Smoking Cessation and the GLBT community

Evaluation by Gentium Consulting on behalf of the
Program Training and Consultation Centre
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BACKGROUND

More and more people are trying to quit smoking. A whole array of resources is offered to general population, such as smoking cessation programs, drops-ins, Nicotine Anonymous, counseling. Though the cessation process might be the same for everyone, the environment in which it is being delivered is of great importance. Smokers differ: if you are a low-income woman or a gay male your lifestyle may be quite different from the 'mainstream'; where, why, and how smoking became a part of your lifestyle may also be different; and issues surrounding your smoking habits will also differ. Being able to freely express yourself is also essential for any kind of group cessation program. A gay, lesbian, bi-sexual or trans-gendered (GLBT) person in a group offered to the general population might encounter prejudice, judgment and even homophobia. It is important to provide all smokers, from all communities and backgrounds, with a cessation environment where they feel comfortable and confident to express their own personal issues.

This project's main objective was to provide and further develop gay-specific smoking cessation programs designed for men and women in both French and English within the City of Ottawa.

This report addresses the following formative evaluation questions:

1. What is the program being evaluated?
2. How was the need for this program identified?
3. How was the GLBT community involved in program design and development?
4. Was the program implemented as planned?
5. Were there any barriers to implementation?
6. How did the program change over subsequent iterations?
7. Were the target groups reached successfully?
8. What were the immediate, short-term outcomes of the program?
9. How satisfied were participants with the program?
10. How did participants assess the usefulness of a GLBT-specific program?
11. How satisfied were the community advisory committee members with the program?
12. What programming issues/ideas emerged?
13. How can the program be improved?

METHOD

To answer the evaluation questions, the consultants used a combination of qualitative and quantitative methods:

- Documents review (background material, proposal, program outlines, reports)
- Participant surveys (pre- and post program)
- Interviews with key informants (facilitator, members of advisory committee).

Surveys

Data were collected from program participants at program intake and at program end. A number of different survey tools were used. Tools included a wide variety of answer formats (e.g., 3 to 5-item Likert scales, multiple choice, yes/no, open-ended).

Intake (pre-program) participant data

Three different intake tools were used:

- ACESS intake questionnaire
- CCHC intake questionnaire
- Stop Dragging Your Butt/Fierté sans fumer intake questionnaire.

Not all participants in all groups filled out all three tools.

Exit (post-program) participant data

At the final meeting of each group, post-program surveys were administered. Two different post-program tools were used:

- ACESS program-end questionnaire
- Evaluation questionnaire developed for Stop Dragging Your Butt/Fierté sans fumer.

Drop-outs and participants who did not attend the final session were not sought out to complete post-program surveys. Some participants completed only one of the two surveys; others completed both. Half of the participants did not complete any post-program survey.

Table 1 below summarizes the survey data available across all five groups. Just under half the participants completed both intake and post-program surveys.

Table 1 Survey data collected

	Frequency	Percent
Intake and post	20	43%
Only intake	27	57%
Total	47	100%

Data analysis

Items from all completed surveys were examined, to determine degree of consistency across the different intake and the different post-program tools. Despite the multiple pre-program tools, many intake questions were worded consistently across tools, and can be compiled. Many post-program survey items also were worded consistently across the two post-program tools.

Items from the pre-program surveys were then compared with items from the post-program surveys. Unfortunately, the majority of items were either not repeated or worded so inconsistently that scores could not be compared pre-to post-program.

For those items which could be compared, individuals were easily matched (names were attached to each questionnaire).

Quantitative data from pre-and post-surveys were entered into an SPSS data base designed for this purpose.

Simple summary statistics were calculated for all pre- and all post- items separately. Pre-and post- scores were compared on two items related to smoking status and cessation.

Qualitative survey data consisted of short answers to open-ended questions. These were transcribed, summarized, and examined for recurring themes.

