantial changes in cessation amongst heavy smokers in Brantford. In summary, these included (but were not limited to) the following: (a) failure to provide feedback to communities so they could monitor their progress and make mid-course changes in strategy; (b) the limited time in which to not only shift social norms but have these changes reflected amongst heavy smokers; (c) the failure to explicitly target low income heavy smokers (the most significant group but traditionally the most resistant to change); and (d) restrictions on BC's ability to work more intensively with members of the Smokers' Network. Also, with a background quit rate of over 5 percent, COMMIT's target of thrice that (10 percent above the comparison community) was judged by many to have been ambitious, given that it is not a clinical cessation intervention (where 6-month quit rates of 25 to 30 percent among participants is considered very good). Although this level of change might have been necessary to being able to detect statistically significant differences in outcomes between intervention and control communities, it could nonetheless be argued that a smaller impact would still be of enormous practical significance (respondent K11).

Discussion about the meaning of different impact levels reflects the fact that outcome evaluation results will not be available until mid-1994. But it is worth considering how a positive or negative outcome might be interpreted both within the trial and by 'outsiders'. What aspects of the program will be seen to have been endorsed by a positive outcome (achievement of the "delta")? If the trial is only marginally successful (i.e. can be shown to have accelerated cessation rates to 5 or 6 percent above normal), as many key informants felt would be the case, what is to be

concluded about the trial? And what will be the impact on ASSIST, which was to have been based on the COMMIT trial but which is already underway? The indications are that there are few formal channels of communication established between the two trials that might facilitate information exchange, and that few ASSIST communities have made much of an attempt to learn from the implementation experiences of COMMIT intervention trial to date. Several researchers wondered whether the results of the COMMIT trial would have much impact on ASSIST one way or the other.

> Suppose the results of the COMMIT trial are totally negative. What is that going to change? Well, I think it'll probably change NCI's willingness to fund such a study again. It will change the political climate. It will set a precedent that people can point to, so it will be harder to get this kind of a project funded than it was before Commit. But on the practical side, I don't think anything's gonna change. I think ASSIST will roar ahead. I think that people are going to continue to use the community model. Not only because it's politically correct, but because we've had problems that are bigger than one individual can deal with. Governments can't deal with them because they have to deal with local norms rather than laws. I think that on a logical basis, the only kind of an approach that makes sense is more of a community approach. (K11, 1158-1182)

If it is in fact the case that increasingly "communities are the way to go" as the most appropriate scale of intervention, then the purpose of the COMMIT trial is cast in a somewhat different light. Rather than the typical clinical hypothesis concerning *whether* a community approach "works" or makes sense, the task becomes learning about *how* to make it as effective as possible. In other words, process assumes greater importance in relation to outcomes.[10]

As indicated in Chapter 4, NCI researchers and their advisors devised an impressive array of surveys and other data collection requirements to measure as reliably as possible across communities their adherence to protocol requirements (e.g. percent of activities completed), protocol implementation (quarterly reports and surveys for intervention receipt in the community) and impact in the community (attitude and behaviour change in smokers and intermediary channels). Researchers will be in an excellent position to investigate the statistical relationships between each of these groups of factors for possible explanations of program success or

[10] With an emphasis on how to maximize the impact of community approaches to health promotion, a trial that encouraged innovation (rather than a standardized protocol) would seem more useful, as discussed above.

failure. On the other hand, one can predict that accounting more exactly for why some programs were more successful than others and what facets of program design or delivery had the greatest impact on cessation rates will not be an easy task.

In this sense, NCI might have done well to include more qualitative data collection than was possible through the fairly structured quarterly reports (question-and-answer format), to allow for the telling of stories and, more importantly, to allow sites to raise their own questions, concerns and issues about protocol design and not just its implementation.[11] Generally speaking, the importance of *how* things were done was under emphasized in the evaluation protocol, in favour of more quantitative measures of activity levels of different types. As a result, one could envision several issues not emerging from the NCI evaluation research that perhaps should. For example, the importance of fun in the creative process, of playfulness and a sense of mischief that one often thinks of as being at odds with the usual "committee" environment was mentioned by several people to have been crucial in Brantford because it contributed to creativity and the building of trust between members. Or details like providing meals to allow busy people to be able to consistently attend Board and Task Force meetings. Or the nuances of turf issues between organizations (see section 10.3.3). Or stories about "self-definitional acts" (K11), pivotal events, and epiphanies and their role in shifting the qualitative feel of how a committee worked together or the confidence level of a Task Force in taking on city hall. These are the sorts of issues that appear not to make their way to NCI via the quarterly reports or through formal survey techniques. In fact, there does not seem to be an analysis plan for distilling the wisdom that is in the quarterly reports as there is for the evaluation survey results. And because of efforts by communities to sidestep onerous restrictions by NCI on working with Network members, quarterly reports submitted to NCI do not always tell the full story. In addition, as mentioned earlier, there are aspects of Brantford culture and things that are known about different people that are widely known in the community but rarely talked about. What emerges for the COMMIT trial, then, is a scenario in which the "official" story contained in the quarterly reports represent only part of the larger

[11] In fact, for maximum learning, protocol critique (as constructive criticism, so as not to damage morale) should have been encouraged, even if this might have been threatening to NCI, who obviously had a lot invested in the protocol as it stood.

"unofficial" story as known by volunteer participants. There may also be a natural tendency on the part of NCI not to "tell all", given how much they have wrapped up in this trial.

The larger issue this raises is not just how to best evaluate the trial, but how best to capture the wisdom generated in communities and research institutions as a result of participation in the trial. It would be a shame if this was left to the ad hoc publication of papers by various researchers in academic journals, although it is encouraging that some sites are preparing papers that reflect on the nature and design of the trial as a whole (e.g. Goldsmith *et al.* 1993).

Another issue to be considered is the degree to which the evaluation methods employed by NCI will do justice to very real changes and progress that has occurred in Brantford and in other intervention sites that will not necessarily be reflected in final outcome measures. For example, considerable organizational change may precede measurable shifts in community norms or smoking behaviour in the population at large. Premature or behavioural outcome oriented measurement may not reflect significant changes that may have occurred in the community.

> I must admit I don't know a lot about the protocol for the evaluation side... [but] my impression is most of what they're going to do is a survey of actual smokers; have you quit or haven't you sort of thing. Which I don't think will get to the organizational side... I would think that to get a true picture of the whole model of this, not just the intervention protocol but the whole structure, there should be some kind of an evaluation component to the organizational side of things. (K17, 824-833)

The formal evaluation protocol seems to have adhered to an implicit model of social change which says that if one puts a unit of intervention in, one gets a unit of effect out, the point of evaluation being to measure the relative size of those units (in this case predefined units of intervention against percentage points of cessation or attitude change). Implicit in this approach to evaluation is a linear incremental change model of social change. A more appropriate analog might be that of critical mass, whereby one would appear to put in considerable effort with little visible effect at first, and then suddenly things seem to come together, because people have been hearing things, skills have been developing and so-forth. The implication of a critical mass model of social change is that interventions may not have an immediate impact, but things are germinating and developing until they coalesce. The timing of

evaluation in such cases is of paramount importance. One respondent (Researcher K15) likened this to a step function comprised of shifts and plateaus, upon which one could identify key or pivotal events. The evaluation of a social change intervention that would use a critical mass or stepwise kind of model, would probably look very different from the sort of evaluation that has been built into the COMMIT trial. The implication is that perhaps the failure to use such a model meant selling COMMIT short as to its impact in Brantford. Including measures of capacity development or leadership (e.g. 'bravery') might have captured some of these missed elements, but they were not specified in the protocol.

Another aspect of the evaluation that has already been mentioned was the "blinding" of communities as to their progress over the course of the 4 year intervention period, due to NCI's fear that comparison communities might be "contaminated". However, this prevented intervention communities from making what might have been very important mid-course alterations. One of the researchers suggested that in fact the science of the trial might have been enhanced in different ways by allowing more leeway for experimentation in the field.

> I think it would have strengthened the science of the project in the sense that if any project leads to negative results, it's less interesting than if it leads to positive results. So if I was doing something like this and it was my call to make, I'd stack the deck in favour of finding an effect. You know, forget about applied science, let's think about basic science. The first principle if you're exploring a new area I think is that if there's a phenomenon, you want to be sure to detect it. You don't want to have a false negative off the bat. And... so my inclination would have been to pull out all the stops and try and make something happen and work at documenting what the actual independent variable was as we went along. I mean, the truth is and taking this approach, we don't have any clearer idea of what the actual independent variable was, I don't think, than if we'd given people that kind of a latitude. We know there's an array of activities, we know which ones people said they did, and take their accounts at face value. But that's an awful long way from knowing what the independent variable was. I mean, I was the independent variable to some extent... Frank was and Ruth was. (K11, 414-437)

In a sense, then, a different sort of evaluation would have required a vastly modified trial design (and vice versa), which would perhaps have had very different consequences in terms of the nature and quality of knowledge generated. The question of how appropriate a strategy the COMMIT trial was for generating the sort of knowledge needed to further community health promotion is thus opened up for debate.

> We're facing another who knows, at least a couple of decades, maybe a half a century of very expensive, very complicated, and very important public health studies, and we're getting into them right now with mainly an epidemiological mindset with a set of methodologies which originated in psychology laboratories principally, and a smattering of well-intended but empirically very poorly-supported community doctrines... It's more or less, depending on the printed line that you're reading, attractive stuff, it's intriguing, some of it brilliant... but proven? And I don't like to sound like a narrow-minded, hard-assed, NCI money-custodian. But the fact is that if you're going to spend... 10 or 20 or 60 or 100 million dollars of public money, you're going to have some reason to believe that what you're doing makes some sense. And one of the lessons of the Commit trial is that if you provide yourselves and the public with... guarantees that you're not taking too big a risk, based upon the conventional ways of doing things, the result is that you don't accomplish anything. It's safe, but... pointless. (K13, 470-496)

In this section, a critique of the intervention protocol was undertaken, in which a number of limitations related to capacity development in the community, allowances for local needs and circumstances, whether to target heavy smokers, middle class bias, and evaluation issues were discussed. In the second part of this chapter, organizational issues involved in running the trial in Brantford are discussed, again drawing on interviews and focus group with key informants.

10.3 ORGANIZATIONAL ISSUES

In this section, some of the relationship and people management issues involved in building and maintaining a new organizational infrastructure are examined. Relationships are the stuff of which interventions are made: the nature of relationships (e.g. trust/mistrust) has a profound impact on the delivery of a protocol in any given community. Therefore, the emphasis in this section is on relations within and between various components of the Brantford trial (researchers, volunteers, staff, other organizations in the community etc.). In particular, three issues are addressed: (a) building credibility for BC in the community; (b) attracting and maintaining volunteer interest; and (c) turf issues with other organizations. Several other organizational and relationship issues have been discussed in the previous section (e.g. reluctance to ruffle feathers).

*10.3.1 **Building credibility for a new initiative in Brantford***

One of the surprises for many people involved with Brantford COMMIT was the degree of effort and time it took to make BC, a newcomer in town, regarded as a *credible* organization. Although precise definitions were not sought, it was clear from respondents' testimony that credibility was predicated, to a certain extent on (a) achieving a high profile (being seen, being connected); and (b) not rocking the boat too much at first (not to be labeled and dismissed as extremist).

> Profile is everything. The higher the profile, the more credibility you have, the more people are willing to listen... and the less intrusive your approach, as opposed to being high-handed, the more willing they are to... be a partnership rather than superior-subordinate or, you know, expert versus dummy and, and all the paternalistic kind of things that, or negative things along with that. (K5, 1094-1100)

One staff member wished that a more aggressive public information campaign had been mounted sooner to raise the level of awareness about COMMIT. However, s/he also acknowledged that you need to set up the organizational infrastructure so that you can respond to people once they start coming to you. Someone else raised the point that you have to build trust first by doing normal, expected things, before you can do more risky things that test that trust. Both issues point again to the need for adequate start-up time: organizations do not spring up overnight, much as NCI might have wished it to be so.

From the experience of key informants, credibility means being taken seriously, as having something to say, and a legitimate task. One's credibility is affirmed when one is approached for advice, guidance or an opinion. It is a feeling that one matters. It means being trustworthy and keeping one's word, and therefore being very skillful at damage control when miscommunication threatens that trust. Credibility means having credible information and an association with credible others, such as the researchers and universities attached to the trial. None of this should be taken for granted. It is typically easier to lose credibility than to gain it, and it means knowing how to work effectively with people: diffuse tension, resolve conflict amiably, pay attention to other people's needs and other people skills often assumed but rarely taught (and perhaps unteachable?) in intervention trials.

Brantford COMMIT's experience of gaining credibility with the local media is a poignant example of the dynamics involved. The media by nature tend to be skeptical of new single-issue groups and sensitive to being manipulated by them.

> [BC is] quite good at, at generating publicity. I mean, that's a large part of what they do. They want public attention. So they're, they're fairly creative... and inventive in coming up with projects or studies or reports or anecdotes or - not anecdotes - but information... that puts a fresh face on what they're doing in the community. Now some, now and again, people in the newsroom said, "Well, that really wasn't a news story. That was just something manufactured by the Commit people to get publicity.". And I've said, "Yeeaahh, okay. But at the same time it's still sort of interesting." But we're getting a... little uhhhhhh, cautious... in just running holus-bolus with anything that they choose to hand out to us. We're looking at them with a more critical eye. Is this really new or is it just a pressure group trying to justify it's existence? (K27, 242-259)

Learning the language, tactics and etiquette of effective media advocacy is essential to building a fruitful relationship with the media.

> I think it wouldn't have felt so uphill if I understood that it was going to take some time to gain some credibility. And what I needed to do was give myself some time in terms of saying, "Ok, I'm going to fire off these first five press releases over the next four months, and they probably aren't going to publish any of them. But after they've heard from us a couple of times and understand that we're affiliated with Waterloo and McMaster and we're credible, then they start saying, `Well, maybe, and it's these guys again, maybe they do have something to say." And I think the other thing is to be very professional with them, to have press conferences, to have packages for them, to have supplementary information that they can have a press release but give them some other names of people to call, give them some extra stats and information, some things that they can be creative with. I mean, these reporters don't just want to take something back and say, "Oh here's something already typed up, just throw that in the paper." If they've taken the time to come here, then give them books and give them then some other things that they can add to the story and call it their own. (K37, 1000-1024)

The difficulty is that publicity about smoking all seems like 'old hat' to the media, even though historically they may not have been very good about devoting space to smoking issues. Getting smoking issues (and COMMIT) covered by the media was an uphill battle against those who, by nature, are more interested in the latest, sensational new story than in plugging away diligently at long-standing social problems. As the testimony of one local media person avows:

> I think the thing is we've read it all before, we've seen it all before. There's nothing new to say. It's become almost uh... well, boring. You know, I mean I have no interest this week or next week in writing yet another predictable editorial about how bad smoking is. You can only say it in so many ways, so many times. And I think.. it's just become platitudinous, you know what I mean. What more can you say? Almost

> everyone can tell you there's 30,000 related deaths in a year and so on and so on... and, we know it all. That's why this Commit group tries to be very ingenious in finding something fresh to say that will get people's attention. And that's why we sometimes wonder if their main function is to sit around trying to think of something, cudgeling their brains to come up with some little wrinkle that will attract some interest. Because you can't just keep banging the same drum forever.. and hold people's attention. And I think that is a danger. We're sort of overloaded with repeated information. (K27, 365-392)

10.3.2 Attracting and maintaining volunteer interest

Volunteers became involved in Brantford COMMIT for a variety of reasons (Table 10.5), mostly to do with personal and professional interest, and the chance to be affiliated with a cadre of high caliber researchers. The majority of volunteers had never smoked themselves, although some had had family members or friends succumb to tobacco-related disease, or themselves had allergies or an aversion to cigarette smoke. When asked what they got out the COMMIT experience, most said that working with people, participating in a large international study, and a chance to make a difference locally as the main reasons (see Table 10.6). Amongst those interviewed, all felt good about the experience, and were glad to have been involved.[12] Some of the frustrations experienced by volunteers in terms of dealing with turf issues and people's reluctance to ruffle feathers are discussed elsewhere in this chapter.

10.3.3 Turf issues with other organizations

The lukewarm reception that the trial received from organizations such as the Lung Association and the Cancer Society was a source of ongoing surprise, disappointment, frustration and even resentment for many volunteers and researchers.

> There seems to have always been an edge, whether it was by reluctant participation or conscientious monitoring. There has always seemed to be an over-the-shoulder glance, and comparison.. and I'd even say organization rivalry, jealousy. (K5, 122-125)

> The mindset is that they didn't want us here to begin with, they don't want us here [now, and] they can hardly wait to get rid of us. (K1, 9-11)

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[12] It should be noted no special effort was made to ensure that volunteers who became disenchanted with the project and resigned were interviewed.

The one event that crystallized the growing discomfort many volunteers and researchers had about the local chapters of the Lung Association and the Cancer Society was the retreat in the final year of the project that was convened to talk about the future of COMMIT in Brantford. It was in this meeting that these organizations let it be known they would not be directly involved in the next phase of the project, whatever form it took.

> I think we see the reaction of it more now at the end... You know, one of the comments [at the retreat] was, "Well, we just wish Commit would... go away and things would go back to the way they were." I mean how could...?! (laughs) I just couldn't believe that! (K4, 54-57)

> I was dumbfounded at the lukewarm reception that continuing got, or that the possibility of continuing got. I was sitting at that meeting and I heard... one individual who's been very closely tied with Commit, on the board for example, is also on the Lung Association board, say "Smoking is not a priority for the Lung Association." (laughter) Can you believe it?! I damn near fell out of my chair! If the Lung Association doesn't see smoking as a priority, what the hell does it see as a priority?! I was just absolutely dumbfounded! And the woman from the Cancer Society basically said, "Well, me too." She was basically saying they're too busy. Uh... I experienced a lot of emotion at that meeting (K11, 1551-1569)

> Were you at that retreat at the tenth? I mean that was the proof in the pudding. That was to say to all these people who have had some leadership opportunities on smoking cessation in Brantford... who have peripherally or directly involved with the COMMIT project to come forward and say would they like to continue in some way, shape or form, a structure to be determined, a mission to be determined, a set of programs and services to be determined, staffing to be determined, at the... behest of government in that we would apply for funds and hopefully receive funds and so that by injecting new money, we wouldn't be competing for fundraising and we wouldn't have to use volunteers to fundraise, so we would have, you know, a different kind of philosophy, but everybody seems to... the turf... It's not even a turf war, because.... I think it's an unduplicated product. The smoker's network, self-help groups, work site consultations, some of the quit and win, the contests, the media exposure. I mean, all of that stuff is something that nobody else had been able to achieve. So I think that a lot of people are, you know, worried about the boogie man and they're afraid of something they don't understand, rather than having faith that they're bringing the right mix of people with the right agenda and the right resources, they will come to some equilibrium. ...That to me that's so parochial. (K5, 75-111)

Insofar as the mandate of organizations such as the Lung Association and the Cancer Society included smoking cessation activities, or at the very least addressed diseases with proven links to smoking, one might presuppose a certain level of enthusiasm for more concerted efforts in tobacco control and smoking cessation on their part. But by the same token, substantially raising the profile of smoking issues in Brantford would also highlight how little by comparison these organizations had been doing in this area prior to COMMIT.

> ...what we've also been able to show is that the status quo wasn't doing much (K5, 58-59)

Several other explanations might be offered for why these organizations might have felt threatened or why those involved with BC might have perceived them to be reluctant participants (Table 10.7).

> Whether it's the personalities involved, or whether it's something that's an integral part of the structural integration of those agencies in the community, I have no idea what the actual root cause is. I have a funny feeling it's all the above. It's people, it's organizations, it's history, it's tradition. There's... fears, anxieties... the whole nine yards. So, I don't know. And I've been a little frustrated in our inability to unbundle that, to identify it and work towards it's resolution. Rather we keep it in the suitcase and every now and then this ugly little thing surfaces it's head and then we run around managing the damage, rather than having been more mature about the whole thing and putting in up front, identifying it and collectively working to resolve the concerns and the communication and all that stuff. I think that's probably the most... disturbing. (K5, 126-143)

It is significant that the issue does not seem to have been ever openly aired and resolved at an organizational level or within the Board or the Task Forces, even though participants felt the perceived tensions were detracting from the operation of the group. In fact, it seems that the Board did most of the "damage control" and brokered conflicts and potential conflicts on a reactive one-on-one basis.

> [The Board] didn't just let [these problems] go and hope that they'd go away. We actually, I think, did a whole lot of work ...with the staff to find ways of supporting the task forces and the board and so on in a positive way... I mean it wasn't the overwhelming activity of the whole project, but it was a conscious effort. You know, it didn't just sort of happen: we ended up consciously working with the dynamics of those groups and finding solutions. We didn't get them all.... (K4, FG 1956-1969)

One of the most enduring frustrations was the generally negative and defeatist attitude key informants felt these organizations had towards escalating smoking cessation and tobacco control activities in Brantford. This combined with a lack of shared vision to give the impression that the Lung Association and Cancer Society were throwing up barriers to progress on the smoking issue in Brantford.