Interviews

Key informant interview schedules were designed, administered, and analyzed by the consultants. Interviews took between 45 minutes and 90 minutes, and were conducted over the telephone. Permission was obtained from informants to either tape record or take verbatim notes (computer word processing) during the interview. Two interviewers were present at the interview with the facilitator; one undertook the other key informants interviews alone. Interview data were summarized in relation to the overall evaluation questions; additional themes and contrasting perspectives were noted where relevant.

Limitations

Data from a multiplicity of participant surveys were compared, but the evaluators did not develop the tools for data collection for the purpose of this particular evaluation.

Tools were not consistently administered across all five groups.

Not all post-program data were available at the time of this evaluation (e.g., one-month survey data for Groups 2-4).

The final questionnaire was not administered to participants who dropped out of the group program prior to the last session. As a consequence, there are very few post-program surveys available, and only 20 that can be matched pre-and post.

Program materials are in a developmental stage, and no 'final' program outline manual or detailed description of activities is yet available.

Due to very limited resources available for this evaluation, no program participants were interviewed, nor were long-term effects assessed.

In the short time available, no community or Advisory Committee informant was located who could provide direct insight into the program adaptation for the lesbian or co-ed target groups, or into the possibly distinct needs of either Francophone or lesbian sub-populations.

FINDINGS

1. What in the program is being evaluated?

Program description

The program consists of five smoking cessation groups targeted to the GLBT community of the Ottawa region. The groups were offered at no cost to participants, between September 2003 and December 2004. The English version of the program was called "Stop Dragging Your Butt"; the French version, "Fierté sans fumer."

The community group ACESS (Accessible Chances for Everyone to Stop Smoking) funded two of the groups. Health Canada, through the Program Training and Consultation Centre (PTCC) provided funding for three others, and for evaluation. Several community service organizations provided in-kind contributions.

Each group ran for eight one and a half hour sessions, with one follow-up session available. A total of 47 GLBT participants attended the program over this period of time. Three groups were offered only to males; one group was for females; and one group was co-ed.

The following tables illustrate the distribution of program participants across groups (by gender; by language).

Table 2 Type of group attended

	Frequency	Percent
Male only	25	53%
Female only	10	21%
Co-ed	12	26%
Total	47	100%

Figure 1

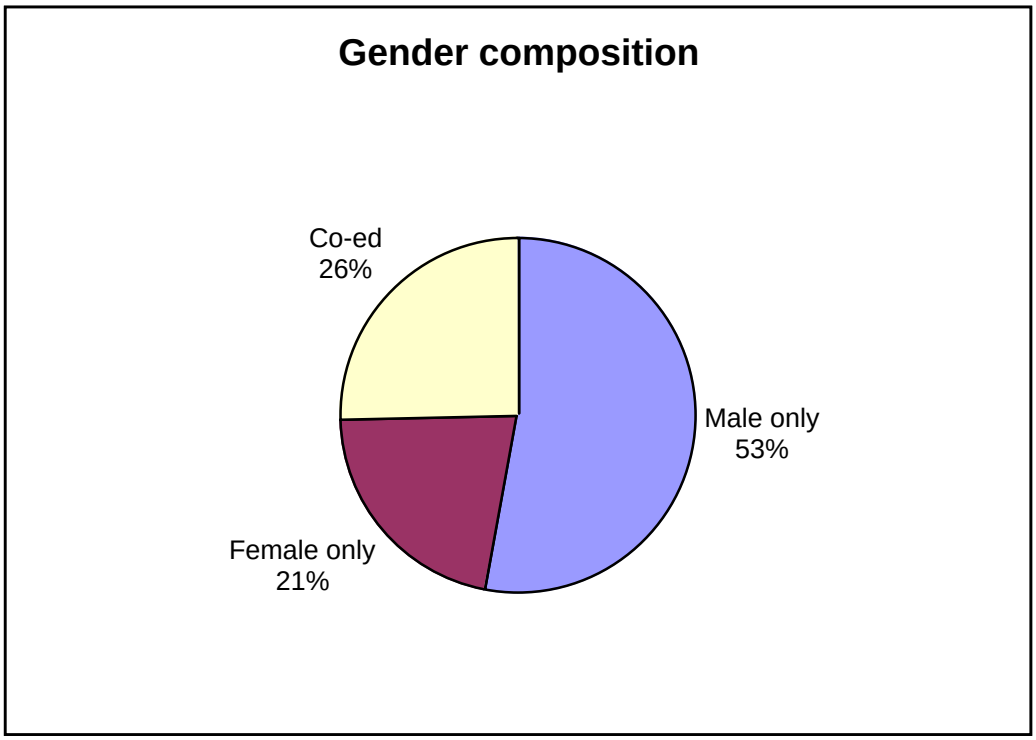


Table 3 Program language

	Frequency	Percent
English	40	85%
French	7	15%
Total	47	100%

The same experienced facilitator delivered all groups. A Community Advisory Committee provided guidance and supervision. The facilitator had previously been trained by PTCC, to deliver smoking cessation programming.

Standard components, based on a variety of smoking cessation programs (see bibliography) were delivered for every group, and generally in the same sequence, depending on needs.

Adaptations and additions to make the sessions GLBT-specific are described in detail below.

2. How was the need for this program identified?

The GLBT population suffers considerable health disparities. Despite an absence of Canadian statistics, anecdotal evidence and several local health-issues reports suggested that the smoking rates of Canadian GLBT people are likely to be well above the 'mainstream' norm, and might closely match US estimates In a literature review done by the Ontario Tobacco Research Unit, it was estimated that smoking rates for lesbians, gays and bisexuals ranged from 11% to 50% among adults. Although these studies are American, we can extrapolate that the GLBT smoking rates in Canada are not different and that smoking rates are higher for the GLBT compared to the general population. (*Smoking Among Lesbians, Gays and Bisexuals: A Review of the Literature, Literature Review Series No. 14, July 2001).*

Smoking has a long history within the GLBT bar scene, and is really

> "encultured into the gay men's community. A similar case can be made for lesbians. That was the issue at the broad level." (Advisory Committee Member (AC), 1)

A focus group carried out at the beginning of this project also confirmed the need for a gay-specific smoking cessation program (see below). Further details about the documented and perceived need for smoking cessation programs for GLBT populations are provided in the April 2004 Project Report. A recent study of the GLBT population of Ottawa (Social Data Research et al, 2001) also identified a number of wellness issues in the GLBT community (self-esteem, loneliness, relationships, mental health, risk-taking, disregard for own health, lack of access to services, addictions, peer pressure, drinking, stress), which are linked to smoking behaviour.

The Gay Men Wellness Initiative of Ottawa first enunciated the need for smoking cessation among the GLBT community some years ago, and was the driving force behind starting the current program.

> "I probably brought this to the table a year before got it started. I'm on the board of the Canadian Rainbow Health Coalition, and we had been looking at health disparities with GLBT people generally, and knew that statistically gay men smoke at one and a half to two times the rate of non gay men." (AC1)

Once the issue was raised, it found an echo among other community organizations. For example, the Centretown Community Health Centre informant recalls that:

> "We offer a lot of services for GLBT community, and we wanted to offer more services. It [the need for smoking cessation programming] had been raised for me by some of my colleagues here at the health centre, and as well by …our manager of our primary care program health centre. She is on a city-wide coordinating committee and it was raised there as well. So through a couple of different sources it came to me." (AC2)

GLBT-services organizations recognized that

> "The significance of smoking in gay men's culture is quite different from that in non-gay culture, and has to be addressed in a different way."

In addition, the dynamics and philosophy of a group cessation program are based on developing a certain amount of trust among members and ensuring a safe environment to discuss, for instance, stressors and triggers for smoking behaviours. Given the realities of homophobia, this might be difficult to create in a mixed group. As one AC member mentioned:

> "You get into very personal issues around this… What had to be created was a level of trust that was gay-specific. I don't think we wanted to wind up educating the non-gay people about our culture. We've got enough to do without that." (AC1)

3. How was the GLBT community involved in program design and development?

Despite the recognized need, however, no GLBT-specific cessation programs existed in the Ottawa area; in fact, a review of recent resources and literature suggests that no such program exists in Canada.