> I, quite frankly, am fatigued at trying to change their mindset. Because they will not budge, you know, they come from the negative all the time. And, I don't know why. (K1, 153-155)

> They don't proactively try and change, you know, policies or whatever. They wait for people to come to them. You can't do that if you want to move ahead. (K1, 44-47)

Respondents also spoke about the Brantford tendency to see challenges as insurmountable problems and excuses for inaction, rather than as opportunities to create something new. This also affected relations between BC and other like-minded organizations in the community.

> I spoke with [so-and-so from the Lung Association] this past Monday, who set up all sorts of roadblocks and said, "Well we can't move ahead with this because there are no volunteers" you know, there's this and that. And I'm saying "there are lots of people out there who are in a recession. There are people without jobs that may want to just get out of the house for goodness sake, let alone pick up new skills. I mean, now is the time to be recruiting." But s/he doesn't agree. And s/he's saying people won't do it, and my response is, "Don't make those decisions for them. You can't do that." You know, I'm an idealist and s/he's a realist, is what s/he tells me. I said, "Well, maybe so. But at least I have a goal to reach for." (K1, 127-141)

To some extent, the "problem" may be the trouble organizations have working together on issues of mutual concern.[13]

> I think it's characteristic of Brantford, that people don't seem to be able to get... a hold of things and get enthusiastic and work collaboratively. They all want to do their own thing in their own associations or organizations and are very protective of their own turf and... they can't seem to go beyond that. (K4, 28-38)

> ...they all realize that the lack of co-ordination has split the agenda and as a consequence, ipso facto, that we have the highest incidence of smoking... and that's why Brantford was picked. I mean, that statistic alone tells us that what we were doing wasn't working. (pause) So if it isn't working, why do we continue to do it? And if it isn't working, why do we continue to prevent someone who's got a new approach from even trying? In fact the logic escapes me, and I can either discount that to uninformed people, paranoid people or uncaring people. (pause) ...Or a combination of all the above. (K5, 160-172)

Part of the resistance of these organizations in the community was due to a certain jealousy at the amount of resources BC had at its disposal that allowed it to do things these organizations felt they could not do, and that by comparison made them seem shabby.

> [One person from the Lung Association] was really concerned that Commit was ruining the community for other groups, because we had so many resources that we

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[13] Although difficulties with inter-agency cooperation were identified as characteristic of Brantford, they are by no means unique to Brantford. In fact, much has been written in the literature on the sociology organizations and management studies about managing change and conflict within and between organizations (e.g. Hampton, Summer and Webber 1982). While this literature would no doubt provide insight into the Brantford COMMIT experience, it is beyond the purview of this chapter to delve into it in much detail.

> were doing things that made other groups look shabby in comparison and when we went they'd continue to look shabby. These are my words. And I find myself really frustrated at some of the thinking, but I kind of understand. I mean, nobody likes to be put out of business... or shown up. And maybe we failed somehow to work with those people and created a sense that we were working against, but that's been one of the really surprising things to me. The territoriality, the negativism. I don't understand it. (K11, 1609-1639)

Although most respondents focused their discussion on the shortcomings of these organizations, the question also arises as to how COMMIT might have better anticipated these conflicts and provided sites with the skills, training and direction within the protocol for managing conflict and establishing ongoing mechanisms for addressing the (sometimes hidden) agendas of other organizations involved in smoking cessation in the community. Since it is easier to destroy trust than build it, a few early "mishaps" can linger on in the memory of community organizations for the duration of the intervention.

> [The] territorial rights of the Lung Association... stemmed back originally when we were first approached... about what the protocol would be... We were left with the impression that night that they would not be duplicating services. It would be building on the strengths of the community. And somehow the key thing that made everybody upset was the work site clean air award. It was the simple matter of, "Why couldn't of somebody picked up the phone and said, "Are you doing anything this in area?" So it was more of the concern of duplication of services... And maybe the communication at the very beginning and the reassurance probably to not just one association but other associations that, "Look it, this is how we see the protocol going. If you think throughout the point, you know, that we're not doing what we're saying we're doing, or you have concerns..." Then there should be some mechanism in place where they could meet outside of those COMMIT Task Force and Board members with a mediator, with a researcher and say, "This is how I perceived the situation" And I'm not sure.. I mean, there was a lot of talking and a lot of *tete a tete*, but I don't know whether there was one open mediating process. Maybe it just got blown out of proportion, you know. (K6, FG 1916-1940)

10.4 SUMMARY AND CONCLUSION

This chapter contained two main sections, dealing with protocol issues and organizational issues. In the first section, the merits and drawbacks of the COMMIT intervention protocol as described by key informants were discussed in terms of (a) the very existence of a standardized protocol, and (b) the nature of the protocol to be implemented. Particular emphasis was placed upon (a) flexibility of the protocol to adapt to local conditions; (b) the nature of Brantford as context for the intervention (especially the general reluctance to "ruffle feathers"); (c) changing environments

versus targeting the intervention by socio-economic status and amount smoked; and (d) evaluation issues. In the second section, some of the organizational and relationship-building (or people management) issues involved in building and maintaining a new organizational infrastructure were examined. The emphasis in this section was on relations within and between various components of the Brantford trial (researchers, volunteers, staff, other organizations in the community etc.). In particular, three issues are addressed: (a) building credibility for BC in the community; (b) attracting and maintaining volunteer interest; and (c) turf issues with other organizations. This chapter drew mainly on the testimony of key informants involved in the BC trial or having some dealings with it. This group was able to identify a number of issues concerning protocol design and implementation that would not be apparent to target groups or service clientele, thereby showing the advantages of consulting a variety of stakeholder groups, including both target population and intervention staff and volunteers, since our understanding of the intervention is correspondingly broadened.

It should be reiterated that the predominantly negative tone in this chapter stems from having asked respondents to reflect upon the difficulties encountered by COMMIT in Brantford and what they might have wished to do differently. The author felt that the strengths of the trial would speak for themselves and be well represented in the published papers arising from the trial. In the main, these relate to (a) innovative design features (multi-sectoral, randomized trial at the community level, community mobilization approach); and (b) the energy and commitment of the people involved (researchers, staff, volunteers).

In the next and concluding chapter, the responses of key informants and members of the Smoker's Network are compared and contrasted. Also, the concept of empowerment and community development approaches in health are explored to illustrate an alternative model for how the COMMIT trial might have been organized, and by comparison to shed light on the nature of the intervention as it actually occurred.

Table 10.1 Some difficulties for Brantford inherent in the COMMIT intervention protocol, as perceived by key informants

- insufficient allowance for getting up and running, building credibility & relationships
- lack of attention to skills development rather than mobilization
- emphasis on smoking cessation to the relative exclusion of prevention
- limited flexibility to adapt to "local culture" (especially Canadian vs US)
- lack of feedback on key outcome variables during the course of the trial
- "management by objectives" and checking off protocol activities wasn't conducive to seeing the big picture, innovation, enthusiasm, or seeing the protocol as a springboard (going beyond the protocol)
- NCI restrictions on accessing the Smokers' Network, or auxiliary surveys such as needs assessments with smokers
- no allowance for significant change midstream (like dropping emphasis on social and religious organizations)
- standardized design doesn't encourage field-level innovation & bottom-up learning
- failure to explicitly anticipate small-town conservatism and provide strategies to deal with this
- having the outcome measures in terms of quit rates amongst heavy smokers but not targeting programs directly at that group
- little self-critical analysis built into the trial to indicate how this sort of thing ought to be structured in the future
- timing of evaluation and relatively short duration of trial may fail to demonstrate changes that began to occur in the 3rd and final year
- failure to specify need to recruit smokers and members of disadvantaged groups onto the Board and Task Forces
- heavy emphasis on planning at the beginning of the project meant not enough "doing" and small initial successes
- timing of planning cycle mandated by NCI did not coincide with the community's activity patterns (annual action plans to be prepared in the summer)
- little guidance on how to set up an effective Board, how to manage volunteers, how to deal with the media, how to lobby effectively etc.
- evaluation protocol doesn't capture the "unofficial story" behind the trial in each community (e.g. activities somewhat subversive of the protocol)
- a set of guiding principles or value statement would have been valuable (e.g. treating smokers with respect, establishing a 'can-do' attitude etc.)
- could have fostered more collaboration and competition between intervention sites
- no explicit mechanism for transition and long-term follow-up in intervention sites (especially re sustainability & diffusion)

Source: adapted in part from transcript material and from Goldsmith *et al.* (1993)

Table 10.2 Instances epitomizing reluctance to ruffle feathers and defeatism in Brantford

1. Refusal of police chief and mayor to endorse sting operation
2. Labour's flaccid participation in WOTF perhaps to ensure status quo
3. Barriers to work places adopting smoking policies
4. Board's tendency to water down WOTF ideas/initiatives
5. A local donut shop became smoke-free but manager not willing to take public stand
6. Doctor's testimony about the near hopelessness of influencing patient behaviour
7. Lack of personal willingness of BC volunteers to say much in situations involving smokers in their own daily lives (movement on this during trial)

Table 10.3 Some concepts of community
(categories not mutually exclusive)

- community as *functional* entity or system
  - includes administrative definitions based on geographic service boundaries
  - tends towards linear, mechanistic interpretations
- community as *sphere of social relations*
  - includes psychological and sociological perspectives, "sense of community" and "sense of place" (c.f. Eyles 1985)
- community as *buffer* between the personal and the impersonal, the individual and the institutional, the informal and the formal
  (e.g. Berger and Neuhaus 1977; Bracht 1990)

Table 10.4 Old and new concepts of community

	Old	New
Definition	natural areas	cognitive image collective representation
Origin	emerged naturally,	intentionally created by internal or external agents
Boundaries	follow gradients in physical & social characteristics, especially costs of land and transportation routes, which often coincide with natural boundaries	follow gradients only where these are cognitively imposed; otherwise, imposed by physical or psychological barrier that deters movement
Characteristics	primordial solidarity among residents	solidarity based on need, issue, purpose
	homogeneous	heterogeneous
	participation is prescribed on basis of residence	participation is voluntary
Identity	determined by internal characteristics: what is unique or typical of the population or place	determined by external agents: what differentiates this part of the city; or, determined by internal agents: what is distinctive about our area?

Source: Smith 1984, 53 (originally adapted from Suttles 1972)

Table 10.5 Some reasons volunteers gave for why they got involved[14]

- own personal or career interest in smoking (topic) or in community-based health promotion (method)
- personal conviction about attributable burden of illness, health care cost implications of smoking etc. (some more militant than others)
- "mover and shaker" in the health field; familiar with the "committee" type environment
- excited by the research aspect and affiliation with university/researchers
- organization is relevant; overlapping organizational agendas (e.g. Lung Association)
- personal connections ("oh, we should ask so-and-so"); snowball sample
- represent a sector that needs to be included (ethnic minority, labour etc.)

Table 10.6 What volunteers got out the BC experience

- it was fun
- personal growth in terms of leadership skills, networking etc.
- feeling you've made a difference, even if it doesn't show up in the delta
- meet and work with interesting people
- learned a lot about scientific research etc.
- observe the process from the inside
- some frustrated by not being aggressive enough, while others threatened by having to take a stand
- keeping BC from encroaching on your turf; wanting to be part of it but not at the expense of your own organization (motive imputed by others)

[14] These are not mutually exclusive categories nor the only reasons, but rather the main themes that emerged when volunteers discussed their own involvement in the project in terms of original interest in participating.

Table 10.7 Some explanations for the perception that the Lung Association and Cancer Society were relatively unenthusiastic about the COMMIT trial in Brantford

- smoking is not at or near the top of their priority list
- not used to being very proactive on the smoking issue
- they don't want to be shown up or made to seem shabby in comparison
- general Brantford negativism and defeatism, and lack of vision which combine to take on the appearance of throwing up barriers
- personality conflicts
- time-limited nature of the trial
    - wait it out till BC gone & things return to "normal"
- failure on the part of BC and NCI to anticipate or plan for dealing with turf conflicts
    - minimal up-front consultation (protocol parachuted in)
    - one or two early 'bad experiences' regarding perceived duplication
    - lack of established mechanism for managing inter-organizational relationships, brokering agendas and turf etc.

CHAPTER ELEVEN

SUMMARY AND CONCLUSIONS

11.1 INTRODUCTION

This chapter has five main sections. The first three sections are devoted to a summary review of the main themes arising from previous chapters. These are organized according to each of the research objectives for this study, as described in Chapter 1. First, Brantford COMMIT's track record in meeting the needs of smokers in Brantford is reviewed, together with an appraisal of how well it was able to meet some of the other objectives set for it by NCI. Second, some of the main barriers and facilitators of program success are reviewed. In the third main section, the implications for community mobilization for smoking cessation are considered. Policy implications are discussed in the fourth section. The chapter concludes with suggestions for future research in community mobilization for smoking cessation.

11.2 OBJECTIVE ONE: DID BC MEET THE NEEDS OF SMOKERS?

Since the primary outcome for evaluating the COMMIT trial was the rate of cessation among adult smokers, it is logical that an evaluation of BC try to understand ways in which the intervention was able to address the needs of smokers for assistance in quitting. Several approaches were taken in this research that addressed this issue: (a) smokers were asked about their expectations of and reactions to the program; (b) smokers were asked about perceived changes in the intermediary channels targeted by the intervention (such as physicians and workplaces); and (c) smokers were asked about their own needs for assistance in quitting, so that this could be compared with what BC was able to provide.

The impacts of the trial on adult cessation rates in Brantford will not be known for several months, after the trial-wide evaluation results are released. Brantford COMMIT was certainly successful at recruiting smokers onto the Smokers' Network, in producing sustained mailings to members, and in staging a number of successful events such as several sting operations, neighbourhood cessation programs, and a smoke-free restaurant day. The question, of course, is whether this 'made a difference'. Was it sufficient to motivate the necessary number of smokers to quit and remain quit so that BC could 'make its delta'?

The material that emerged from depth interviews and focus groups with smokers suggests two things in particular regarding the 'performance' of BC. First, smokers valued BC just 'being there' for them. There was a symbolic importance attached to the fact that an organization had been established to help them quit, that it made opportunities and resources available to smokers, and that it followed through with regular mailings and opportunities such as the Quit and Win contests, even if members did not 'hold up their end of the bargain'. Second, and on the other hand, the testimony of members of the Smokers' Network indicated that the program had not been as successful as had been hoped in terms of assisting smokers to quit. Valuing the existence of BC did not depend upon respondents finding the activities or resources themselves to be of practical utility in helping them quit. Only a minority of respondents felt that their expectations had been met, and many were not clear about what BC had to offer even after having been members for months or years. The emphasis on mailings gave the impression of sustained support over time, but few respondents indicated that the care package or newsletters had been important factors in their own cessation. Rather, it appears that the relationship established with Network members was one that cast a passive role for smokers as recipients of information from experts. The support group was poorly attended and the telephone hotline was not used by most members even in times of crisis and need.

It is noteworthy that meeting the needs of smokers for assistance in quitting was never an explicit objective of the COMMIT trial. With few exceptions, smokers were neither consulted regarding their needs, nor encouraged to participate in the

administration of the trial. And despite the emphasis on heavy smokers in the design and evaluation of the trial, minimal efforts were made to target heavy smokers or gear channel-specific interventions to this group. Although the protocol effectively denied communities the opportunity to target or consult heavy smokers, there were also several missed opportunities to learn from smokers that suggested other barriers to a client-centred approach than the protocol. On the other hand, when smokers were asked to define their needs as part of this study, they had difficulty doing so, and it seemed that they might not always use some of the things they claimed to want.

It is also instructive to consider some of the goals that NCI did set for the trial (Chapters 1 and 4). It seemed that BC had been successful in increasing the priority of smoking as a public health issue at both an organizational level and amongst the general public. It is more difficult to determine how successful it was in improving the community's ability to modify smoking behaviour. It seems that most of the intervention implementation targets for each intermediary channel (in terms of mandated activities) were met, but it is not clear if substantial changes in practice have occurred as a result. In the case of the Health Care Providers Task Force, the requisite number of physicians received the mandated training program. However, interviews with physicians and their patients suggests that much remains to be done in terms of how (and how often) physicians encourage patients to quit. Patients want both encouragement and practical tips, but without the patronizing lectures. Physicians too worry about alienating patients by 'harping on' about smoking. The activities of the Public Education Task Force were considered in Chapter 7 in terms of (a) the profile of COMMIT in Brantford, (b) smokers' reactions to prevention and cessation messages in the media, and (c) perceived changes in social norms. As members of the BC Smokers' Network, respondents might have been expected to indicate they had heard or seen a fair amount about BC in the community more often than in fact they said they did. One of the other goals of the intervention was to increase social norms and values supporting non-smoking (COMMIT Research Group 1988). While smokers felt the social acceptability of smoking had changed dramatically in the last decade or two, it is not clear what COMMIT's contribution to changes in social norms was in Brantford. The attitude questions on the periodic NCI surveys would provide a more accurate picture about changes during the course

of the trial. Smokers' perceptions of cessation courses, support groups, and smoking cessation-related organizations suggested the need for organizations in the business of designing and running smoking cessation programs need to more carefully consider how such programs are marketed and how to address perceived barriers to participation.

The trial also sought to increase the influence of existing policy and economic factors that discourage smoking in the community. The activities of the Worksites and Organizations Task Force addressed this objective as well as the one discussed above. It was evident that BC was not successful in reaching social and religious organizations, and that perhaps this had not been a realistic or appropriate requirement in the protocol. Several conclusions concerning work site smoking policies emerged from discussions with smokers and key informants. First, a majority of smokers supported the principle of restrictions on smoking in the workplace as a courtesy to non-smoking coworkers, but they would much prefer that this took the form of designated areas rather than a total ban. Second, while most respondents agreed that they smoked less during working hours when restrictions were in effect, they were divided as to whether they "made up for lost time" at breaks and after hours. Third, a socio-economic bias seems to have characterized (a) the adoption and implementation of workplace policies (with white collar workers more likely to have restrictions and more stringent restrictions than blue collar workers), and (b) the social culture amongst workers, with blue collar employees more likely to be exposed to ridicule for trying to quit, and to be exposed to social environments outside of work that are supportive of smoking rather than cessation. Although there was general appreciation in theory of an SES gradient in smoking by BC volunteers on the WOTF, it does not appear that the practical ramifications (as discussed in Chapter 9) were either fully appreciated, openly discussed, or directly addressed except sporadically by intervention staff and volunteers.

11.3 OBJECTIVE TWO: IDENTIFY THE BARRIERS AND FACILITATORS OF SUCCESS?

The picture of the intervention that is painted throughout this study is one of an organization trying to create meaningful change in a number of key sectors of the community with relatively little time for community mobilization and in the face of considerable pockets of inertia (systemic, organizational, and personal in nature). An evaluation of these activities should be undertaken with the understanding that there are many other forces at work in each of these sectors of the community, some of which contribute to BC's success and others which detract from it.

The sometimes modest results achieved were not for a lack of energy and commitment on the part of researchers, staff and volunteers, for there were many barriers to success. Some of these were beyond COMMIT's control, while others were inherent in the protocol design and could perhaps have been better anticipated. If one defines success in terms of the ability to meet the needs of smokers for assistance in quitting, then among the primary barriers to success for BC were (a) the restrictions imposed by NCI regarding what communities were allowed to do with members of the Smokers' Network; and (b) the failure to target low income and heavy smokers in intervention activities. Environmental change, in terms of policy reform and shifting community social norms, needs to be supported by changes at the micro social level and by intensive follow-up with smokers on an individual or small group level. Much more attention was paid in the trial to recruiting new members than to supporting existing members with intensive face-to-face follow-up. Despite wanting to quit, smokers provided many reasons for not quitting smoking that could act as barriers to cessation. Traditional health education messages focus on the health risks of smoking and do not devote sufficient attention to addressing smokers' fears about quitting. Smokers also faced a number of fears and constraints about reaching out for help, which may help explain why programs that appear in principle to be highly popular with smokers are less than widely used in practice. These barriers should be identified and addressed directly in the design and marketing of support options for smokers.

The fact that BC intentionally recruited active professionals (movers and shakers) as volunteers was useful in some respects and less so in others. The

participation of people familiar with a particular administrative style of operation (Task Force structure, board meetings, Robert's Rules of Order) facilitated the administrative operation of the intervention. Having Task Force and Board members who were well connected and who knew how to get things done helped BC achieve credibility and a measure of organizational cooperation in Brantford. This was no small feat, given that politicians were reluctant to take risks and several local organizations were concerned about jurisdictional ('turf') issues. However, having movers and shakers administer the trial also made for a few problems. First, the 'wearing of several hats' limited the ability of some members to take a public stand on smoking. Second, with few exceptions, issues of social justice and class inequalities in smoking and in environments conducive to smoking were rarely made explicit or constructively addressed. And third, since professionals are used to being 'experts' they felt they knew best, and were less inclined to insist on consulting smokers or less well educated members of Brantford society concerning their needs.

An examination of factors that facilitated program success suggests that BC's motto could have been "our strength is people". The caliber, commitment and decency of the researchers, staff and volunteers were tremendously important to the credibility of the trial, and to the innovative adaptations and extensions to the protocol that were made, most notably the neighbourhood cessation programs, the sting operations, and smoke-free restaurant day. It also meant that, for the most part, people genuinely enjoyed working together and that this, in addition to their commitment to smoking cessation, is what kept them together. Despite its limitations, the protocol also contributed in its own way to the success of the trial because it provided communities with an immediate action plan, so that they could begin activities relatively quickly. On the other hand, more attention could have been devoted to getting communities skilled and competent, in keeping with a community development agenda. Changes at the provincial level (the development of the new Ontario Tobacco Strategy that eventually included an extension of BC as a provincial demonstration site) and changes in the social climate in favour of tobacco control also contributed indirectly to the work of BC, although it is unlikely to have affected the 'delta' insofar as many of these developments were also shared with Brantford's comparison community (Peterborough).

11.4 OBJECTIVE THREE: IMPLICATIONS FOR COMMUNITY MOBILIZATION FOR SMOKING CESSATION

In this section, the implications of this research for community mobilization for smoking cessation are organized into three main topic areas. First, the implications for working with smokers are considered. Second, the implications for research and evaluation methods are discussed. Finally, several implications for the practice of health promotion more generally are considered. Policy implications are discussed in section 11.5.

11.4.1 Implications for working with smokers

Smoking is a powerful psychological and physiological addiction. Smokers also face multiple environments conducive to smoking, particularly at the micro social level of interaction with family, friends and coworkers. These environmental contexts are not evenly distributed, but 'favour' groups of lower socio-economic status. Within individual workplaces, policies for the factory 'shop floor' differ from those of the office. Some types of workplaces are more likely to have restrictive policies than others. Social settings frequented by blue collar groups (bars, bingo halls, homes of friends and neighbours) are more likely to be unregulated and contain a majority of smokers. Yet, few tobacco control strategies or interventions have acknowledged these class-based inequalities, or have devised methods of addressing them, despite the well-known class-biases in smoking prevalence. The free choice rhetoric of social marketing that exhorts smokers to simply 'make healthier choices' based on a logical assessment of the physical health risks of smoking ignores the context in which smokers operate, and contributes to the stigmatization of smokers. To borrow the wording from a recent ad for the Nicoderm Patch, smokers feel that "You don't need lectures. You need help." Smokers need empathy and practical tips for cessation. In Chapter 8, the lay conceptual dichotomy between motivation and technique were used as a basis for categorizing needs for assistance.

Since the majority of smokers profess a desire to quit, and many of those that have not yet succeeded say that they are not 'ready', it seems appropriate that health education move away from getting people to want to quit (based on health risks and

diminished social acceptability) to getting them 'ready' to quit. Motivational needs among smokers relate primarily to "being ready" and "being determined" to quit as prerequisites for successfully initiating and maintaining cessation. But attempts to engage respondents in reflection and discussion about what constituted "being ready", how one gets "ready", and how one knows one is "ready", were not particularly fruitful. While many respondents identified motivation as a key factor in the success of initiating and maintaining cessation, few seemed equipped to identify strategies for boosting their own motivation. Yet the self-help and pop psychology sections of many bookstores are replete with alleged motivational 'technologies', and psychologists have made considerable progress in the analysis of human motivation. There seems to be an obvious need to repackage some of this knowledge (e.g. Robbins 1986; Dyer 1977; Rossman 1987; Fritz 1984; Rubin 1980; Emotions Anonymous International 1978) together with state-of-the art knowledge about smoking cessation adapted from clinical settings (c.f. Shiffman 1982; Guba, Christen and Christen 1989; Klein *et al.* 1989) and from lay smoker perspectives (e.g. Ferguson 1988; Casey 1987; Farquhar and Spiller 1990; Walker 1989) to produce a high-quality motivating guide to smoking cessation that is more holistic, humanistic and powerful than existing self-help literature pamphlets for smokers distributed by health agencies. To some extent Ferguson's (1988) book does this, and perhaps (as indicated in Chapter 6) his book, together with a list of others, their local availability and prices, could have been included as part of the cessation package distributed to new members.

An intervention that allows smokers to pick and choose from among a menu of support options and to alter their tailored support system over time would appear to offer greater chances for success than a one-size-fits all approach, since needs for assistance vary between smokers and also over time for each of them. It may be possible to design a system that is modular yet cost effective. In addition, a guide to helping smokers quit that is written for non-smokers might help friends, family, health professionals and policy-makers better understand the realities of tobacco addiction and ways of helping smokers. Smokers frequently complain that even when others support their efforts to quit, they are sometimes counterproductive (e.g. "nagging"). Ferguson's (1988) book contains a section for non-smokers that distinguishes between positive and negative reinforcement, and outlines what

research has shown to be most effective in supporting the efforts of smokers to quit at the interpersonal level.

11.4.2 Implications for research and evaluation methods

In terms of research methods directed at improving community-based health promotion interventions, one is compelled to ask if the randomized control trial is the most sophisticated or sensitive means of unraveling the complexities of communities and social relations as they affect changes in the behaviour of groups and individuals in particular social contexts. Perhaps a more flexible, responsive methodology such as a multiple case study design (c.f. Yin 1989) is required so as to (a) maximize intervention impact, and (b) maximize learning about how to do it better next time. Unfortunately, the application of a standardized protocol meant considerable sacrifice and compromise on both counts. In allowing communities to make few decisions of their own, the protocol implied that there was little that could be learned from the people in each site that were to act as the 'channels' for protocol delivery. A different design that was honest about current gaps in knowledge such as how best to work with low SES smokers, might have encouraged creative and effective solutions not anticipated by NCI. By the same token, there is equally little to recommend a totally 'sink or swim' 'hands off' approach either. Rather, a preferable model might have been an intelligent summary of the available research on smoking cessation and a menu of options that allowed for more creativity on the part of the teams in each site as they gained confidence over the course of the trial. Communities should be provided with the same flexible and modular support system and leeway for initiative that should be provided to smokers.

The case has been made throughout this dissertation for the use of critical-interpretive evaluation methods. By interviewing smokers and key informants, part of the 'inside story' on the intervention was provided that would not have been available through the application of telephone survey methods. In addition, many aspects of the trial were revealed beyond what could be recorded as part of the 'official story' in the standardized quarterly report. On the whole, the testimony of smokers did not contradict that provided by key informants, and in fact they complemented each other. However, while the advantages of hearing from target populations speaks for itself, more work needs to be done on how lay perceptions

should be used in evaluation research, given that (a) smokers had difficulty identifying needs for assistance, and (b) that there appeared to be a discrepancy between what people said they wanted and what they actually would use if those services were made available. In addition, more work needs to be done on applying Freire's methods of education for critical consciousness in a North American contexts, in order to "make smokers more effectively angry at the tobacco industry", as one key informant put it (respondent K5).[1] Researchers have long argued that evaluation be built into interventions from the beginning because it has implications for intervention design and the collection of baseline data. The use of critical-interpretive methods in evaluation research suggests that evaluations that involve multiple stakeholders and critical-interpretive methods have impacts of their own and ought be an integral part of the intervention. The challenge then becomes making health promotion research empowering without sacrificing the impartiality needed to make a critical assessment of the intervention. More research of this kind needs to be undertaken in the evaluation of community and health promotion interventions, for many of these issues to be resolved.

11.4.3 Implications for the practice of health promotion

Many of the methodological issues troubling health promotion at the moment would be more easily resolved if health professionals committed themselves to a core set of values to guide the discipline. In Chapter 2, seven areas of debate in social theory were presented which could act as a decision tree for selecting a methodology for the discipline that would be truer to the rhetoric of the 'new' health promotion than existing quantitative methods are. Committing oneself to social justice, human welfare and the reduction of inequity has a way of clarifying agendas and separating what is important from what is not. It may also cast existing activities in a different light. However, a focus on the reduction of human suffering and relieving oppression make tobacco control strategies more empathic. At times, tobacco control appears to be a moral crusade to manipulate others to be more like ourselves, or simply to rationalize health care expenditures.

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[1] There may be merit in this approach in other contexts, such as against the marketing of junk food, or advertisements for alcohol using sex appeal and images of 'the good life', for example.

11.5 POLICY IMPLICATIONS

In this section, two policy issues are considered in light of the evaluation of Brantford COMMIT. First, are community interventions worth pursuing as a health promotion strategy? And second, what should tobacco control policy be in light of the BC experience?

11.5.1 Are community interventions worth pursuing?

The community level appears to be a useful scale for the implementation and extension of federal and provincial tobacco control initiatives. It allows for local autonomy and flexibility, and is a manageable scale that includes environmental and policy influences on the determinants of health as well as the role of individual behaviour. However, it is not a panacea. Community level interventions are just as likely to be co-opted by special interest groups and professional elites as are provincial or federal initiatives. At its best, the community focus is probably an umbrella encompassing clinical, policy and other interventions, rather than a replacement for these activities. In the case of smoking, the focus is still ultimately on changing the behaviour of individuals. There are many other forces at work on communities (such as economic recession and restructuring) that affect health and health promotion but are not directly within the grasp of communities to change. Also, it is important to bear in mind what one intends by the term 'community', and that there are multiple communities of interest in each locale. This means being sensitive to who is included and who is left out. There are also different ways of working with communities: community development, community mobilization, community-based operations, and community-oriented interventions each have different implications for ownership of the change process and the role of the professional in community action.

11.5.2 What should tobacco control look like?

Historic trends in smoking suggest that tobacco control is having an effect on cessation rates. This study suggests that many smokers feel stigmatized by the way in which tobacco control policies are formulated and implemented. Although most of the smokers consulted were happy to extend consideration to non-smokers, they felt that tobacco control goes further than this and persecutes them for their

addiction. They argued that if the government is sincere about providing healthy environments, it should pay the same attention to industrial polluters as it does to victimizing smokers, and tobacco control should be aimed at providing at least the option for buildings to provide designated areas, rather than a total ban on smoking in the workplace. They also felt that if the government is serious about helping them quit, then there should be the same sort of state-funded treatment centers as there are for drug addicts (e.g. detox centre), with a portion of tobacco taxes earmarked for treatment options if necessary. Most smokers supported prevention efforts for children and youth, as well as enforcement of age restrictions on the purchase of tobacco products, which provides an opportunity for mobilizing smokers publicly against smoking. Smokers also need to be involved in shaping their destiny and in the formulation of tobacco control policies (see below).

11.6 FUTURE DIRECTIONS

A number of unresolved issues were raised during the course of this research. How best to help smokers and how to implement similar interventions in the future are both considered below in terms of what aspects merit further research. Outstanding issues regarding the application of critical-interpretive evaluation methods were mentioned above and in Chapter 5.

11.6.1 Helping smokers to quit

As indicated earlier in this chapter, many smokers wish to quit but do not feel ready. Not enough is known about what constitutes 'being ready', how one gets 'ready', and how one knows when one is 'ready'. A focused qualitative study, as well as research in social and behavioural psychology might be helpful in this regard. Also, while it is recognized that individual counseling and support needs to be supplemented by environmental and policy change, it is not always clear what the most useful types and blend of supports would be for traditionally 'hard to reach' groups such as low income smokers. And while there is considerable research indicating what methods are most effective in supporting cessation in a clinical setting, it is less clear what 'makes a difference' in the community and micro social settings of smokers' everyday lives.

11.6.2 Running similar interventions in the future

Despite the apparent merits of participatory intervention design, implementation and evaluation, not enough is known about the most effective mechanisms for involving lay people in what has traditionally been a professional administrative exercise. What is the best forum for soliciting input from smokers? How can those who have little formal education be involved on an ongoing basis? The participation of movers and shakers is critical to the success of organizational networking and legislative reform. Lay participants may have less to lose in terms of "wearing several hats", and can perhaps be more effective by being confrontational when the need arises. Since participation in formal committees is intimidating for lay participants and rarely provides a level playing field (Paap and Hanson 1982), is the creation of a parallel grassroots structure to be recommended? This is perhaps where the community development and social action literatures might yield insights based on experiences in other contexts.

Two other issues warrant attention as well. First, how is it best to deal with a community's reluctance to be controversial, or more properly, that of the professional volunteer pool? Brantford COMMIT was successful in encouraging volunteers to examine their own willingness to confront smokers in their daily personal lives, with positive consequences for their willingness to take professional risks. Is it possible to document these changes more precisely so that they might guide intervention design and implementation in other contexts and places? Second, as indicated in Chapter 7, there appears to be relatively little detailed qualitative research that deals with contextual factors that facilitate or hinder the adoption of restrictions on smoking in the workplace.

Some of the findings of this study were summarized in this chapter as they pertain to the three main research objectives. It was suggested that although smokers valued the existence of Brantford COMMIT and generally appreciated what they received as Network members, the intervention does not appear to have been as successful in helping smokers to quit and maintain cessation as one might have hoped. Several barriers to and facilitators of program success were reviewed as they pertain to the nature of the protocol and the intervention community. The Brantford

COMMIT experience suggests several implications for working with smokers, for the research and evaluation of community interventions, and for the practice of health promotion. Several policy implications regarding the merits of the community approach and the nature of tobacco control were also discussed. The chapter concluded with several suggestions for further research into how best to help smokers quit, and for running similar interventions in the future. It is hoped that a critical-interpretive perspective on Brantford COMMIT contributes to knowledge development in community mobilization for smoking cessation and for community interventions more generally.

APPENDICES

APPENDIX A:

LETTERS OF PERMISSION TO REPRODUCE MATERIAL CONTAINED IN CHAPTER TWO AND CHAPTER THREE

Chapter 2 contains a reworked version of a paper first published in the *Canadian Journal of Public Health*, 1993, Volume 83, Supplement 1, pages S31-S46.

Chapter 3 contains a reworked version of a paper first published in *The Operational Geographer*, 1993, Volume 11, Number 3, pages 23-27.

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ASSOCIATION CANADIENNE DE SANTÉ PUBLIQUE
1565 CARLING, SUITE 400, OTTAWA, ONTARIO, CANADA K1Z 8R1
(613) 725-3769 TELEX 21-053-3841 FAX (613) 725-9826

August 17, 1993

Mr. Blake Poland
Doctoral Candidate
Department of Geography
McMaster University
1280 Main Street West
Hamilton, ON
L8S 4K1

Re: Learning to Walk Our Talk: The Implications of Sociological Theory for Research Methodologies in Health Promotion

Dear Mr. Poland,

In response to your fax. of August 5, 1993, I am writing to formally grant permission to reproduce the abovementioned article which appeared in the *Canadian Journal of Public Health*, Vol.83, Supplement 1, March/April 1992.

The *CJPH* will permit a non-exclusive licence to reproduce your thesis to McMaster University, and in the case of a Ph.D. thesis, to the National Library of Canada.

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Karen Craven

Karen Craven
Assistant Editor, *CJPH*

RYERSON
SCHOOL OF APPLIED GEOGRAPHY, FACULTY OF ARTS

Blake Poland
Department of Geography
McMaster University
Hamilton, Ontario

August 6th 1993

Dear Mr. Poland,

Further to your letter of this date regarding permission to reproduce your paper entitled "Pitfalls of Lay Perception Research in the Social and Health Sciences" that appeared in volume 11, number 1 of The Operational Geographer, please be advised that such permission is granted to yourself to reproduce the paper as you see fit. Further, pursuant to McMaster University policy, we grant a non-exclusive license to McMaster University and to the National Library of Canada to reproduce this thesis.

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APPENDIX B:

THE INTERSECTION OF AGENCY AND STRUCTURE

One approach that has been an influential springboard for a more dynamic theorizing of the intersection of agency and structure is symbolic interactionism. Its basic ideas were first advanced by Mead (1934) and subsequently consolidated by, in particular, Herbert Blumer (1969). The basic premises of symbolic interactionism are perhaps best articulated by Meltzer, Petras and Reynolds as follows:

> The influence that stimuli have upon human behavior is shaped by the context of symbolic meanings within which human behavior occurs. These meanings emerge from the shared interaction of individuals in human society. Society itself is constructed out of the behavior of humans, who actively play a role in developing the social limits that will be placed upon their behavior. Thus, human behavior is not a unilinear unfolding toward a predetermined end, but an active constructing process whereby humans endeavor to 'make sense' of their social and physical environments. This 'making sense' process is internalized in the form of thought...(in which) there occurs an interaction with oneself...Any complete understanding of human behavior must (therefore) include an awareness of this covert dimension of activity, not simply the observation of overt behavior.. (1975, vii)

The 'symbolic' component of symbolic interactionism thus serves to distinguish action involving thought (reflexivity) from other forms of action. The social origins of meaning imply that they are as much learned as they are actively created by thinking subjects (Ritzer 1983). This is especially apparent in the case of social (cultural) symbols, many of which we use to define our own self-image (e.g. styles of automobile or clothing).[1] Because language is a vast shared system of symbols, perception and interaction are active processes that bind agency and structure. The ability to imagine how others see us (Cooley's 'looking-glass self') guides our actions and interactions, and is central to the staged presentation of our image the world. This dramaturgical analogue (Goffman 1959) helps to explain the adoption of ideal-typical social 'roles', as well as the joint nature of the interaction process (through a shared understanding of what is expected in certain settings and

[1] Many health-adverse behaviours such as smoking are acutely bound up in self-image and self-concept: indeed they are marketted as such. This may help explain why rationalistic appeals based solely on statistics about likely future detrimental health effects have been insufficient motivators for behaviour change among many target groups, particularly in cases where the postponement of gratification is perhaps a less widely socialized phenomenon.

conversational contexts). The relative ease with which this occurs in everyday life is testimony to the taken-for-grantedness of these intersubjective understandings, which has been the central concern of phenomenologists (Husserl, Shutz) and ethnomethodologists (Garfinkel). Although Blumer recognized the existence of macro-level patterns (social structure), he saw them as evolving from patterns of social interaction, guided in part by systems of pre-established meanings such as culture and social order. More weight was therefore accorded to agency, while social structure was viewed as the framework within which social life takes place. [2]

Structuration theory, as formulated particularly (but not solely) by Giddens, represents a more systematic attempt to transcend the dualism between structure and agency in a manner that allows for intentionality (seen as the basis of human agency) and habit (routine activity). For Giddens, "analyzing the structuration of social systems means studying the modes in which such systems, grounded in the knowledgeable activities of situated actors who draw upon rules and resources in the diversity of action contexts, are produced and reproduced in interaction" (1984, 25). Concepts of *reflexivity* (the agent's purposive and knowledgeable monitoring of social life central to social competence) and *recursiveness* (social system as both medium and outcome of social interaction: the 'duality of structure'), central to structuration theory, show distinct parallels with symbolic interactionism. Giddens construes structure in terms of recursively organized systems of rules (relating to the constitution of meaning and the sanctioning of modes of conduct) and resources central to routine life. Part of the uniqueness of structuration theory is therefore its treatment of social praxis (the production and reproduction of social life)(Cohen 1987), in which (routine) time-space relations are seen as fundamental (Thrift 1985), particularly in later formulations of his work.

Habermas' formulation of critical theory focuses on language, its components (speech acts) and its modes (types of validity claim) as the 'glue' bonding agency and structure in terms of types and settings of communication and interaction. As with symbolic interactionism and structuration theory, critical theory posits agency and structure as constituting one another in mutual interdependence. Habermas provides a characterization of agency in terms of a complex web of types of interests

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[2] This raises some interesting questions about the process of socialization, a topic never fully addressed by symbolic interactionists because of their largely ahistorical and non-biographical stance, discussed below.

(technical, practical, emancipatory). Critical theory also represents a creative synthesis of Marx's historical materialism and Weber's views on rationalization, and in doing so it attempts a more historically rooted understanding of social life than either symbolic interactionism or structuration theory. In particular, Habermas takes an evolutionary perspective that is driven by the vision of a fully 'rational' society. Emancipation is seen to be achieved through the realization of an 'ideal speech community' based on discursive argumentation (as a basis for equalizing power relations and medium of social change). The relevance of Habermas' critical theory to the health promotion project is somewhat obscured by the mechanistic portrayal of agency linguistically mediated and by the supremacy accorded to rationality as an emancipatory mechanism and as essential driving force of human agency, but as one of the most serious attempts to bridge structure and agency, it deserves our attention.

The purpose of introducing symbolic interactionism, structuration theory, and critical theory is to illustrate how three leading social theorists have attempted to come to terms with the implications of the reflexive and recursive nature of social life on the interdependent relationship of agency and structure.

APPENDIX C

LETTER INVITING MEMBERS OF THE SMOKERS' NETWORK TO PARTICIPATE IN THE EVALUATION STUDY

(merge with respondent address file onto Brantford COMMIT letterhead)

February 5, 1992

<<firstname>> <<lastname>>
<< street >>
Brantford, Ontario
<<postcode>>

Dear <<firstname>> <<lastname>>:

I haven't forgotten about you! Because of delays in getting the interviews typed up (over 1000 pages) and summarized, it will be a few more weeks before you will receive a typed copy of your interview (for those of you who requested one) and a summary based on interviews with the 44 other smokers and recent ex-smokers I spoke with.