To reach a minority target population with health programming, two approaches are possible. One is to lower barriers to 'mainstream' services; the other is to develop minority-specific services. Key community members had come across gay-specific cessation programs from the United States, which were gay-affirming, specifically targeted to gay men. The gay-specific approach was chosen for this project, and strongly supported by the GLBT community as the best way of achieving the goal of recruiting GLBT members to smoking cessation programs in Ottawa.

Centretown Community Health Centre (CCHC), which offers services to the GLBT population and also offers smoking cessation programs to the mainstream population, agreed to be the sponsor for a first pilot group (Group 1) directed at gay men, to be funded by ACESS. An Advisory Committee (AC), consisting of representatives from PTCC, CCHC, Pink Triangle Services (PTS), Public Health, OTTAWA Gay Men's Wellness Initiative and ACESS was created. Several AC member organizations provided in-kind contributions (photocopying, telephone line, space, advertising, etc.) to the program, as well as helping to promote it.

The main responsibilities of the AC were:

- obtain funding for the first group program
- develop a job description for the facilitator
- recruit and hired the facilitator
- obtain funding for additional group programs
- provide guidance, ideas, suggestions for recruitment
- provide information about materials and resources.

Once the facilitator was hired, the AC had the function "to ensure that this was going to happen, to facilitate that it did happen" (program facilitator, PF). They were especially helpful at the initial phase, identifying what groups to target. It was decided to begin with a gay men's group in English.

In the summer of 2003, the AC also helped to organize a focus group with gay men. The focus group explored ideas about:

- specific needs
- program content
- differences in smoking between GLBT and mainstream populations
- gay-specific barriers to cessation
- scheduling, timing, length
- marketing approaches.

Focus group results confirmed the need for such a program. Participants identified the need to include gay specific issues: isolation, bar culture, self-esteem, empowerment, high-risk behaviours, peer pressure, image and lifestyle, and the desire for connection and authenticity. They emphasized the importance of having a gay-friendly environment, and recommended housing the group/s at Pink Triangle Services.

The AC provided additional suggestions about advertising and promotion, and support to the facilitator. The AC became less actively involved as the program implementation progressed, however, meeting with less frequency in the latter months.

Individual AC member organizations also offered specific program support. An essential partner was ACESS, a MOHLTC-funded Regional Heartbeat group, whose purpose is to help people who would not otherwise be able, to access appropriate services, including smoking cessation. They subsidized the development of the program, and the delivery of two cessation groups (Groups 1, 5). The Centretown Community Health Centre provided a telephone line that participants could call to register, and technical support, such as access to photocopiers. As one AC member described:

> "By default, when you sponsor a group you're involved at the level of contributing in-kind resources. We paid for bus tickets and snacks and photocopies. We hired the facilitator... We promoted the group. My time would have been a contribution. And we also housed the phone line where people register for that group... So although they received Health Canada funding to run some other groups, …my health centre still promoted those groups and offered the phone line protocol to register." (AC 2)

Pink Triangle Services provided the location for all the groups to meet, as recommended by the focus groups. This was an important contribution to the program's success:

> "We wanted it in a gay related space. Now we could find other spaces make them gay related, we don't always want to make people truck all over the place, but it really has to be offered through I believe not just gay positive, that's why we did not use Centretown, but actually gay- identified space. There's a difference between being gay identified and gay positive." (AC1)

During the summer of 2003, the Program Facilitator was hired.

The first task of the Program Facilitator (PF) was to review available cessation programming that was targetted to the GLBT population and/or that could be adapted for the target groups.