I want to thank you again for having participated in this first part of our study on the experiences and needs of smokers in Brantford. I was very touched by how friendly and open everybody was who I had the pleasure of talking to. There is a lot of material in the over 60 hours of tape that I think you will find very interesting. I look forward to sharing it with you in the upcoming summary.

Hopefully you had a wonderful and restful holiday. For those of you who have tried again to quit since Christmas, congradulations! I look forward to hearing from you again (whether you have quit or not) during the focus group meetings which will be arranged once you have received your next package.

Sincerely,

Blake D. Poland
McMaster University Researcher
(and for Dianne Ferster, Executive Director of Brantford COMMIT)

APPENDIX D

TELEPHONE INTRODUCTION FOR RECRUITING SMOKERS

PHONE INTRODUCTION (smokers)

Hello _____? It's Blake Poland from McMaster calling on behalf of Brantford COMMIT. Are you still interested in quitting smoking? (congradulations/encouragement).

The reason I'm calling is that as you probably know we've been trying different ways of helping people quit smoking in Brantford, but we're not sure which ones have been most useful for you or not. We'de like to hear your perspective and share with you what other smokers find helpful when they've been trying to quit.

For that reason, we sent you and a small group of other people from the Smoker's Network a letter asking you to participate in our survey. Did you get that letter?

Do you think you could spare a few minutes sometime for us to get together over coffee and chat about your experience?

YES: Wonderful. Is there a particular day of the week or time that is best for you? (offer to meet them at their home at a time & day convenient to them; or if uneasy to meet in public place like coffeeshop or even at COMMIT office).

NO: reiterate that their views are important and valid; that time & location are flexible etc

if still no, then politely thank them for their time and move on to the next call

APPENDIX E

RECRUITMENT FORM LEFT IN THE MAILBOX OF SMOKERS NOT REACHABLE BY TELEPHONE

BRANTFORD

COMMIT

233 COLBORNE STREET, SUITE 403
BRANTFORD, ONTARIO N3T 2H4
(519) 758-1985

☐ YES, I am willing to participate in the Brantford COMMIT study.
The most convenient time for me is (check one slot below):

	Sat Dec14	Sun Dec15	Mon Dec16	Tues Dec17	Wed Dec18	Thurs Dec19
Morning						
Afternoon						
Evening						

The most convenient place for us to meet would be:

___ here at my home

___ at work (specify address & tel: _____)

___ at nearby coffee shop (specify: _____)

___ at the COMMIT office (233 Colbourne, 4th floor)

☐ NO, I do not wish to be part of the Brantford COMMIT study.

PLEASE PUT THIS FORM IN THE ENVELOPE PROVIDED AND LEAVE IT IN YOUR MAILBOX (or by your door) FOR US TO PICK UP TOMORROW (Friday).

APPENDIX F

TOPIC CHECKLIST FOR INTERVIEWS WITH SMOKERS

INTRO
- interested in your experiences & what found useful
- 50 smokers & ex-smokers in Brantford
- ok to tape? (confidential) (only *summary* to COMMIT, no names attached to quotes)

STARTED
- when/why/experience & stories
- liked/disliked then & now (benefits & costs)

CURRENT SMOKING STATUS
- amount
- when (times of day etc)
- where (places most/least comfortable smoking)
- smoking status of friends, relatives & coworkers ("do most of your _____ smoke?")

Hooked?
- do you remember when you first realized you were hooked? (discuss meaning & role of addiction)

QUITTING NOW
- what motivated you to quit this time?
- feel under pressure to quit?
- strategies pursued

PREVIOUS QUIT ATTEMPTS
- when, why and how
- obstacles: personal / social / structural
- how to overcome / what will it take to make it work?
- quitting mostly a question of motivation or technique?

EXPOSURE to help
- pamphlets / self-help materials, courses, worksites etc
- hc providers ("has your doctors mentioned anything to you about smoking?")
- cessation messages in the media

COMMIT
- what have you seen/noticed of COMMIT in Brantford?
- what did you think you would get by joining the network?
- were your expectations met?
- has BC made a diff to you?
- what should BC be doing?
- mandate to chg social norms: do think that will work?

is there SOMETHING MISSING in Brantford that would help you quit? OR *NEEDS* re decision or followup

GOV'T - prevention role (even #1 problem)
Should society (or gov't) care if you smoke?
- reactions to strategies such as *taxes*,
restrictions on where can smoke,
ban on advertising

How do you feel about the TOBACCO INDUSTRY? (farmers/corporation)

HEALTH STATUS
- general compared with peers
- what things affect health? Who responsible for health?
(why might some people be healthier than others?)

OTHER HEALTH-RELATED BEHAVIOUR / PLANS

CONCLUSION
- Anything else to add?
- would you like a copy of interv and/or summary?
- would you be interested in participating in a discussion group?

APPENDIX G

FIELDNOTE INFORMATION FORM FOR DEPTH INTERVIEWS

ROUND 1 INTERVIEW INFORMATION SHEET

Day: ____

Sample #: ____
Interview #: ____

Name: _____ Interview date: _____

Tel: _____ Interview time: _____ AM PM

Address: _____ Interview location: _____

Age: ____ Area: ____ Smkg: hvy ___ / lm ___

Notes from telephone conversation: _____

INTERVIEW Duration: _____ minutes Material distrib: Y___ / N___ _____

SES: prof ___
wkg1 ___
wkg2 ___

Level of interest in talking: low 1___2___3___4___5 high

Degree of my comfort in interviewing: low 1___2___3___4___5 high

C.interv: Y___ N___ DA___
Summary: Y___ N___ DA___
Focus Grp: Y___ N___ DA___

Areas not covered: _____

General comments:

APPENDIX H

LETTER TO MEMBERS OF THE SMOKERS' NETWORK APOLOGIZING FOR DELAY IN MAILING OUT THE SUMMARY OF THE INTERVIEWS

(mail merge with respondent address file and printed onto BC letterhead)

February 5, 1992

«first» «last»
«street»
«city», «prov»
«postcode»

Dear «first» «last»:

I haven't forgotten about you! Because of delays in getting the interviews typed up (over 1000 pages) and summarized, it will be a few more weeks before you will receive a typed copy of your interview (for those of you who requested one) and a summary based on interviews with the 44 other smokers and recent ex-smokers I talked to.

I want to thank you all again for having participated in this first part of our study on the experiences and needs of smokers in Brantford. I was very touched by how friendly and open everybody was who I had the pleasure of talking to. There is a lot of material in the over 60 hours of tape that I think you will find very interesting. I look forward to sharing it with you in the upcoming summary.

Hopefully you had a wonderful and restful holiday. For those of you who have tried again to quit since Christmas, congratulations! I look forward to hearing from you again (whether you have quit or not) during the focus group meetings which will be arranged once you have received your next package.

Sincerely,

Blake D. Poland
McMaster University Researcher

APPENDIX I

PACKAGE SENT TO INTERVIEWEES FROM THE SMOKERS' NETWORK

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6 items:

1. covering letter
2. introductory notes about the transcripts
3. summary of the interviews with smokers
4. focus group sign-up sheet
5. comment sheet
6. suggested readings

ITEM 1: COVERING LETTER

(mail merged with respondent address file and printed onto BC letterhead)

February 24, 1992

«first» «last»
«street»
«city», «prov»
«postcode»

Dear «first» «last»:

Well, here it is at last: a chance for you to find out what other smokers and ex-smokers had to say about their experiences. Thanks again for sharing with me, and ultimately now through this package, with each other (anonymously of course).

I think it is important that we continue to let non-smokers, cessation services, and others know how you feel rather than them assuming they know best how to help you to quit. That way we can encourage COMMIT and other organizations to consider your needs and preferences more completely than perhaps they have been able to in the past. By building upon what we have already shared, the discussion groups in a few weeks will be a part of that ongoing process of defining your perspectives and your needs for us and others to take into consideration. I hope you will be able to be part of these discussion groups.

In this package you will find:

- a short summary of the interviews I conducted with 45 heavy and light-to-moderate smokers and recent ex-smokers
- for some of you, a copy of our own interview together
- a ***sign-up sheet for discussion/focus groups*** where we can explore in more detail what other smokers had to say about quitting smoking and about Brantford anti-smoking policies, as well as about the help that's out there for smokers. This will be a chance to brainstorm about how we can help each other as smokers to overcome our addiction, and about where COMMIT or other groups might fit into that picture. Most of you indicated you would like to be part of a discussion group, and I hope that's still the case. Of course, as before participation is voluntary. But, whether you are still smoking or not, whether you would like to see something new being done or even something stopped that is bugging you now, I'd like to hear from you.
- a comment sheet where you can add anything you wish that was not covered properly in the interview or that you have thought of since then
- some literature from Nicotine Anonymous, an AA-style group for smokers who are trying to kick the habit

Please return the sign-up sheet and comment sheet to us in the pre-addressed stamped envelope as soon as possible.

I hope you find this material useful and informative. If you have any questions regarding these matters please leave a message at 758-1985 for me (including the best time to reach you) so that I may return your call.

I look forward to seeing you again in the discussion groups.

Sincerely,

Blake Poland
McMaster Researcher

ABOUT THE TRANSCRIPTS

1. For those of you who don't have one:

Some of you did not feel you would be very interested in a copy of our chat, and that's fine. If you change your mind, you know where to reach me.

In a few cases the tape quality was so poor (for example too much background noise, or the tape batteries too weak to pick much up) that we were not able to get the conversations typed up. In those cases I apologize but I don't have a typed record of our conversation to send you. The best I could do is send you a copy of the tape, but you may find it hard to hear some or much of what was being said.

2. For those of you who do have one included in this envelope:

Some of you thought that having the chance to look over what you said might help you learn something about how or what you think. After all, it is not every day that we get the opportunity to talk with someone for 30 minutes to an hour or more about smoking. I hope you find this as useful as you were hoping it would be. If you have any comments after having read over the material, please take a moment to fill out the comment sheet (back of the focus group sign-up sheet) and return it to us in the enclosed envelope.

There are a few points you may need to know to help you read through our interview. For all interviews, "I:" stands for "interviewer" (me) and "R:" stands for "respondant" (you). If your spouse, friend or children piped in, they were included as "R2" or "R3" and so-forth. If you see a string of "x"s like this xxxxxxxx, that stands for a passage where we couldn't make out what was being said. "[Tx]" is my own notation for the fact that the voice activation was mistakenly on during the interview and those parts of the conversation the tape machine was too slow to pick up. "(???)" means the typist wasn't sure if what she put down was what you really said. Also, the conversation begins whenever the tape was turned on, so that may be in mid-sentence or part-way into a topic. Likewise, in most cases there is no record of what was said once the tape turned off (or even while it was being flipped to side 2).

Everything is transcribed verbatim, including "uh-huh"s. Because we tend to speak differently than we write, it is sometimes a bit weird or dissappointing to see it written down how we speak ("do I really talk like that?!").. but don't worry, we're all in the same boat!

Please remember that nothing you have said can be traced back to you: I have protected your identity, so that you do not have to worry about having criticized COMMIT or about any repercussions from what you have said.

SUMMARY: WHAT WE SAID ABOUT SMOKING

Because I have the privilege of sharing with you, in general terms, what 44 other smokers had to say about smoking and quitting, I consider this to be a sort of "open letter" from yourselves to each other. In summarizing your views I have therefore chosen to write from the perspective of the people I spoke with, and use terms like "we" and "us" as if you were in fact writing to each other on behalf of the group, through me.

How we starting smoking:

- most of us started when we were in our very early teens, with friends
- often one or both of our parents smoked, as well as our brothers and sisters and many of our friends and relatives
- we saw smoking then as something 'cool' or 'grown-up' to do
- for most of us we began smoking before the dangers of tobacco use were widely publicized. In fact it seemed like a pretty normal thing to do
- smoking for us was part of fitting in (peer pressure) and sometimes as a bit of a rebellious thing to do
- by 16 or 18 many of us were smoking on a regular basis and have been pretty much ever since

Where, when and why we smoke:

- most often we smoke after meals, with coffee or over a drink, on the phone, and/or when driving. For those of us who are heavier smokers almost all activities are associated with smoking and we have difficulty imagining ourselves without the habit
- many of us use tobacco to relax, and do so more during stressful situations or stressful periods in our lives
- because of the tendency to smoke to relieve stress, tension, anxiety or anger, some of us have come to see cigarettes as a 'crutch' or 'friend', and to use smoking as a way of managing our emotions. For this reason, the crankiness that often accompanies withdrawal is perhaps the most upsetting part of quitting for some of us. We did not want to be 'bitchy' to our children and husbands or wives, and so we often started smoking again with the thought that it was better to die early and sane than to have that madness continue. However, those of us who have been able to quit have seen that we can find other ways to deal with unpleasantness in our lives.

- with mounting social pressure and restrictions on smoking at work and in public places, our smoking is increasingly limited to our homes and those of our friends, as well as establishments such as restaurants, bars and coffee shops. Smoking is becoming more of a problem for us because the craving for nicotine comes whether we are where smoking is permitted or not, and so we must adjust our routines accordingly. Therefore the addiction itself becomes a source of tension, which we are tempted to relieve with yet another cigarette!

Our experiences in trying to quit:

- many of us think we are quite strong-willed in other areas of our lives, and we do not like the idea that smoking controls us rather than us controlling the smoking. But the truth is that for many of us smoking has come to rule our lives. We must always be sure to leave the house with a lighter and our cigarettes, and in situations when we cannot smoke it is all we can think about. More and more we feel guilty and harassed about our smoking but find it hard to control the addiction.

- most of us have made several attempts to quit. Sometimes we manage a few days, weeks or even months but for many of us we eventually start again. Often we cannot say why we started again, or else the reason seems trivial now. Sometimes alcohol weakened our resolve, or we thought we could have "just one". Some of us even made a conscious decision to start again to relieve the symptoms we were feeling, but knowing that sometime we would have to try again.

- inevitably we feel worse about ourselves for having 'fallen off the wagon'. We feel somehow that our willpower was not strong enough, that we 'failed'. For some of us we resign ourselves to what seems to be the inevitable failure and we do not try again for some time, while others redouble their efforts with new resolve. Perhaps we can trust and build upon past experience, that failures aren't really failures but lessons. A few of us found that quitting was easier than we had expected, but many did not.

- some of us forget that our circle of friends and coworkers is limited to a small segment of society and so we choose not to believe the statistics about the majority of Canadians being non-smokers when we look around us and see that most of our buddies smoke. We even suspect that there is a conspiracy among non-smokers of which these statistics are a deliberate part

- we find that when we look at it we have many reasons to quit. The cost, smell, stains, burn holes, our own health and that of loved ones, and not wanting to be controlled by the addiction are the main reasons we use. One of the great pleasures of quitting is that we notice these things more once we have been free of nicotine for a while. Our sense of smell returns so that now we know more than ever how bad it was. We often begin to feel healthier, and to feel better about ourselves.

- the most common 'technique' that we have used is 'cold turkey', but this has not worked for all of us. Some of us claim success with acupuncture, hypnosis, Life Sign, Nicorette gum or subliminal tapes but many others of us also claim to have been unsuccessful with these techniques, or to know of others that have been similarly dissappointed. For some of us a wager (bet) or contest worked well, often in terms of quitting with a friend (or spouse), but we need more than that to stay off nicotine in the long run.

- many of us are anxious to find out how other smokers quit and what methods they used, but when we reflect on it we admit that motivation is perhaps just as or more important than technique, although often we are not sure how to get more of that necessary motivation for ourselves

- some of us feel that it is best to take one thing at a time when it comes to quitting, to not make too many changes at once. On the other hand, those of us who make several changes at once towards a healthier lifestyle find that we are more successful because each of the new activities reinforces the fact that we are now healthier and happier, and it helps form a new identity for ourselves as non-smokers in which smoking itself has little place. Some of the new activities like exercise may even help us feel less like smoking.

- sometimes the thought of never smoking again, of saying "this is my *last* cigarette", is a little spooky, but some of us have found that taking it a day at a time, even one hour at a time, we somehow make it through

How we feel about COMMIT:

- even though many of us found the COMMIT 'quitpak' material useful, not all of us were able to quit for good soon after joining COMMIT. Something more was needed. Some of us felt that a phone call (preferably from a fellow smoker) in the first few days that we had quit would be good, then perhaps a week or so and then again a month or so later. Some of us were willing to be 'buddies' for someone else who is trying to quit. Some of us did not realize that COMMIT has a hotline we can call when we need support. Practical suggestions for how COMMIT could improve their service to us and to the community were made. This included (a) improving the enforcement of restrictions on the sale of tobacco to minors, (b) more statistics and "gorry details" on the health risks of smoking, (c) more personalized support (like phone calls), and (d) a forum or group meeting system where smokers could meet with and share anonymously with other smokers and ex-smokers about our experiences.

Things to think about:

- for some of us, the restrictions on where we can smoke and the frequent messages on tv and elsewhere asking us to quit make us feel defensive and we "dig our heels in". In particular, we get concerned about our "rights" as smokers. Perhaps we could also ask ourselves whether we would be tempted to encourage someone else to stop doing something that was harming themselves and those around them. True there are some vocal non-smokers who seem to show us little respect, and we wonder if any non-smoker can ever really understand what it is that we have gone through. But even if it were true that we had the right to willingly hurt ourselves, can we blame others for trying

to help even if we do not like how they go about it or if their efforts actually seem to backfire and make us more determined to smoke?

On the other hand, we may be correct to ask how much they do so for their own benefit or interests (which everyone has a right to do, although they may pretend it is out of concern for us) and how much of it comes out of genuine concern for us as fellow human beings. And although some of us feel strongly about our "rights", others of us no longer enjoy smoking, don't want to smoke and by and large feel that even though non-smokers could be more tolerant at times, the restrictions are basically a good idea and have caused us to cut down.

- some of us feel that society should be more concerned with alcohol than with tobacco consumption, because of the abusive nature of some intoxicated individuals or because of the dangers of drunk driving or of chronic alcoholism. We do not wish to diminish the importance of alcohol abuse. On the other hand, there is no safe level of consumption for tobacco as there is for alcohol, and tobacco kills more people in this country each year than heroin and alcohol combined. It is for these reasons that health officials have seen fit to take smoking seriously, and rightly or wrongly we feel the brunt of their efforts to reduce the use of tobacco in society.

- most of us feel (perhaps appropriate) sympathy for tobacco farmers but we forget that their prosperity has been at our expense, or more exactly that the tobacco companies have used the farmers and us to make a few corporate owners very rich and have attempted to supress the truth about the harmful effects of their products. These corporations have tried to get our children to smoke knowing full well what it can do to them. And now they are pursuing new markets in the Third World where health restrictions are more relaxed, where now many new generations are getting hooked on the same tobacco products that now control us

- as a society we need to realize that many of us have addictions, not only to smoking but to alcohol, gambling, drugs, food, sex, shopping, work etc. What is it about society or our way of life in the world today that causes so many people to need to escape or to control their emotions through an addiction? If overcoming addiction is a goal for many people in our society, could we begin to recognize that we are really 'all in the same boat', so that rather than emphasizing our differences we work together to learn what it is about addictions that is so powerful over us and how to overcome these?

mutual aid: helping eachother quit

- most of us have been saying that only other smokers or former smokers can really understand us, that only they can really know what it is like to be addicted to nicotine. With over 1700 people in COMMIT's Smoker's Network who have expressed a desire to quit smoking, there is a big potential here for us to learn how to motivate and help eachother rather than relying always on ourselves by ourselves or being coached or lectured by non-smoker organizations. Maybe we could form (for those who are interested) self-help groups of our own for the purposes of helping eachother overcome our addictions. It may need, first and foremost, to be our own group, and not one organized by professionals. Maybe something more will come of this in the discussion groups we will have in a few weeks (dates on sign-up sheet).

- many of us have asked if there was some non-political non-profit group or organization in existence comprised of smokers and non-judgemental ex-smokers devoted solely to the purpose of helping eachother to overcome the addiction to nicotine; something like a "Smoker's Anonymous" (to borrow from the AA model). In fact such a thing does exist - they call themselves Nicotine Anonymous - but the nearest existing group is in Toronto. Nicotine Anonymous, like AA, does not advertise or recruit members: participation is entirely voluntary (for anyone who wants to overcome nicotine addiction) and word-of-mouth (see enclosed pamphlet). They are not affiliated with COMMIT or any other organizations.

  Nicotine Anonymous groups meet 3 times a week in Toronto: (a) Tuesdays at 7:30pm and Saturday at 4pm at the Addiction Research Foundation (33 Russell St, near College & Spadina), and (b) Thursdays at 6pm at the Advent Lutheran Church (2800 Don Mills Rd near Sheppard). Feel free to attend any or all of these. Also, any two or more persons with a desire to stop using nicotine could form their own Nicotine Anonymous group here in Brantford (provided that as a group you have no outside affiliation with any other group: the principle of anonymity is important). To start a group you can arrange to have a "starter kit" sent to you by contacting (and listing with) Nicotine Anonymous World Services at 2118 Greenwich Street, San Francisco, CA 94123 (at 415-922-8575) (they can also send you more pamphlets and other literature).

  I will have a bit more information about Nicotine Anonymous at the discussion groups, for those of you who would like to know more about it.

FOCUS GROUP SIGN-UP SHEET

As I explained to many of you when we last talked, I am hoping that we can meet in small groups to explore in more detail what other smokers have been telling us and to brainstorm ideas on how we can help each other more as smokers, and what COMMIT's role should be. If you would like to see anything in particular being done, if you would simply like to find out what other smokers have to say, or even if there is something you wish weren't being done to (or for) smokers, then please come and let us know and we can hash it out as a group. Whether you are still smoking or not, we would like to hear from you! (If lack of transportation would prevent you from attending, I can arrange a ride for you).

Four meeting times have been scheduled for late March. We will meet for about an hour starting at the times indicated below. All meetings will be held in the COMMIT office downtown on the 4th floor at 233 Colbourne Street (parking to the rear). The dates and times are as follows (please pick a first and second choice by putting numbers 1 and 2 next to your preferences):

___ Wednesday, March 25, at 8:00 p.m.

___ Thursday, March 26, at 8:00 p.m.

___ Sunday, March 29, at 3:00 p.m.

___ Monday, March 30, at 8:00 p.m.

___ I am unable to attend these dates but I am still interested in being part of a discussion group if another day and/or time could be arranged. Please specify what day and time would be best for you: _____)

___ I do not wish to be part of a discussion group at all

You will be contacted by phone to confirm your attendance one week prior to your chosen date.

PLEASE RETURN THIS SHEET TO US
USING THE PRE-ADDRESSED STAMPED ENVELOPE
INCLUDED IN THIS PACKAGE.

(Please see Comment Sheet on reverse)

COMMENT SHEET

If you have any comments about the interview process, the material in your transcript (if applicable) or anything else relevant to your experience in trying to quit smoking, please feel encouraged to take the opportunity to write these to us below. If you have opinions on tobacco control issues in Brantford that you think you may not have already voiced please include them also. It may be that while reading your transcript you realized there was something either of us said that you no longer agree with, or something you forgot to add at the time (or that I mistakenly cut you off from saying). Or perhaps rereading what we talked about caused you to think more clearly about a certain point that you could now share with me and other smokers.

(Please add additional pages if needed)

Literature you might consider interesting

There are many self-help books written for smokers, not all of which are necessarily good. The few that I have seen or have had recommended to me that you may find interesting or helpful include the following:

Smoker: Self-Portrait of a Nicotine Addict by Ellen Walker (Harper & Row, 1989)
One woman's powerful story of being caught in the "nicotine trap", that also includes factual information and tips on how to quit. Other smokers have said this is a must-read.

The Last Puff: Ex-Smokers Share the Secrets of their Success by John Farquhar and Gene Spiller (W.W. Norton, 1990)
32 ex-smokers share their stories of how they quit, what it was like, and how they remained smoke-free. Near the end of the book a number of common lessons from these people's experiences are summarized to help other people quit.

Smoking: the Artificial Passion by David Krugh (W.H. Freeman, 1991)
This book is one of the best and most readable investigations of why people smoke and why it is so hard to quit, including a lot of medical evidence about the addictive and chemical properties of tobacco.

Nicotine Anonymous: The Book, a Work in Progress by Nicotine Anonymous Big Book Committee (1990)
This book tells the stories of smokers who have been part of Nicotine Anonymous, including responses to a questionnaire (193 different questions about people's addiction to tobacco). It also contains a detailed guide to the 12 steps to recovery for smokers (adapted from AA): a program designed to remove your addiction to nicotine and keep it that way.

I will have copies of these and other materials at the discussion groups for those of you who would like to take a closer look at them.

APPENDIX J

MATERIALS USED FOR THE FOCUS GROUPS WITH SMOKERS

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5 items:

1. Telephone recruitment pitch
2. Topic checklist for discussion groups
3. notes on running the focus groups
4. local statistics to have on hand
5. overhead summarizing goals of the COMMIT project

WHAT TO SAY ON THE PHONE (RECRUITING FG PARTICIPANTS)

- Hi, its Blake Poland from Brantford COMMIT

- did you receive the package with your transcript and summary from the other interviews? Was that package interesting/helpful?

- I'm calling about the discussion groups, to see if you would be able to join us for one meeting in the next week or two

Pitch
This will give you the opportunity to meet and chat with other smokers and recent quitters from the Smoker's Network, to trade experiences and to have an input into how smokers and smoking issues are treated in Brantford in the future. (In a sense you will act as 'advisors' to COMMIT and the community)

It'll be an informal discussion on several interesting topics arising from the interviews and having to do with smoker's rights, issues of motivation. willpower and addiction, and a chance to talk about what the group would like to see in terms of support in the future for people trying to quit smoking in Brantford. It is voluntary and confidential.

- Would you mind being part of a small discussion group of other smokers?

- Can you make one of the times that was listed in the sign-up sheet? They are:
  Wednesday March 25th @ 8pm
  Thursday March 26th @ 8pm
  Sunday March 29th @ 3pm
  Monday March 30th @ 8pm

- It seemed like the simplest thing was to meet at the commit office. Do you have a way of getting here? (I can pick you up and drop you off after, if that would help)

- Thanx for your time and support. I'll call again the night before just as a reminder. Would that be alright?

MESSAGE TO LEAVE ON ANSWERING MACHINES:

Hi _____, its Blake Poland from Brantford COMMIT. Just calling to see if you got the information package and if you can join us for a small group discussion next week.

TOPIC CHECKLIST FOR DISCUSSION GROUPS WITH SMOKERS

Introduction
- start by introducing eachother and go around the table sharing personal smoking histories

Stories about the good and bad of smoking
- positive experiences of being helped to not smoke by others
- are there times when it felt like it wasn't worth trying to quit anymore? What kept you going?
- stories about timesw when people felt awkward/guilty/uncomfortable about their smoking or made adjustments to their lives because of smoking
- negative experiences of interactions with others about smoking

Rights of individual versus those of society
- how far should society go to encourage people to stop smoking?
- how should we balance the rights of smokers and non-smokers?

Issues of control
- do we control our smoking or does smoking control us?
- who is "to blame" for people smoking in our society? (encourage them to think about root causes)

External systemic factors
- what do you think should be done about the role of the tobacco industry in promoting smoking? (refer to stats sheet)
- what impact has tobacco legislation had on your lives? (esp. restrictions on smoking in the workplace and in public places)

Risk
- is it important to focus on risk in health education messages? If so, how, how much and what type?
- what sorts of health impacts of smoking are you most/least worried about? What about non-health impacts?

COMMIT
- experiences of being pleased or displeased with COMMIT (share stories)
- what is appropriate level of support from COMMIT?
- show overhead of trial-wide goals & objectives and get their reactions

Wrap-up
- anything else anyone would like to add?
- thank them for coming, for their time & interest
- ask them to complete evaluation of the evening's discussion
- remind them that there is Nicotine Anonymous literature and other books on display table that they can look at

NOTES ON CONDUCTING FOCUS GROUPS WITH SMOKERS

Things to do

- ask "helper" to (a) log who speaks (sequence), (b) operating cassette recorder, (c) share general impressions about how the evening went
- have smoking statistics on hand
- refreshments: coffee, biscuits, timbits, fruit
- note that smoking prohibited (smoke-free building)
- set up display table with smoking cessation literature
- have requisite number of evaluation forms on hand

Introductory remarks

- introduce assistance & their role
- review purpose of focus group discussion
  - to get together following the interviews, to:
  (a) have the opportunity to share experiences
  (b) there were a few things that came up in the interviews that I was hoping we could discuss as a group (themes, possible contradictions etc)
- clarify the nature of my connection with Brantford COMMIT (arms length evaluation) and encourage frank discussion
- acknowledge and afirm that all opinions & experiences valid & worth sharing
- explain a few 'rules' to guide discussion:
  - one person talking at a time, but no particular order necessary (after first go-around)
  - this is not an interview, but a fairly free-flowing discussion. I have some topics I would be interested in pursuing, but feel free to add others of your own

Things to bring

- tape recorder
- batteries (2 sets)
- tapes (3)
- refreshments (TimBits, cookies, coffee, juice, fruit)
- notepad + clipboard
- topic checklist (2 copies)
- list of participants and information about each one
- overhead projector + overheads
- cash to reimburse people for parking or other transportation costs
- focus group evaluation forms
- Nicotine Anonymous literature and other smoking cessation literature for display
- extra copy of the package sent to interviewees summarizing the interviews with smokers
- sheet of local statistics

LOCAL STATISTICS TO HAVE ON HAND FOR FOCUS GROUPS

Prevalence

Brantford	20,500 adults
Ontario	
Canada	about 30% or 5.8 million (1990)
USA	50 million

Attributable deaths kills one quarter of users; relative risk = 1.7

Brantford	10 to 15 per month
Ontario	13,400 per year
Canada	38,000 per year
	30% of all cancers, 26% of all deaths for 35-84 year olds
	$1 billion in health care costs
	$4.6 billion in economic losses
USA	390,000 per year (3,800 from ETS)
World	nearly 50,000 per day

Cigarette sales/consumption (# per year)

Brantford	380,000 per day or 140 million pieces per year
	$16 million per year in sales
Ontario	
Canada	more than 50 billion pieces per year (2500 per person)
USA	$1 billion tobacco advertising & same on cancer research

Quitting

%	half of those who ever smoked have quit
	each year, 35 to 40% of smokers try to quit
	each year, 5% of smokers succeed in quitting
	35 to 40% of those who try actually succeed
	(60% relapse rate)
Brantford	1000 last year
Canada	3.5 million have quit
USA	3 million per year quit = 35 million over last 20 yrs

GOALS OF THE COMMIT PROGRAM (paraphrased)

1. increase the importance of smoking as a public health issue in Brantford

   (a) get smokers and non-smokers concerned about smoking

   (b) increase public awareness of the risks of smoking and of the risks of second-hand smoke

2. increase Brantford's ability to get people to quit smoking by devoting more time and money to anti-smoking activities and by creating a coordinated plan for combatting smoking

3. support things that discourage smoking in Brantford

   (a) create more smoke-free environments

   (b) better enforcement of smoking control regulations

   (c) reduce influence of pro-smoking and smokers rights groups

4. encourage social values against smoking

   (a) support good health values

   (b) decrease social acceptability of smoking in Brantford

   (c) promote benefits and possibility of quitting

   (d) support efforts by people to quit smoking

OBJECTIVE: extra 10 percent decline in the number of smokers

APPENDIX K

TOPIC CHECKLIST FOR INTERVIEWS WITH KEY INFORMANTS

[for person w, day x, time y, location z. I expect we may need a little over an hour]

(All opinions and information volunteered will be kept in confidence. You may wish to receive a copy of the transcript of our interview)

- background
  - how did you come to be involved in Brantford Commit?
  - had you previously been involved in the tobacco control lobby?

- mobilization
  - can we talk a bit about the early mobilization experience? Was it difficult getting people onside? Has it been difficult to put smoking on the community agenda? In your assessment, why has that been the case? Were there any surprises (positive or negative)?
  - there is alot of emphasis in the protocol on ensuring that ownership is transferred to the community. In your opinion, what does it take for COMMIT to become Brantford COMMIT? How fully has that occurred, and why or why not?
  - overall assessment of degree of (a) community involvement, (b) grassroots involvement
  - has the need for concilliation with local bodies compromised the viability of the trial here?

- Task Force X (refer to the one with which they were involved, if any)
  - can you tell me a little bit about what it was like to be part of the xxTF? Were you comfortable with this group? What was the group like? What were the group dynamics like?
  - do you feel that this group's activities had the desired impact?
  - are you pleased with how this group went? Looking back over the history of this group from its inception to the present time, what have you been most happy about or disappointed in?

- health care providers (where relevant to the respondant)
  - re the early "we can help" slogan for HCTF, did health care professionals really feel like they *did* have something to offer? I think the impression among many smokers is that they don't.
  - impressions of physicians in Brantford: are they receptive to this? What was turnout & reactions to training seminars like?
  - do they really have anything to offer their patients? (Do you think they do? Do they think that they do? Do their patients think that they do?) (R1 feedback: alot of patients feel dr doesn't have much to offer)

- impact

- overall assessment of likelihood of acheiving outcome objectives (& why or why not)
- what do you think the fate of COMMIT will be in the long run? In 5 or 10 years will we look back and say that it was one of the best things that happened to this town? Will it have made a difference?
- what areas has COMMIT excelled in? In what areas have you been less successful? What do you see as having been the major obstacles to success?

• <u>to do differently</u>
- what would you do differently the second time around? what would be your advice to ASSIST communities about to undertake what you have done here?

• <u>low SES smokers</u>
- do you get the impression that (social)*class* has been an important consideration in the activities of, in particular, the PETF & CRTF? Why or why not?
- do you think we are reaching the low income heavy smoker? Why or why not?

• <u>Smokers' Network</u>
- considerable effort has gone into recruiting people into the Smokers' Network, and by all accounts this has been very successful (in terms of numbers and % of smokers in Brantford). Are you happy with what has been done with smokers on the network once they have been recruited? What more could have been done, in your opinion? What is your assessment of what prevented that from taking place? Were smokers perhaps mislead about the potential benefits of joining the Network?

• <u>tensions</u>
- any (notable) tensions (between staff or task force members or between COMMIT and other local organizations) created as a result of (a) budgetary issues, (b) adherence to protocol, (c) turf wars, (d) how forceful to be about tobacco control

• <u>setting</u>
- is there anything about this community or the people that you dealt with that made Commit's work here more difficult or easy? What about things going on at the national or provincial level?

• <u>the nature of health promotion</u>
- what might "empowerment" mean in the context of smoking cessation? Is the social marketting approach consistent with notions of empowerment?
- to what extent do the ends justify the means in health promotion? Does an attempt to influence norms constitute social control? a degrading of the respect and dignity of smokers, or of their right to choose/determine their own behaviours? Is that justified?

APPENDIX L

QUESTIONNAIRE COMPLETED BY A SUBSET OF KEY INFORMANTS

INITIAL ASSESSMENT OF BRANTFORD COMMIT

Brantford COMMIT has been an experiment in community-based social change regarding cigarette smoking using a variety of channels and methods. Because it will serve as an example for other communities, it is important that any information concerning the positive and negative impacts of the project be included in decisions about how smoking cessation will be promoted in other communities. Your input is being sought for an independent evaluation of Brantford COMMIT. You are asked to participate in a private taped interview of approximately one hour in length to be scheduled at your convenience, and to complete a short questionnaire (below). Please rest assured that all information you provide will be kept in the strictest confidence: only aggregate scores will be reported in the research reports.

I would like you to rate the performance of Brantford COMMIT, as you see it, in the following areas. Please score each of the following according to the seven point scale provided [performance ranging from poor (1) to excellent (7)] (circle the appropriate number):

1. Providing information to heavy smokers on the health effects of smoking	poor 1 2 3 4 5 6 7 excellent
2. Providing information to smokers on available cessation resources and services in the community.	poor 1 2 3 4 5 6 7 excellent
3. Providing information to smokers on the various activities of Brantford COMMIT in all its areas of activity	poor 1 2 3 4 5 6 7 excellent
4. Not patronizing smokers (instead according them respect and dignity)	poor 1 2 3 4 5 6 7 excellent
5. Facilitating interaction between smokers (self-help and mutual aid)	poor 1 2 3 4 5 6 7 excellent
6. Providing opportunities for (& encouraging) smokers to have input into matters affecting them	poor 1 2 3 4 5 6 7 excellent
7. Supporting the efforts of individual smokers to quit	poor 1 2 3 4 5 6 7 excellent

8.	Involving all sectors of the community in the workings of Brantford COMMIT	poor 1 2 3 4 5 6 7 excellent
9.	Resolving conflicts between Brantford COMMIT and other agencies or individuals	poor 1 2 3 4 5 6 7 excellent
10.	Likelihood that Brantford COMMIT will "reach its delta" (have a significant impact on the prevalence of smoking in Brantford, particularly among heavy smokers)	poor 1 2 3 4 5 6 7 excellent
11.	Insofar as it does not harm others, respecting the right of smokers to choose whether to continue smoking	poor 1 2 3 4 5 6 7 excellent
12.	The flexibility of the protocol to be adapted to local circumstances	poor 1 2 3 4 5 6 7 excellent
13.	The support provided by the research institution	poor 1 2 3 4 5 6 7 excellent
14.	The support provided by like-minded organizations in Brantford	poor 1 2 3 4 5 6 7 excellent
15.	Reaching low income heavy smokers	poor 1 2 3 4 5 6 7 excellent
16.	The need for concilliation and getting the approval of a range of community stakeholders has resulted in a "watering down" of the intervention which has compromised it's chances of success	agree 1 2 3 4 5 6 7 disagree

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

QUESTIONNAIRE RESULTS
Ranked by mean score

Q#	Mean*	Dimension
2	5.8	Providing info to smokers on avail cess res/services
4	5.8	Not patronizing smokers (ie smokers accorded respect & dignity)
13	5.8	Support provided by the research institution
7	5.6	Supporting the efforts of individual smokers to quit
3	5.3	Providing info to smokers on all Brandford COMMIT activities
8	5.1	Involving all sectors of the community
1	5.0	Providing info to heavy smokers re health effects of smoking
9	5.0	Resolving conflicts between Brantford COMMIT & other agencies
11	5.0	Respecting right of smokers to choose to continue smoking
12	4.8	Flexibility of the protocol to be adapted to local circumstances
5	4.5	Facilitating interaction between smokers (mutual aid)
14	4.5	Support provided by likeminded organizations
16	4.4	Need for compromise = watering down of the intervention
10	4.3	Likelihood of reaching the delta
6	3.9	Providing opportunities for smokers to have input
15	3.2	Reaching low income heavy smokers
Total	4.9	average score for COMMIT based on aggregation across these dimensions

* Likert scale: 1=poor & 7=excellent (4=halfway point)

e.g: "score perceived performance for each issue on the following scale:"

poor 1 2 3 4 5 6 7 excellent (circle one number)

* N=21

APPENDIX M

PACKAGE SENT TO KEY INFORMANTS PRIOR TO FOCUS GROUP

---

3 items:

1. covering letter
2. annotated agenda
3. preliminary notes on the Task Force and Community Board experience

TO: ~~Respondent A~~ 519-xxx-xxxx
~~Respondent B~~ 519-xxx-xxxx
~~Respondent C~~ 519-xxx-xxxx
~~Respondent D~~ 519-xxx-xxxx
~~Respondent E~~ 519-xxx-xxxx
~~Respondent F~~ 519-xxx-xxxx
~~Respondent G~~ 519-xxx-xxxx

FROM: Blake Poland

RE:Focus group on the Task Force and Community Board Experience in Brantford Commit

---

Thank-you for agreeing to participate in our focus group discussion of the Task Force and Community Board experience in Brantford Commit. As Rosemary Walker indicated in her communication to you, we hope to be able to share this ainformation, and the lessons that were learned, with other communities in Ontario who are involved in similar endeavors (including the Brant Commit demonstration project, if they so wish).

The meeting has been set for the following time and place:

DATE: Tuesday, March 30, 1993

TIME: 8:30 am to 10:30 am

PLACE: Brant Commit boardroom
(4th floor of 233 Colborne Street)

The discussion will be tape-recorded for later transcription (certain passages can be marked as "off the record" if you wish). My wife Brenda will be joining us to keep track for the transcriber who has spoken in what order. Coffee, muffins and fruit will be provided.

I have attached an agenda for the meeting and some preliminary notes compiled from my interviews with you to stimulate our discussion. I'm looking forward to a lively and informative session.

The Task Force and Community Board Experience in Brantford Commit

- annotated agenda for a focus group -
- to be held March 30, 8:30-10:30am in the Brant Commit boardroom

The focus group agenda

This focus group of Task Force chairs and community board members is meant to comment on and add to material gathered through participant observation and interviews, the focus being on the Task Force and Community Board Experience in Brantford Commit. Thank-you for sharing your ideas with me along the way and for your support. It has been a joy to work with you all.

In preparing the agenda for our meeting, I've compiled a list of themes that emerged in the process of looking at some of the interview material. These are preliminary in nature, so please consider this "work in progress".

What we would like to do is focus on the following topics as they pertain to each task force and the community board:

- overall, what went well or not well for each task force & the community board
- what were the surprises
- what were the major challenges, disappointments, victories and acheivements
- what factors were conducive to or detracted from effective performance
- how successful each task force and the community board was
- what attracts and sustains volunteer interest
- how each task force and the board has evolved over time (dynamics, skills, comfort level etc)

If you were consultants for the next phase (Brant Commit), what would you recommend?

For each Task Force and the Community Board, in retrospect what would you have liked to have done differently or in addition to what was done?

In the attached notes, I have listed a number of issues under each of these headings. I would like to know: are my hunches off base? What have I missed? What pivotal or memorable events seem best represent each of these issues? This will be the basis of our focus group discussion on Tuesday.

Please bring a list other successes or challenges or issues that are not on this agenda (that you feel should be) so that we can talk about them. I would like, if possible, to collect these lists from you at the end of the meeting.

Contrary to the individual interviews, where I have careful to maintain confidentiality, we would like to make this session more "on the record". However, if there are remarks that you wish to keep "off the record", and you are able to indicate which ones, this will be honored.

Preliminary notes on the task force and community board experience in Brantford Commit

What went well, successes

Leadership of the chair is crucial to group dynamics and success of the TFs and Board

What makes a group "tick"? What are the elements of "group chemistry" and leadership?

Factors that fostered the development of a collaborative inter-agency coalition

Relationships between Task Forces: Integrating Forum a successful model

Commit acheived a high profile and public support in the community

Network membership recruitment exceeded expectations

Post-NCI funding for Brant Commit

HCTF: quickly fulfilled the majority of requirements around physician and dentist training

WOTF: in the end a committed and fun group
excellent staff support (Debbie then Jill)
video contest
smoke-free restaurant day and editorials that came from that

PETF: sting operation & publicity that came from that
legislative sub-committee (a lot of hard work here but by-law changes didn't materialize)

CRTF: neighbourhood cessation program
newsletter (but do we know how target group felt about it?)
getting the hotline moved to Brantford
the Quit and Win contests

Challenges &/or disappointments

Determining optimal division of labour between volunteers versus staff: what and how much
- brainstorming vs implementation
- "keepers of the protocol": creativity vs scientific demands

Determining optimal group size

Wearing several hats: participating as an individual but also organizational agendas

Dealing not just with personality issues but organizational agendas as well

Reluctance to "ruffle feathers"

Reluctance to voice concerns or lack of clarity on an issue which may be marring ones involvement

Lack of feedback on progress and its impacts on volunteer motivation or midcourse alterations to program design

Groups out of synch with each other with respect to level of activity: does this matter?

Detrimental precision of the protocol (encouraged tunnel vision, thinking like managers vs entrepreneurs)

Hazards inherent in TF structure: incomplete follow-through on ideas, too busy to see the whole picture

Insufficient allowance for startup time in early mobilization phase: esp. skills like media advocacy

Brant vs Brantford (geographic boundaries)

Concern that NCI evaluation methods would not capture the full flavour of what took place here

Limited understanding of the experiences and needs of smokers

Administrative bias was organizationally efficient but may have acted as a barrier to broader participation (ie Roberts Rules of order, typical committee meeting structure)

Standardized protocol and other barriers to using a community development approach

Restrictions on accessing the Smokers' Network (for needs assessment, advertising, recruitment)

Lack of NCI support (in protocol) for targetting economically disadvantaged heavy smokers

Early consultations with smokers and other opportunities to learn from smokers do not always seem to have been used in subsequent activity planning.

WOTF: social and religious organizations hard to reach
difficulty getting going at first
difficulty recruiting and keeping labour representation
resistance from Chamber of Commerce
too much focus on workplace policy and not enough on behavioural interventions in the work place

HCTF: getting motivated to go beyond the protocol
how to market training to those who didn't see the need for it
reluctance to pressure colleagues?

involving nursing and allied health care professionals (= physician bias?)
addressing the fact that many nurses smoke
difficulty getting people to come out to meetings

CRTF: dealing with organizational agendas: committment but not wanting to be "shown up"
small committee being stretched too thin?
initial lack of clarity or vision as to what Commit and CRTF was about

PETF: not having a stronger mandate (in protocol) in the area of prevention
difficulty bringing politicians on-side for legislative reform (by-law subcommittee)

Surprises

Significant investment of time and energy

Taking 2 years to get rolling

Challenges involved in working with other voluntary organizations

Changes over time within TFs, Board

Leadership of the chair is vital

The importance of fun in the creative process

Becoming more "daring" over time

Coming to grips with need to target economically disadvantaged heavy smokers
- neighbourhood cessation programs
- stress management, financial management counselling
- shift from "its my right to smoke" to "I'm not ready to quit yet" as potentially signif.

Attracting and maintaining volunteer interest

Why you got involved, as a combination of professional interest, research component, personal convictions, and going along for the experience &/or contacts

Personal experience with smoking: self, family & social network

What you got out of it: was it what you were expecting?

Lack of feedback on progress and its impacts on volunteer motivation

Level of comfort with administrative style of doing business (committee meetings)

Uncertainty about roles & responsibilities

Relationship with Research Institute

Generally characterized very positively as supportive, talented etc

Importance of university affiliation for credibility of Brantford Commit

Relationship with NCI

Central meetings where could compare notes with other sites were helpful, invigorating

Frustrations around planning/reporting requirements & OMB restrictions on accessing the Network

"What NCI doesn't know can't hurt them...": the "official" vs "unofficial" story

APPENDIX N

TOPIC CHECKLIST FOR FOCUS GROUP WITH KEY INFORMANTS

A. What would your advice be to the new Brant COMMIT?

B. What (else) worked well/not well

Looking back over the 4 years of the project, what worked well for the TFs & Comm Brd? (then prompt for each TF: change / add to list)

Looking back over the 4 years of the project, what did not work so well for the TFs & Comm Brd? (then prompt for each TF: change / add to list)

C. Update list of surprises, changes over time, rel'p w/ RI & NCI

C. Attracting & maintaining volunteer interest

D. Specific issues:

Specific challenges (that I'd like to know a bit more about)
- what makes a TF or CB group tick? Group chemistry
- factors that encouraged or discouraged inter-agency collaboration
- wearing several hats
- relp of volunteers with staff (brainstorming vs implem, protocol)
- groups out of synch w/ eachother
- detrimental precision of protocol: tunnel vision, managers vs entrep)
- insuff startup time re media advocacy skills etc
- lack of feedback to monitor progress

General concerns: (that I think are really interesting and would like to share w/ you, reactions)
- administrative orientation a factor in ltd grassroots particip
- opportunities to learn about the needs and experiences of smokers
- growing awareness of the need for targetting low SES smokers
- reluctance to "ruffle feathers"
- tob control as politically correct

APPENDIX O

CODING SCHEME USED FOR RESEARCH JOURNAL

Locations coded as follows:
yr-mo-day-pg-place(t,m,b)-paragraph

Chapters
- 1- intro
- 2- CJPH
- 3- TOG
- 4- methods
  - data collection
  - analysis process
- 5- smkr persp on BC
  - BC activities
  - needs, expectations etc
- 6- smkr persp on legisl
- 7- lessons (R3)
- 8- concl

Descriptive re BC (org, funding etc)
Health promotion general
Own smoking exper
CRG meetings
Supervisory meetings
Other stuff in my life

APPENDIX P

CODING SCHEME USED FOR INTERVIEWS AND FOCUS GROUPS WITH SMOKERS

NUDIST STAND-ALONE v.2.3 FOR MACINTOSH

This file created on 1993 Feb 25, 9:53:36.

****
LIST OF NODES FOR NUDIST PROJECT
****

R1 CODES: SMOKERS

(2)	**/started**
(4)	**/smoking status**
(4 1)	/smoking status/amount
(4 2)	/smoking status/timing
(6)	**/cigarettes**
(6 1)	/cigarettes/brand
(6 2)	/cigarettes/tobacco industry
(6 2 1)	/cigarettes/tobacco industry/corporation
(6 2 2)	/cigarettes/tobacco industry/farmers
(7)	**/second hand smoke**
(8)	**/actors**
(8 1)	/actors/self
(8 2)	/actors/smokers
(8 3)	/actors/non-smokers
(8 3 1)	/actors/non-smokers/never smoked
(8 3 2)	/actors/non-smokers/'reformed'~
(8 4)	/actors/peers
(8 4 1)	/actors/peers/friends
(8 5)	/actors/family
(8 5 1)	/actors/family/parents
(8 5 2)	/actors/family/siblings
(8 5 3)	/actors/family/kids
(8 5 4)	/actors/family/partner
(8 5 5)	/actors/family/other
(8 6)	/actors/workplace
(8 6 1)	/actors/workplace/coworkers
(8 6 2)	/actors/workplace/boss
(8 7)	/actors/doctor_nurse
(8 9)	/actors/fanatics

(10) **/interaction**
(10 1) /interaction/re smoking
(10 2) /interaction/anti-smoking
(10 2 1) /interaction/anti-smoking/support quitting
(10 2 2) /interaction/anti-smoking/bugged, harassed
(10 3) /interaction/pro-smoking

(12) **/attributions re people**

(14) **/smoking history (others)**

(15) **/health of others**

(16) **/quitting experience (others)**

(18) **/against smoking**
(18 1) /against smoking/waste $
(18 2) /against smoking/tired of it
(18 3) /against smoking/dont want to do it
(18 4) /against smoking/smell
(18 5) /against smoking/own health
(18 5 1) /against smoking/own health/emphysema,breathing
(18 5 2) /against smoking/own health/cancer
(18 5 3) /against smoking/own health/hc$ argument
(18 5 4) /against smoking/own health/other
(18 6) /against smoking/spouse's health
(18 7) /against smoking/children
(18 7 1) /against smoking/children/health
(18 7 2) /against smoking/children/bugging 'em to quit
(18 7 3) /against smoking/children/set example
(18 8) /against smoking/control
(18 9) /against smoking/fire hazard
(18 11) /against smoking/hassle
(18 12) /against smoking/healthy s-image
(18 13) /against smoking/retirement plans
(18 14) /against smoking/other
(18 14 1) /against smoking/other/horrible
(18 14 2) /against smoking/other/shouldn't be
(18 14 3) /against smoking/other/kick myself
(18 14 4) /against smoking/other/makes me sick
(18 14 5) /against smoking/other/silly
(18 14 6) /against smoking/other/stupid
(18 14 7) /against smoking/other/weakness
(18 14 8) /against smoking/other/maint relp with non-smkr
(18 14 9) /against smoking/other/in the back of my head
(18 14 10) /against smoking/other/religion
(18 14 11) /against smoking/other/stains on skin
(18 15) /against smoking/temp stopping
(18 15 1) /against smoking/temp stopping/pregnancy
(18 15 2) /against smoking/temp stopping/illness
(18 15 3) /against smoking/temp stopping/w certain others
(18 15 4) /against smoking/temp stopping/other reasons
(18 16) /against smoking/stated importance

(18 17) /against smoking/own freq & history of quitting

(20) **/strategies**
(20 1) /strategies/individuals
(20 1 1) /strategies/individuals/cold turkey
(20 1 2) /strategies/individuals/reducing
(20 1 2 1) /strategies/individuals/reducing/tapering down
(20 1 2 2) /strategies/individuals/reducing/milder brands
(20 1 2 3) /strategies/individuals/reducing/not inhaling
(20 1 3) /strategies/individuals/Life Signs
(20 1 4) /strategies/individuals/Nicorette
(20 1 5) /strategies/individuals/nic.patch
(20 1 6) /strategies/individuals/treatments: acup, hyp, laser
(20 1 7) /strategies/individuals/keeping busy & substitution
(20 1 8) /strategies/individuals/Δ routine etc
(20 1 9) /strategies/individuals/new yrs resolutions
(20 1 10) /strategies/individuals/lifestyle Δ
(20 1 11) /strategies/individuals/being ready
(20 1 12) /strategies/individuals/one day at a time
(20 1 13) /strategies/individuals/keeping leftover pack with you
(20 1 14) /strategies/individuals/telling other people I quit
(20 1 15) /strategies/individuals/imagining self without smoking
(20 1 16) /strategies/individuals/putting $ would have spent in jar
(20 1 17) /strategies/individuals/sports,being physically active
(20 1 18) /strategies/individuals/other
(20 1 19) /strategies/individuals/lkg for magic solution
(20 2) /strategies/mutual aid & support
(20 2 1) /strategies/mutual aid & support/bets
(20 2 2) /strategies/mutual aid & support/quitting w friends, spouse, others
(20 2 3) /strategies/mutual aid & support/AA model, support groups
(20 2 4) /strategies/mutual aid & support/other
(20 2 5) /strategies/mutual aid & support/being nagged
(20 5) /strategies/making profit from others' misery
(20 6) /strategies/motivation vs technique
(20 7) /strategies/at a loss what to do
(20 8) /strategies/aversion therapy
(20 9) /strategies/quitting aids that kill or harm
(20 10) /strategies/different strokes for different folks
(20 11) /strategies/only you can do it
(20 12) /strategies/saving up savings

(22) **/against quitting**
(22 1) /against quitting/unable to quit
(22 2) /against quitting/unsure what works
(22 3) /against quitting/lack info
(22 3 1) /against quitting/lack info/re health effects
(22 3 2) /against quitting/lack info/re techniques
(22 4) /against quitting/$ for tmt programmes
(22 4 1) /against quitting/$ for tmt programmes/dont have it
(22 4 2) /against quitting/$ for tmt programmes/wouldnt spend it on quitting
(22 5) /against quitting/lack willpower
(22 6) /against quitting/lack motivation

(22 6 1) /against quitting/lack motivation/a bit of a statement
(22 6 2) /against quitting/lack motivation/a social thing
(22 6 3) /against quitting/lack motivation/addiction,nicotine
(22 6 3 1) /against quitting/lack motivation/addiction,nicotine/we all have them
(22 6 3 2) /against quitting/lack motivation/addiction,nicotine/s-assessed level
(22 6 3 3) /against quitting/lack motivation/addiction,nicotine/compare with alcohol or drugs
(22 6 4) /against quitting/lack motivation/better to smk & die than be bitch
(22 6 5) /against quitting/lack motivation/crutch
(22 6 6) /against quitting/lack motivation/doesnt cause illness, just aggravates
(22 6 7) /against quitting/lack motivation/weight gain
(22 6 8) /against quitting/lack motivation/enjoy smoking
(22 6 9) /against quitting/lack motivation/gotta die of something
(22 6 10) /against quitting/lack motivation/habituated, habit
(22 6 11) /against quitting/lack motivation/circumstances not right now
(22 6 12) /against quitting/lack motivation/low self-esteem
(22 6 13) /against quitting/lack motivation/my right
(22 6 14) /against quitting/lack motivation/not now but later
(22 6 15) /against quitting/lack motivation/part of who I am
(22 6 16) /against quitting/lack motivation/permissable transgression
(22 6 17) /against quitting/lack motivation/stress
(22 6 18) /against quitting/lack motivation/too old or late anyhow
(22 6 19) /against quitting/lack motivation/things that go with smkg
(22 6 20) /against quitting/lack motivation/probably start again anyhow
(22 6 21) /against quitting/lack motivation/thinking about it makes you smoke more
(22 6 22) /against quitting/lack motivation/nonsmkrs get cancer&emphesema too
(22 6 23) /against quitting/lack motivation/just not motivated right now
(22 6 24) /against quitting/lack motivation/too available
(22 7) /against quitting/withdrawal
(22 7 1) /against quitting/withdrawal/craving
(22 7 3) /against quitting/withdrawal/cranky, hostile, snapping
(22 7 5) /against quitting/withdrawal/reactions
(22 7 5 1) /against quitting/withdrawal/reactions/not worth it
(22 7 5 2) /against quitting/withdrawal/reactions/lucky not too bad
(22 7 5 3) /against quitting/withdrawal/reactions/other
(22 8) /against quitting/lack of support
(22 8 1) /against quitting/lack of support/exposure to smoke
(22 8 2) /against quitting/lack of support/told to smoke
(22 9) /against quitting/everything goes with smoking
(22 10) /against quitting/synergy w coffee & booze
(22 11) /against quitting/just one cant hurt
(22 12) /against quitting/inner conflict, pushme pullyou
(22 13) /against quitting/need program, cant do it on own
(22 14) /against quitting/lack of time for courses, support grp etc

(22 15) /against quitting/cig=my friend

(23) **/own quitting experiences**

(24) **/needs for assistance**
(24 1) /needs for assistance/"I need.." statements

(26) **/reflections on having quit**
(26 1) /reflections on having quit/whether better off
(26 2) /reflections on having quit/other thoughts

(28) **/plans**
(28 1) /plans/yes
(28 1 1) /plans/yes/sometime
(28 1 2) /plans/yes/but no strategy
(28 1 3) /plans/yes/always in back of mind
(28 2) /plans/not really

(30) **/slips**
(30 1) /slips/partial
(30 2) /slips/planned
(30 3) /slips/expected but didnt
(30 4) /slips/unplanned, stories

(32) **/social acceptability**
(32 1) /social acceptability/should society care?

(34) **/COMMIT**
(34 2) /COMMIT/joining
(34 3) /COMMIT/interaction
(34 4) /COMMIT/attributions
(34 5) /COMMIT/support level
(34 6) /COMMIT/expectations
(34 6 1) /COMMIT/expectations/didnt really have any
(34 6 2) /COMMIT/expectations/not met
(34 6 3) /COMMIT/expectations/met
(34 7) /COMMIT/profile
(34 8) /COMMIT/made a diff?
(34 9) /COMMIT/mandate to Δ social norms
(34 10) /COMMIT/shoulds & coulds
(34 11) /COMMIT/infopack
(34 12) /COMMIT/newsletter
(34 13) /COMMIT/contests
(34 13 1) /COMMIT/contests/quit & win
(34 13 2) /COMMIT/contests/wkplace challenges
(34 14) /COMMIT/t-shirt
(34 15) /COMMIT/support grp
(34 16) /COMMIT/hotline
(34 17) /COMMIT/the subsidized Lung Assoc course
(34 18) /COMMIT/commit's future
(34 19) /COMMIT/wkpl initiatives
(34 20) /COMMIT/all

(36) **/prev & cess**

(36 1) /prev & cess/education
(36 1 1) /prev & cess/education/school-based
(36 1 2) /prev & cess/education/s-help lit
(36 1 3) /prev & cess/education/courses
(36 1 4) /prev & cess/education/media-based msgs
(36 2) /prev & cess/statistics
(36 2 1) /prev & cess/statistics/who smokes
(36 2 2) /prev & cess/statistics/health effects
(36 2 3) /prev & cess/statistics/local
(36 3) /prev & cess/taxation
(36 4) /prev & cess/legislation
(36 4 1) /prev & cess/legislation/access
(36 4 1 1) /prev & cess/legislation/access/minors
(36 4 1 2) /prev & cess/legislation/access/pts of sale
(36 4 2) /prev & cess/legislation/places can smoke
(36 4 2 1) /prev & cess/legislation/places can smoke/public places
(36 4 2 2) /prev & cess/legislation/places can smoke/workplaces
(36 4 2 3) /prev & cess/legislation/places can smoke/hc facilities
(36 4 3) /prev & cess/legislation/ban on advertising
(36 4 3 1) /prev & cess/legislation/ban on advertising/in-store advert
(36 4 4) /prev & cess/legislation/cig pack labels & warnings
(36 4 5) /prev & cess/legislation/outright ban on tobacco
(36 5) /prev & cess/other grps
(36 5 1) /prev & cess/other grps/Lung Assoc
(36 5 2) /prev & cess/other grps/Cancer Society
(36 5 3) /prev & cess/other grps/non-smkr rights
(36 6) /prev & cess/young people smoking
(36 7) /prev & cess/other prev & cess ideas
(36 10) /prev & cess/reactions
(36 10 1) /prev & cess/reactions/in favour
(36 10 2) /prev & cess/reactions/against
(36 10 2 1) /prev & cess/reactions/against/cant push anyone to quit
(36 10 2 2) /prev & cess/reactions/against/why not booze?
(36 10 2 3) /prev & cess/reactions/against/good for kids but not me
(36 10 2 4) /prev & cess/reactions/against/targetting users vs pushers
(36 10 2 5) /prev & cess/reactions/against/focus on +ve rather than -ve
(36 10 2 6) /prev & cess/reactions/against/digging heels in
(36 10 2 7) /prev & cess/reactions/against/^taxes will just ^crime
(36 10 2 8) /prev & cess/reactions/against/infringement of rights
(36 10 2 9) /prev & cess/reactions/against/other things more harmful & not so harshly dealt with
(36 10 2 10) /prev & cess/reactions/against/thin edge of the wedge
(36 10 2 11) /prev & cess/reactions/against/make up for lost time by smkg more
(36 10 2 12) /prev & cess/reactions/against/not child anymore,dont tell me what to do
(36 10 2 13) /prev & cess/reactions/against/my business as long as not hurting anyone else
(36 10 2 14) /prev & cess/reactions/against/already know risks
(36 10 2 15) /prev & cess/reactions/against/will never elim it completely
(36 10 2 16) /prev & cess/reactions/against/govt just hurting themselves
(36 10 2 17) /prev & cess/reactions/against/tobacco is legal
(36 10 2 18) /prev & cess/reactions/against/approach is patronizing

(36 10 2 19) /prev & cess/reactions/against/cant relate to it
(36 10 2 20) /prev & cess/reactions/against/goes too far
(36 11) /prev & cess/what to change
(36 12) /prev & cess/among low SES groups
(36 13) /prev & cess/living with the restrictions

(38) **/health**
(38 1) /health/own status
(38 1 1) /health/own status/health problems
(38 1 2) /health/own status/wrt peers
(38 2) /health/beliefs
(38 2 1) /health/beliefs/determinants
(38 2 1 1) /health/beliefs/determinants/mis-seen as not smkg-related
(38 2 2) /health/beliefs/other
(38 3) /health/own actions
(38 3 1) /health/own actions/other than cess
(38 3 2) /health/own actions/planned
(38 4) /health/events
(38 4 1) /health/events/death

(40) **/change over time**

(42) **/places**
(42 1) /places/where smoke
(42 1 1) /places/where smoke/own home
(42 1 2) /places/where smoke/outings
(42 1 3) /places/where smoke/transportation

(43) **/ctty devt**
(43 1) /ctty devt/nghd level wk

(44) **/contradiction**
(44 1) /contradiction/taxes don't wk but $ main reason to quit
(44 2) /contradiction/rates own h favourably despite numerous chronic h problems
(44 3) /contradiction/AA-style thing would be good but not for me
(44 4) /contradiction/comments discounting strength of own convictions
(44 10) /contradiction/other

(46) **/context**
(46 1) /context/the economy
(46 1 1) /context/the economy/stress means people need fags
(46 1 2) /context/the economy/layoffs = employers reluctant to hit wkrs with restrictions
(46 1 3) /context/the economy/ltd $ for hp
(46 1 4) /context/the economy/more int in jobs than smkg
(46 2) /context/the environment
(46 3) /context/crime
(46 4) /context/suspicion of government
(46 5) /context/own job & other lifestory info
(46 6) /context/about Brantford and Brantford people
(46 6 1) /context/about Brantford and Brantford people/small town vs large

```
(46 6 2)        /context/about Brantford and Brantford people/conservative
(46 6 3)        /context/about Brantford and Brantford people/blue collar
(46 6 4)        /context/about Brantford and Brantford people/friendly
(46 6 5)        /context/about Brantford and Brantford people/other
(46 6 6)        /context/about Brantford and Brantford people/Cdn vs US
                  context
(46 7)          /context/other social change
(46 8)          /context/provl policies
(46 8 1)        /context/provl policies/lack teeth for enforcemt

(48)            /themes
(48 1)          /themes/choice vs peer pressure
(48 3)          /themes/care,compassion,empathy
(48 4)          /themes/fatalism,inevitability,pointlessness
(48 5)          /themes/respect,consideration
(48 6)          /themes/rights
(48 7)          /themes/deception
(48 7 1)        /themes/deception/fooling yourself
(48 7 2)        /themes/deception/being fooled by others
(48 7 3)        /themes/deception/hiding from others
(48 8)          /themes/tranquilizers
(48 9)          /themes/patronization

(50)            /classic quotes

(52)            /behaviours
(52 1)          /behaviours/accepting
(52 2)          /behaviours/advising
(52 3)          /behaviours/denying,rejecting
(52 4)          /behaviours/exagerating
(52 5)          /behaviours/preaching
(52 6)          /behaviours/rebelling
(52 7)          /behaviours/ridiculing
(52 8)          /behaviours/stealing
(52 9)          /behaviours/learning to smoke

(54)            /feelings
(54 1)          /feelings/amused
(54 2)          /feelings/depressed
(54 3)          /feelings/disgusted
(54 4)          /feelings/hate
(54 5)          /feelings/hope
(54 6)          /feelings/perplexed
(54 7)          /feelings/resigned
(54 8)          /feelings/stupid
(54 9)          /feelings/not stupid
(54 10)         /feelings/defiant
(54 11)         /feelings/guilt
(54 12)         /feelings/bored
(54 13)         /feelings/angry, irritated


(56)            /questions
(56 1)          /questions/re COMMIT
```

(56 1 1) /questions/re COMMIT/funding
(56 1 2) /questions/re COMMIT/mandate & activities
(56 1 3) /questions/re COMMIT/staff
(56 1 4) /questions/re COMMIT/future
(56 2) /questions/re my study
(56 2 1) /questions/re my study/purpose
(56 2 2) /questions/re my study/process
(56 2 3) /questions/re my study/findings
(56 3) /questions/re myself
(56 3 1) /questions/re myself/program of study
(56 3 2) /questions/re myself/whether I smoked
(56 3 3) /questions/re myself/my affect on their smoking
(56 4) /questions/re other
(56 4 1) /questions/re other/techniques & cess resources
(56 5) /questions/re techniques, cess resources

(58) **/other respondants**
(58 1) /other respondants/statements about interviewee's testimony
(58 2) /other respondants/statements about their testimony made by interviewee
(58 3) /other respondants/views re restrictions,taxation etc
(58 4) /other respondants/views re COMMIT & other help
(58 5) /other respondants/their own smkg & quitting experience, history
(58 6) /other respondants/other talk

(60) **/transcriber notes**
(60 1) /transcriber notes/my reactions

(62) **/fieldnotes**
(62 1) /fieldnotes/re interview
(62 1 1) /fieldnotes/re interview/particulars
(62 1 2) /fieldnotes/re interview/methods
(62 1 3) /fieldnotes/re interview/highlights
(62 1 4) /fieldnotes/re interview/my disposition
(62 2) /fieldnotes/re interviewee
(62 3) /fieldnotes/re other actors
(62 4) /fieldnotes/re followup particulars
(62 5) /fieldnotes/subsequent contact or progress or change
(62 6) /fieldnotes/actions I need to take
(62 7) /fieldnotes/Michelle's comments

(69) **/evaluation R1**

Base Codes for Smokers

```
(100)              /respondant
(100 1)            /respondant/age
(100 1 1)          /respondant/age/<25
(100 1 2)          /respondant/age/26-35
(100 1 3)          /respondant/age/36-50
(100 1 4)          /respondant/age/51+
(100 2)            /respondant/smoking status
(100 2 1)          /respondant/smoking status/on sign-up
(100 2 1 1)        /respondant/smoking status/on sign-up/hvy
(100 2 1 2)        /respondant/smoking status/on sign-up/l-m
(100 2 1 3)        /respondant/smoking status/on sign-up/quit
(100 2 2)          /respondant/smoking status/@interview
(100 2 2 1)        /respondant/smoking status/@interview/hvy
(100 2 2 2)        /respondant/smoking status/@interview/l-m
(100 2 2 3)        /respondant/smoking status/@interview/quit
(100 2 2 3 1)      /respondant/smoking status/@interview/quit/<1mo
(100 2 2 3 2)      /respondant/smoking status/@interview/quit/1-6mo
(100 2 2 3 3)      /respondant/smoking status/@interview/quit/>6mo
(100 2 3)          /respondant/smoking status/started young
(100 2 3 1)        /respondant/smoking status/started young/at 10-16yo
(100 2 3 2)        /respondant/smoking status/started young/at 17 or 18 years
                    old
(100 2 4)          /respondant/smoking status/#yrs smkg
(100 2 4 1)        /respondant/smoking status/#yrs smkg/<10yrs
(100 2 4 2)        /respondant/smoking status/#yrs smkg/10-25yrs
(100 2 4 3)        /respondant/smoking status/#yrs smkg/>25yrs
(100 3)            /respondant/SES
(100 3 1)          /respondant/SES/professional
(100 3 2)          /respondant/SES/wkg1:waged
(100 3 3)          /respondant/SES/wkg2:low incm
(100 4)            /respondant/LI
(100 4 1)          /respondant/LI/high
(100 4 2)          /respondant/LI/med
(100 4 3)          /respondant/LI/low
(100 5)            /respondant/wrt COMMIT
(100 5 1)          /respondant/wrt COMMIT/time on
(100 5 1 1)        /respondant/wrt COMMIT/time on/<2mo
(100 5 1 2)        /respondant/wrt COMMIT/time on/2-6mo
(100 5 1 3)        /respondant/wrt COMMIT/time on/>6mo-1yr
(100 5 1 4)        /respondant/wrt COMMIT/time on/>1yr
(100 5 2)          /respondant/wrt COMMIT/referral pt
(100 5 2 1)        /respondant/wrt COMMIT/referral pt/Mohawk
(100 5 2 2)        /respondant/wrt COMMIT/referral pt/wksite
(100 5 2 3)        /respondant/wrt COMMIT/referral pt/physician
(100 5 2 4)        /respondant/wrt COMMIT/referral pt/activities:
                    Q&W,picnic,ButtOut etc
(100 5 2 5)        /respondant/wrt COMMIT/referral pt/advertising
(100 5 2 6)        /respondant/wrt COMMIT/referral pt/husbands wksite
                    challenge
(100 5 2 7)        /respondant/wrt COMMIT/referral pt/family,friends
(100 5 2 8)        /respondant/wrt COMMIT/referral pt/own wkpl challenge
(100 5 3)          /respondant/wrt COMMIT/expectations
```

```
(100 5 3 1)         /respondant/wrt COMMIT/expectations/not met
(100 5 3 2)         /respondant/wrt COMMIT/expectations/didn't really have any
(100 5 3 3)         /respondant/wrt COMMIT/expectations/met
(100 6)             /respondant/sex
(100 6 1)           /respondant/sex/female
(100 6 2)           /respondant/sex/male

(105)               /interviewer
(105 1)             /interviewer/MC
(105 1 1)           /interviewer/MC/high
(105 1 2)           /interviewer/MC/med
(105 1 3)           /interviewer/MC/low

(110)               /interview
(110 1)             /interview/location
(110 1 1)           /interview/location/COMMIT office
(110 1 2)           /interview/location/coffee shop
(110 1 3)           /interview/location/respondants home
(110 1 4)           /interview/location/respondants wkplace
(110 2)             /interview/duration
(110 2 1)           /interview/duration/short
(110 2 2)           /interview/duration/med
(110 2 3)           /interview/duration/long
(110 3)             /interview/distractions
(110 4)             /interview/content
(110 4 1)           /interview/content/re social acceptability
(110 4 1 1)         /interview/content/re social acceptability/apologetic
(110 4 1 2)         /interview/content/re social acceptability/indignant re
                     rights
(110 4 1 3)         /interview/content/re social acceptability/sensitive about
                     stigmatization
(110 4 1 4)         /interview/content/re social acceptability/ok with it
(110 4 2)           /interview/content/re AA-style mtgs
(110 4 2 1)         /interview/content/re AA-style mtgs/wanted
(110 4 2 2)         /interview/content/re AA-style mtgs/not wanted
(110 4 2 3)         /interview/content/re AA-style mtgs/not discussed
(110 5)             /interview/pieces missing

(115)               /other actors
(115 1)             /other actors/spouse
(115 1 1)           /other actors/spouse/freq input
(115 1 2)           /other actors/spouse/smkg status
(115 1 2 1)         /other actors/spouse/smkg status/smokes
(115 1 2 2)         /other actors/spouse/smkg status/doesnt smoke
(115 1 2 2 1)       /other actors/spouse/smkg status/doesnt smoke/quit
(115 1 2 3)         /other actors/spouse/smkg status/d.k.
(115 1 2 5)         /other actors/spouse/smkg status/dont know
(115 1 3)           /other actors/spouse/n.a.
(115 2)             /other actors/kids
(115 2 1)           /other actors/kids/<18yo
(115 2 2)           /other actors/kids/>18,@home
(115 2 3)           /other actors/kids/moved out
(115 2 4)           /other actors/kids/@interview
(115 2 5)           /other actors/kids/>half smkd
```

```
(115 2 6)          /other actors/kids/<half smkd
(115 2 7)          /other actors/kids/dk prop smkd
(115 2 8)          /other actors/kids/n.a.
(115 3)            /other actors/siblings
(115 3 1)          /other actors/siblings/>half smkd
(115 3 2)          /other actors/siblings/<half smkd
(115 3 3)          /other actors/siblings/dk prop smkd
(115 3 4)          /other actors/siblings/n.a.
(115 4)            /other actors/parents
(115 4 1)          /other actors/parents/dad smkd
(115 4 2)          /other actors/parents/mom smkd
(115 4 3)          /other actors/parents/either had smkg-related death or
                    illness
(115 5)            /other actors/%friends smkg
(115 5 1)          /other actors/%friends smkg/>half
(115 5 2)          /other actors/%friends smkg/<half
(115 5 3)          /other actors/%friends smkg/dk
(115 6)            /other actors/%cowkrs smkg
(115 6 1)          /other actors/%cowkrs smkg/>half
(115 6 2)          /other actors/%cowkrs smkg/<half
(115 6 3)          /other actors/%cowkrs smkg/dk
(115 6 4)          /other actors/%cowkrs smkg/n.a.
(115 7)            /other actors/wkpl restrictions
(115 7 1)          /other actors/wkpl restrictions/none
(115 7 2)          /other actors/wkpl restrictions/designated areas
(115 7 3)          /other actors/wkpl restrictions/prohibited
(115 7 4)          /other actors/wkpl restrictions/n.a.
(115 7 5)          /other actors/wkpl restrictions/d.k.

(120)              /person
(120 1)            /person/R1 only
(120 2)            /person/R1 & R2
(120 3)            /person/R3

(125)              /document
(125 1)            /document/R1
(125 2)            /document/R2
(125 2 1)          /document/R2/fg1
(125 2 2)          /document/R2/fg2
(125 3)            /document/R3ki
(125 4)            /document/journal
(125 5)            /document/proposal
(125 6)            /document/readings,literature
(125 7)            /document/analysis notes
```

APPENDIX Q

CODING SCHEME USED FOR INTERVIEWS AND FOCUS GROUPS WITH KEY INFORMANTS

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                NUDIST STAND-ALONE v.2.3 FOR MACINTOSH
                ======================================

This file created on 1993 Feb 25, 9:53:36.

*****************************************
LIST OF NODES FOR NUDIST PROJECT                  R3 CODES:      KEY INFORMANTS
*******************************************************************************

(70)                    /players
(70 1)                /players/Commit
(70 1 1)              /players/Commit/staff
(70 1 2)              /players/Commit/early planning grp
(70 1 3)              /players/Commit/Exec Committee
(70 1 4)              /players/Commit/Comm Brd
(70 1 5)              /players/Commit/task forces
(70 1 5 1)            /players/Commit/task forces/pub ed
(70 1 5 2)            /players/Commit/task forces/hlth care
(70 1 5 3)            /players/Commit/task forces/wksites & org
(70 1 5 4)            /players/Commit/task forces/cess res
(70 1 5 5)            /players/Commit/task forces/TF volunteers
(70 1 6)              /players/Commit/other interv sites
(70 2)                /players/RI
(70 2 1)              /players/RI/CRG
(70 2 2)              /players/RI/pd staff
(70 3)                /players/NCI
(70 4)                /players/likeminded orgs
(70 4 1)              /players/likeminded orgs/Lung
(70 4 2)              /players/likeminded orgs/Cancer
(70 4 3)              /players/likeminded orgs/Hrt&Stroke
(70 4 4)              /players/likeminded orgs/DPHS
(70 4 5)              /players/likeminded orgs/MOH
(70 4 6)              /players/likeminded orgs/Council for Tob-Free Ont
(70 4 7)              /players/likeminded orgs/non-smkr rights grps
(70 4 8)              /players/likeminded orgs/DHC
(70 4 9)              /players/likeminded orgs/Heart Health
(70 4 10)             /players/likeminded orgs/other
(70 5)                /players/tob ind
(70 5 1)              /players/tob ind/manufacturers
(70 5 2)              /players/tob ind/farmers
(70 5 2 1)            /players/tob ind/farmers/alternate crops
(70 5 2 2)            /players/tob ind/farmers/government support for farmers
(70 5 2 3)            /players/tob ind/farmers/plight of farmers
(70 5 2 4)            /players/tob ind/farmers/about tobacco farming
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(70 5 3)          /players/tob ind/retailers
(70 6)            /players/tob users
(70 6 1)          /players/tob users/smokers
(70 6 1 1)        /players/tob users/smokers/who want to quit
(70 6 1 2)        /players/tob users/smokers/who don't give a shit
(70 6 2)          /players/tob users/reformed ex-smokers
(70 6 3)          /players/tob users/smoker rights grps
(70 6 4)          /players/tob users/smokeless tob users
(70 6 5)          /players/tob users/minors
(70 6 6)          /players/tob users/women
(70 7)            /players/other
(70 7 1)          /players/other/worksites
(70 7 1 1)        /players/other/worksites/mgt
(70 7 1 2)        /players/other/worksites/labour, unions
(70 7 1 3)        /players/other/worksites/wkrs, wkforce
(70 7 2)          /players/other/orgs
(70 7 2 1)        /players/other/orgs/religious
(70 7 2 2)        /players/other/orgs/soc grps
(70 7 2 3)        /players/other/orgs/s-help grps
(70 7 3)          /players/other/law enforcement
(70 7 4)          /players/other/politicians
(70 7 5)          /players/other/non-smkg public
(70 7 5 1)        /players/other/non-smkg public/Brantford
(70 7 5 2)        /players/other/non-smkg public/outside Brantford
(70 7 6)          /players/other/schl teachers
(70 7 7)          /players/other/hlth care
(70 7 7 1)        /players/other/hlth care/physicians
(70 7 7 1 1)      /players/other/hlth care/physicians/training
(70 7 7 1 2)      /players/other/hlth care/physicians/relp with pts, smkrs
(70 7 7 1 3)      /players/other/hlth care/physicians/relp with hc proffesionals
(70 7 7 2)        /players/other/hlth care/nurses
(70 7 7 3)        /players/other/hlth care/hc facility support staff
(70 7 8)          /players/other/aboriginal people

(71)              /specific psuedofolk
(71 1)            /specific psuedofolk/Aaron Wilcox
(71 2)            /specific psuedofolk/Albert Seavers
(71 3)            /specific psuedofolk/Alice Pumphrey
(71 4)            /specific psuedofolk/Arthur Spiegal
(71 5)            /specific psuedofolk/Ashley Jervais
(71 6)            /specific psuedofolk/Beatrice Alexis
(71 7)            /specific psuedofolk/Beatrice O'Connor
(71 8)            /specific psuedofolk/Beau Smith
(71 9)            /specific psuedofolk/Bertha
(71 10)           /specific psuedofolk/Brett Spitz
(71 11)           /specific psuedofolk/Brian Deutch
(71 12)           /specific psuedofolk/Bruce French
(71 13)           /specific psuedofolk/Casey
(71 14)           /specific psuedofolk/Cecil Williams
(71 15)           /specific psuedofolk/Charles Harris
(71 16)           /specific psuedofolk/Christina, staff
(71 17)           /specific psuedofolk/Clarissa Steeles
(71 18)           /specific psuedofolk/Connor Jameson
(71 18 1)         /specific psuedofolk/Connor Jameson/.
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(71 19)          /specific psuedofolk/Daryl Smart
(71 20)          /specific psuedofolk/Dawn Goodwin
(71 21)          /specific psuedofolk/Dennis Litman
(71 22)          /specific psuedofolk/Elena Collin
(71 23)          /specific psuedofolk/Emma, staff
(71 24)          /specific psuedofolk/Erica Thornton
(71 25)          /specific psuedofolk/Ernest Burch
(71 26)          /specific psuedofolk/Estelle Montgomery
(71 27)          /specific psuedofolk/Felicia Dexter
(71 28)          /specific psuedofolk/Fletcher Maykin, hannah's hubby
(71 29)          /specific psuedofolk/Floyd Hills
(71 30)          /specific psuedofolk/Friar Ed
(71 31)          /specific psuedofolk/Frank Ibley
(71 32)          /specific psuedofolk/Franz Balikci
(71 33)          /specific psuedofolk/Fred Michaels
(71 34)          /specific psuedofolk/Geraldine Bliss
(71 34 1)        /specific psuedofolk/Geraldine Bliss/.
(71 35)          /specific psuedofolk/Gina Douglas, also Barbara
(71 36)          /specific psuedofolk/Godiva Linthead
(71 37)          /specific psuedofolk/Grace Harrowsmith
(71 38)          /specific psuedofolk/Gwen, int 9-31
(71 39)          /specific psuedofolk/Hal Munson
(71 40)          /specific psuedofolk/Hank
(71 41)          /specific psuedofolk/Hannah Maykin
(71 42)          /specific psuedofolk/Harriet Stevens
(71 43)          /specific psuedofolk/Harry Jaggs
(71 44)          /specific psuedofolk/Henry Pike
(71 45)          /specific psuedofolk/Herman Armand
(71 46)          /specific psuedofolk/Irv Smelt at newsppr
(71 47)          /specific psuedofolk/Jack Pimmel
(71 48)          /specific psuedofolk/Jaime Sturrock
(71 49)          /specific psuedofolk/Jane, but see also Hannah
(71 50)          /specific psuedofolk/Jeanette Whistler
(71 51)          /specific psuedofolk/Jeffrey Redwell
(71 52)          /specific psuedofolk/Jenna Hankin
(71 53)          /specific psuedofolk/Joshua Quenell
(71 54)          /specific psuedofolk/Kate Spielberg
(71 55)          /specific psuedofolk/Kathy Anderson
(71 56)          /specific psuedofolk/Kevin Sider
(71 57)          /specific psuedofolk/Kip Tinker
(71 58)          /specific psuedofolk/Leeann Campbell
(71 59)          /specific psuedofolk/Lenny Morrison
(71 60)          /specific psuedofolk/Leroy Kitts
(71 61)          /specific psuedofolk/Lilian Milborrow
(71 62)          /specific psuedofolk/Lorraine Furtig
(71 63)          /specific psuedofolk/Lou Birdsall
(71 64)          /specific psuedofolk/Malcolm Stuart
(71 65)          /specific psuedofolk/Marcy
(71 66)          /specific psuedofolk/Maria Mitchell
(71 67)          /specific psuedofolk/Maria
(71 67 1)        /specific psuedofolk/Maria/.. Marta Graham
(71 68)          /specific psuedofolk/Marta Graham
(71 69)          /specific psuedofolk/Maureen Bower
(71 70)          /specific psuedofolk/Marvin Dobbs
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(71 71) /specific psuedofolk/Mathias Brock
(71 72) /specific psuedofolk/Maury
(71 73) /specific psuedofolk/Melody Rinnet
(71 74) /specific psuedofolk/Michelle Barrett
(71 75) /specific psuedofolk/Mike Ferris
(71 76) /specific psuedofolk/Mitch Peters
(71 77) /specific psuedofolk/Nick Empson
(71 78) /specific psuedofolk/Pauline Christianson
(71 79) /specific psuedofolk/Peggy Greer
(71 80) /specific psuedofolk/Peter Marple
(71 81) /specific psuedofolk/Phil Roberts
(71 82) /specific psuedofolk/Robert Duffy
(71 83) /specific psuedofolk/Rochelle
(71 84) /specific psuedofolk/Roger Thomas
(71 85) /specific psuedofolk/Ron Hankin
(71 86) /specific psuedofolk/Roseanna Smyth
(71 87) /specific psuedofolk/Ross Thorpe
(71 88) /specific psuedofolk/Royce Smith
(71 89) /specific psuedofolk/Russell Singelton
(71 90) /specific psuedofolk/Ruth Hamblin
(71 91) /specific psuedofolk/Sally Freeman
(71 92) /specific psuedofolk/Sam Bender
(71 93) /specific psuedofolk/Tim Parrish
(71 94) /specific psuedofolk/Tony Riordan
(71 95) /specific psuedofolk/Vinnie MacArthur
(71 96) /specific psuedofolk/Wayne Mercier
(71 97) /specific psuedofolk/Xxxxx Gerome
(71 98) /specific psuedofolk/Elmer Fud
(71 99) /specific psuedofolk/Roberta Ferrance
(71 100) /specific psuedofolk/Barbara,staff
(71 101) /specific psuedofolk/Floyd Lockren

(72) **/media**
(72 1) /media/print
(72 1 1) /media/print/local
(72 1 2) /media/print/regional, national
(72 2) /media/electronic
(72 2 1) /media/electronic/local
(72 2 2) /media/electronic/regional, national
(72 3) /media/wrt Commit & smkg issues
(72 3 1) /media/wrt Commit & smkg issues/receptivity & nature of cvg
(72 3 1 1) /media/wrt Commit & smkg issues/receptivity & nature of cvg/+ve
(72 3 1 2) /media/wrt Commit & smkg issues/receptivity & nature of cvg/-ve, unresponsive
(72 3 2) /media/wrt Commit & smkg issues/ability to reach target grps
(72 3 3) /media/wrt Commit & smkg issues/other
(72 3 4) /media/wrt Commit & smkg issues/media advocacy

(74) **/relp & beh**
(74 1) /relp & beh/level
(74 1 1) /relp & beh/level/indiv wrt smkrs
(74 1 2) /relp & beh/level/internal staff
(74 1 3) /relp & beh/level/within TFs

(74 1 4) /relp & beh/level/staff vs TFs
(74 1 5) /relp & beh/level/bn TFs, TF vs Brds
(74 1 6) /relp & beh/level/comm vs RI
(74 1 7) /relp & beh/level/Commit wrt other orgs
(74 1 8) /relp & beh/level/Commit wrt indivs
(74 1 9) /relp & beh/level/Commit with smokers
(74 1 10) /relp & beh/level/Commit with NCI
(74 2) /relp & beh/nature
(74 2 1) /relp & beh/nature/negative
(74 2 1 1) /relp & beh/nature/negative/turf issues, ambition
(74 2 1 2) /relp & beh/nature/negative/personality conflicts
(74 2 1 3) /relp & beh/nature/negative/lack of shared vision
(74 2 1 4) /relp & beh/nature/negative/patronizing, belittling
(74 2 1 5) /relp & beh/nature/negative/shut out from d-mkg
(74 2 1 6) /relp & beh/nature/negative/stereotyping
(74 2 1 7) /relp & beh/nature/negative/stick in the muds
(74 2 1 8) /relp & beh/nature/negative/cautious, not rock boat, tiptoe
(74 2 1 9) /relp & beh/nature/negative/risk, danger
(74 2 1 10) /relp & beh/nature/negative/other -ve
(74 2 2) /relp & beh/nature/+ve
(74 2 2 1) /relp & beh/nature/+ve/wonderful to wk with
(74 2 2 2) /relp & beh/nature/+ve/things going smoothly
(74 2 2 3) /relp & beh/nature/+ve/supporting, encouraging
(74 2 2 4) /relp & beh/nature/+ve/involving, consulting
(74 2 2 5) /relp & beh/nature/+ve/dedicated, enthusiastic, creative
(74 2 2 6) /relp & beh/nature/+ve/fun
(74 2 2 7) /relp & beh/nature/+ve/trust
(74 2 2 8) /relp & beh/nature/+ve/delegating
(74 2 2 9) /relp & beh/nature/+ve/knowing how to wk with people
(74 2 2 10) /relp & beh/nature/+ve/other +ve
(74 2 2 11) /relp & beh/nature/+ve/+ve controversy
(74 2 3) /relp & beh/nature/leadership
(74 2 4) /relp & beh/nature/other
(74 2 4 1) /relp & beh/nature/other/brought dwn to reality
(74 2 4 2) /relp & beh/nature/other/wearing many hats
(74 2 4 2 1) /relp & beh/nature/other/wearing many hats/there as indiv vs agency rep
(74 2 4 3) /relp & beh/nature/other/big time committment
(74 2 4 4) /relp & beh/nature/other/pivotal events
(74 2 4 5) /relp & beh/nature/other/surprises
(74 2 4 6) /relp & beh/nature/other/money issues

(76) /Commit
(76 1) /Commit/attributions about
(76 2) /Commit/felt level & nature of support
(76 3) /Commit/expectations of
(76 3 1) /Commit/expectations of/by respondant
(76 3 2) /Commit/expectations of/by smokers
(76 3 3) /Commit/expectations of/by public at large
(76 3 4) /Commit/expectations of/by NCI
(76 3 5) /Commit/expectations of/by Commit volunteers
(76 3 6) /Commit/expectations of/by staff
(76 3 7) /Commit/expectations of/by RI
(76 3 8) /Commit/expectations of/on the part of orgs

(76 4) /Commit/profile in community
(76 5) /Commit/mandate to chg soc norms, comm-wide focus
(76 6) /Commit/protocol
(76 6 1) /Commit/protocol/accepting it
(76 6 2) /Commit/protocol/understanding it
(76 6 3) /Commit/protocol/flexibility
(76 6 4) /Commit/protocol/keeping up with it
(76 6 5) /Commit/protocol/going beyond it
(76 6 6) /Commit/protocol/ltd contact with network
(76 6 7) /Commit/protocol/always planning
(76 6 8) /Commit/protocol/other limitations
(76 6 9) /Commit/protocol/+ve aspects
(76 7) /Commit/its future
(76 7 1) /Commit/its future/in Brantford
(76 7 2) /Commit/its future/wrt Assist
(76 8) /Commit/perfor, eval
(76 8 1) /Commit/perfor, eval/impact, delta
(76 8 1 1) /Commit/perfor, eval/impact, delta/getting the delta
(76 8 1 2) /Commit/perfor, eval/impact, delta/+ve impact, progress
(76 8 1 3) /Commit/perfor, eval/impact, delta/-ve impact, side effects
(76 8 1 4) /Commit/perfor, eval/impact, delta/lack of mvt
(76 8 2) /Commit/perfor, eval/what TF folk got out of it
(76 8 3) /Commit/perfor, eval/things that worked well
(76 8 4) /Commit/perfor, eval/things that didn't wk so well
(76 8 5) /Commit/perfor, eval/Brantford vs Peterborough
(76 8 6) /Commit/perfor, eval/progress, moving ahead
(76 8 7) /Commit/perfor, eval/what would do differently, ideas
(76 8 8) /Commit/perfor, eval/timing of eval
(76 8 9) /Commit/perfor, eval/nature of eval methods
(76 8 9 1) /Commit/perfor, eval/nature of eval methods/quant surveys
(76 8 9 1 1) /Commit/perfor, eval/nature of eval methods/quant surveys/feedback to comm
(76 8 9 2) /Commit/perfor, eval/nature of eval methods/qual methods
(76 8 9 2 1) /Commit/perfor, eval/nature of eval methods/qual methods/early forum
(76 8 9 2 2) /Commit/perfor, eval/nature of eval methods/qual methods/quarterly reports
(76 8 9 2 3) /Commit/perfor, eval/nature of eval methods/qual methods/my study
(76 8 9 2 4) /Commit/perfor, eval/nature of eval methods/qual methods/comm analysis
(76 8 9 2 5) /Commit/perfor, eval/nature of eval methods/qual methods/other qual info
(76 8 9 3) /Commit/perfor, eval/nature of eval methods/official vs unofficial story
(76 8 9 4) /Commit/perfor, eval/nature of eval methods/other eval ideas
(76 8 10) /Commit/perfor, eval/Brantford city vs county
(76 9) /Commit/activities
(76 9 1) /Commit/activities/TF mtgs
(76 9 2) /Commit/activities/infopack, quitpack
(76 9 3) /Commit/activities/newsltr
(76 9 4) /Commit/activities/contests
(76 9 4 1) /Commit/activities/contests/Q&W
(76 9 4 2) /Commit/activities/contests/wkpl challenges

(76 9 4 3) /Commit/activities/contests/video contest
(76 9 5) /Commit/activities/t-shirt
(76 9 6) /Commit/activities/support grp at Y
(76 9 7) /Commit/activities/hotline
(76 9 8) /Commit/activities/subsidized LA crse
(76 9 9) /Commit/activities/smokers' netwk
(76 9 10) /Commit/activities/prev vs cess
(76 9 11) /Commit/activities/sting
(76 9 12) /Commit/activities/petition for Smk-Free comm
(76 9 13) /Commit/activities/legislative sub-cttee
(76 9 14) /Commit/activities/day for women at the Y
(76 9 15) /Commit/activities/nbhd cess program
(76 9 16) /Commit/activities/integrating forum
(76 9 17) /Commit/activities/photo contest
(76 9 18) /Commit/activities/smk-free restaurant day
(76 9 20) /Commit/activities/other
(76 10) /Commit/other interv sites

(78) **/challenges**
(78 1) /challenges/class
(78 2) /challenges/ownership
(78 3) /challenges/mobilization
(78 3 1) /challenges/mobilization/early, forming TFs etc
(78 3 1 1) /challenges/mobilization/early, forming TFs etc/putting smkg on agenda
(78 3 2) /challenges/mobilization/ongoing, smkg on agenda
(78 3 3) /challenges/mobilization/estab & maint credibility
(78 3 4) /challenges/mobilization/getting low SES folk or smkrs on TFs & Comm brd
(78 4) /challenges/reaching & involving certain grps
(78 4 1) /challenges/reaching & involving certain grps/ethnic minorities
(78 4 2) /challenges/reaching & involving certain grps/to target or not
(78 5) /challenges/helping smkrs
(78 5 1) /challenges/helping smkrs/take 1st step
(78 5 2) /challenges/helping smkrs/maint cess
(78 5 3) /challenges/helping smkrs/feel supported, accepted, dignity
(78 6) /challenges/working with other orgs
(78 7) /challenges/educ
(78 7 1) /challenges/educ/TFs about protocol & nature of trial
(78 7 2) /challenges/educ/TFs about exper of smkrs
(78 7 3) /challenges/educ/public about Commit
(78 7 4) /challenges/educ/public about dangers of smkg
(78 7 5) /challenges/educ/other

(79) **/dilemmas**
(79 1) /dilemmas/change envir vs helping indivs
(79 2) /dilemmas/how radical to be
(79 3) /dilemmas/how directive to be with TFs
(79 4) /dilemmas/interv vs science
(79 5) /dilemmas/prev vs cess

(80) **/soc acceptab**

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(82)            /prev + cess
(82 1)          /prev + cess/educ
(82 2)          /prev + cess/stats
(82 2 1)        /prev + cess/stats/who smks
(82 2 2)        /prev + cess/stats/health effects
(82 2 3)        /prev + cess/stats/local
(82 3)          /prev + cess/taxation
(82 3 1)        /prev + cess/taxation/effectiveness
(82 3 2)        /prev + cess/taxation/smuggling as response
(82 3 3)        /prev + cess/taxation/use cig tax $ for cess & tmt
(82 3 4)        /prev + cess/taxation/tax = more crime
(82 3 5)        /prev + cess/taxation/tax = govt cash cow
(82 4)          /prev + cess/legislation
(82 4 1)        /prev + cess/legislation/access
(82 4 1 1)      /prev + cess/legislation/access/minors
(82 4 1 2)      /prev + cess/legislation/access/pts of sale
(82 4 1 3)      /prev + cess/legislation/access/liscencing retailers
(82 4 2)        /prev + cess/legislation/places can smoke
(82 4 2 1)      /prev + cess/legislation/places can smoke/public places
(82 4 2 2)      /prev + cess/legislation/places can smoke/workpl
(82 4 2 3)      /prev + cess/legislation/places can smoke/hc facilities
(82 4 3)        /prev + cess/legislation/ban on advert
(82 4 3 1)      /prev + cess/legislation/ban on advert/in-store
(82 4 3 2)      /prev + cess/legislation/ban on advert/sports sponsorship
(82 4 4)        /prev + cess/legislation/cig pack labels
(82 4 5)        /prev + cess/legislation/outright ban, prohibition
(82 4 6)        /prev + cess/legislation/municipal bylaws
(82 4 7)        /prev + cess/legislation/public opinion on restrictions
(82 4 8)        /prev + cess/legislation/generic packaging
(82 4 9)        /prev + cess/legislation/enforcement
(82 5)          /prev + cess/other ideas

(84)            /hp issues
(84 1)          /hp issues/empowermt
(84 1 1)        /hp issues/empowermt/dignity & respect for smokers
(84 2)          /hp issues/comm devt
(84 2 1)        /hp issues/comm devt/admin vs grassroots appr, orgl devt
(84 2 1 1)      /hp issues/comm devt/admin vs grassroots appr, orgl devt/real
                 comm devt
(84 2 1 2)      /hp issues/comm devt/admin vs grassroots appr, orgl
                 devt/coalition model
(84 2 2)        /hp issues/comm devt/lin vs critical mass model
(84 2 3)        /hp issues/comm devt/imp or personality, biography
(84 2 4)        /hp issues/comm devt/coalition appr vs key players
(84 3)          /hp issues/soc control
(84 4)          /hp issues/soc mktg
(84 5)          /hp issues/choice vs peer pressure, blame
(84 6)          /hp issues/blaming victim
(84 7)          /hp issues/blaming industry
(84 9)          /hp issues/indiv rights
(84 9 1)        /hp issues/indiv rights/balancing rights of smkrs vs non-smkrs
(84 10)         /hp issues/indiv responsibilities
(84 11)         /hp issues/the imp of HOW you do something
(84 11 1)       /hp issues/the imp of HOW you do something/ends vs means
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(84 12) /hp issues/about hp

(86) /smoking
(86 1) /smoking/benefits
(86 1 1) /smoking/benefits/stress release
(86 1 2) /smoking/benefits/emotion mgt
(86 1 3) /smoking/benefits/grp membership, kinship
(86 2) /smoking/costs
(86 2 1) /smoking/costs/direct effects to smkr
(86 2 2) /smoking/costs/ETS
(86 2 3) /smoking/costs/financial
(86 2 4) /smoking/costs/addiction

(88) /you & Commit
(88 1) /you & Commit/personal window
(88 1 1) /you & Commit/personal window/self, friends, family smk or smkd
(88 1 2) /you & Commit/personal window/exper dealing with smkrs
(88 1 3) /you & Commit/personal window/orgl int in smkg
(88 1 4) /you & Commit/personal window/feelings about smkg, smkrs
(88 2) /you & Commit/reasons for involvement

(99) /*church search*

Base Codes for Key Informants

(200) /Respondant bc
(200 1) /Respondant bc/role
(200 1 1) /Respondant bc/role/Commit
(200 1 1 1) /Respondant bc/role/Commit/Exec brd
(200 1 1 2) /Respondant bc/role/Commit/Comm brd
(200 1 1 3) /Respondant bc/role/Commit/TF member
(200 1 1 3 1) /Respondant bc/role/Commit/TF member/PETF
(200 1 1 3 2) /Respondant bc/role/Commit/TF member/HCTF
(200 1 1 3 3) /Respondant bc/role/Commit/TF member/WOTF
(200 1 1 3 4) /Respondant bc/role/Commit/TF member/CRTF
(200 1 1 4) /Respondant bc/role/Commit/TF chair
(200 1 2) /Respondant bc/role/staff
(200 1 2 1) /Respondant bc/role/staff/Brantford
(200 1 2 2) /Respondant bc/role/staff/RI-based
(200 1 2 3) /Respondant bc/role/staff/other
(200 1 3) /Respondant bc/role/CRG
(200 1 4) /Respondant bc/role/organizations
(200 1 4 1) /Respondant bc/role/organizations/likeminded
(200 1 4 1 1) /Respondant bc/role/organizations/likeminded/Lung Assoc
(200 1 4 1 2) /Respondant bc/role/organizations/likeminded/Cancer Society
(200 1 4 1 3) /Respondant bc/role/organizations/likeminded/Heart & Stroke
(200 1 4 1 4) /Respondant bc/role/organizations/likeminded/DHC
(200 1 4 1 5) /Respondant bc/role/organizations/likeminded/DPHS
(200 1 4 1 6) /Respondant bc/role/organizations/likeminded/MOH
(200 1 4 1 7) /Respondant bc/role/organizations/likeminded/CTFO
(200 1 4 1 8) /Respondant bc/role/organizations/likeminded/Heart Health
(200 1 4 2) /Respondant bc/role/organizations/community
(200 1 4 2 1) /Respondant bc/role/organizations/community/social services

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(200 1 4 2 2)       /Respondant bc/role/organizations/community/other
(200 1 4 3)         /Respondant bc/role/organizations/not likeminded
(200 1 4 3 1)       /Respondant bc/role/organizations/not likeminded/farmers
(200 1 4 3 2)       /Respondant bc/role/organizations/not likeminded/SFS
(200 1 4 3 3)       /Respondant bc/role/organizations/not likeminded/other
(200 1 4 4)         /Respondant bc/role/organizations/other

(202)               /Interview bc
(202 1)             /Interview bc/duration
(202 1 1)           /Interview bc/duration/short
(202 1 2)           /Interview bc/duration/med
(202 1 3)           /Interview bc/duration/long
(202 2)             /Interview bc/distractions
(202 3)             /Interview bc/content
(202 3 1)           /Interview bc/content/likelihood of reaching delta
(202 3 1 1)         /Interview bc/content/likelihood of reaching delta/high
(202 3 1 2)         /Interview bc/content/likelihood of reaching delta/med, unsure
(202 3 1 3)         /Interview bc/content/likelihood of reaching delta/low,
                      probably not
(202 3 1 4)         /Interview bc/content/likelihood of reaching delta/not
                      discussed
(202 3 2)           /Interview bc/content/concern re SES
(202 3 2 1)         /Interview bc/content/concern re SES/alot
(202 3 2 2)         /Interview bc/content/concern re SES/somewhat
(202 3 2 3)         /Interview bc/content/concern re SES/not much
(202 3 2 4)         /Interview bc/content/concern re SES/not discussed
---------------

(120)               /person
(120 1)             /person/R1 only
(120 2)             /person/R1 & R2
(120 3)             /person/R3

(125)               /document
(125 1)             /document/R1
(125 2)             /document/R2
(125 2 1)           /document/R2/fg1
(125 2 2)           /document/R2/fg2
(125 3)             /document/R3ki
(125 4)             /document/journal
(125 5)             /document/proposal
(125 6)             /document/readings,literature
(125 7)             /document/analysis notes
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