> "I looked at the different programs in existence - such as one for low income women developed by ACESS and Somerset West; and the Program: 'It's Time' [Meloche, 1996]; and a few other ones." (PF)

Little or nothing was available, and nothing that was Canadian. Two GLBT-specific programs from the United States ('The Last Drag' and 'QueerTIPS') were reviewed. Although the content was interesting,

> "I didn't really apply it all". For example, "they talked a lot about the connection between a coming-out process and quitting, and using the same set of skills to apply to cessation." (PF)

Other than the City of Ottawa's smoking cessation program for women, very little was available in French. Overall, none of the available resources could be used without considerable modification.

> "Whatever resources I took in English, I adapted or translated. The city resources, I tweaked them a little so they'd fit the target group." (PF)

The Facilitator also adapted general population cessation resources to reflect the language and social context of the GLBT community. The adaptations included

- recognizing that social life is linked to bars and group outings
- developing strategies that acknowledge the importance of socializing
- paying attention to physical appearance as an important issue, especially for gay men
- recognizing the specific living situations of the GLBT community, which include a lot of apartment sharing and cohabitation.

To illustrate some of the issues involved in adaptation, the Facilitator pointed out how a survey question that asks "do you live alone?" often confused GLBT respondents, since it could be interpreted as asking whether the respondent is 'single' (i.e., without a romantic or sexual partner), as well as whether they are sharing accommodation with a person who is not their partner).

The Facilitator also wrote a report summarizing the implementation and achievements of Group 1, and presented findings about the program at various conferences (see references).

4. Was the program implemented as planned?

The following section provides an overview of how "Stop Dragging Your Butt/Fierté sans fumer" was implemented in practice, highlighting changes and modifications to the original plans.

Timeline

The smoking cessation program was delivered five times, as follows:

Group 1 - Fall 2003 - Anglophone gay men - Funded by ACESS
Group 2 - Spring 2004 - Anglophone gay men - funded by Health Canada
Group 3 - Spring 2004 - Anglophone lesbian and bisexual women - funded by Health Canada
Group 4 - Fall 2004 - Francophone gay men- funded by Health Canada
Group 5 - Fall 2004 - Anglophone co-ed (men and women)- Funded by ACESS

Changes: The original timeline for delivery of the Francophone gay men's group was delayed (from spring to fall), due to slow registration.
An Anglophone co-ed group, not originally planned, was added as Group 5.

Location

All groups were held at Pink Triangle Services, a well-established centrally located gay and lesbian service and resource centre.

Changes: Although the CCHC offered support in terms of photocopying of materials, having the groups located at PTS resulted in using PTS support services instead, due to practicality.

Advertising and recruitment

A range of marketing and advertising activities were carried out. According to key informants, these included:

- Graphic design to develop specific GLBT tag-line and 'brand' the program (focus tested with program participants)
- Advertisements placed in mainstream newspapers (for Spring programs only)
- Advertisements placed in GLBT-specific local newspapers
- Notices at CCHC as part of ongoing promotion of cessation programs
- Notices placed on partners' list servs
- Posters in gay bars and bathhouses, and gay-friendly establishments

- Cards distributed at gay-friendly businesses, bars, bathhouses, establishments
- Posters distributed to physicians working in HIV/AIDS, the Cancer Institute
- Repeated mailings to GLBT organizations, social and recreational clubs, sports clubs, dancing clubs, churches
- Information booth in Pride Square during Pride Week events
- Encouraging word-of-mouth
- Campaign for the second round: begins during Pride Week, first week of July; two full months of advertising leading up to fall programmers.

See Appendix A for media file.

Program participants were asked how they heard about the program. The majority of participants (89%) indicated a single source.

The newspaper (Capital Xtra , a local GLBT-specific monthly) was checked by about a third (30%) as the source and was the source most frequently checked, followed by a friend (21%), 19% had learned about the program from a flyer. Fewer respondents had heard about it from a health care provider (3), somebody at CCHC (3), through word of mouth (2), or the Pink Triangle (1).

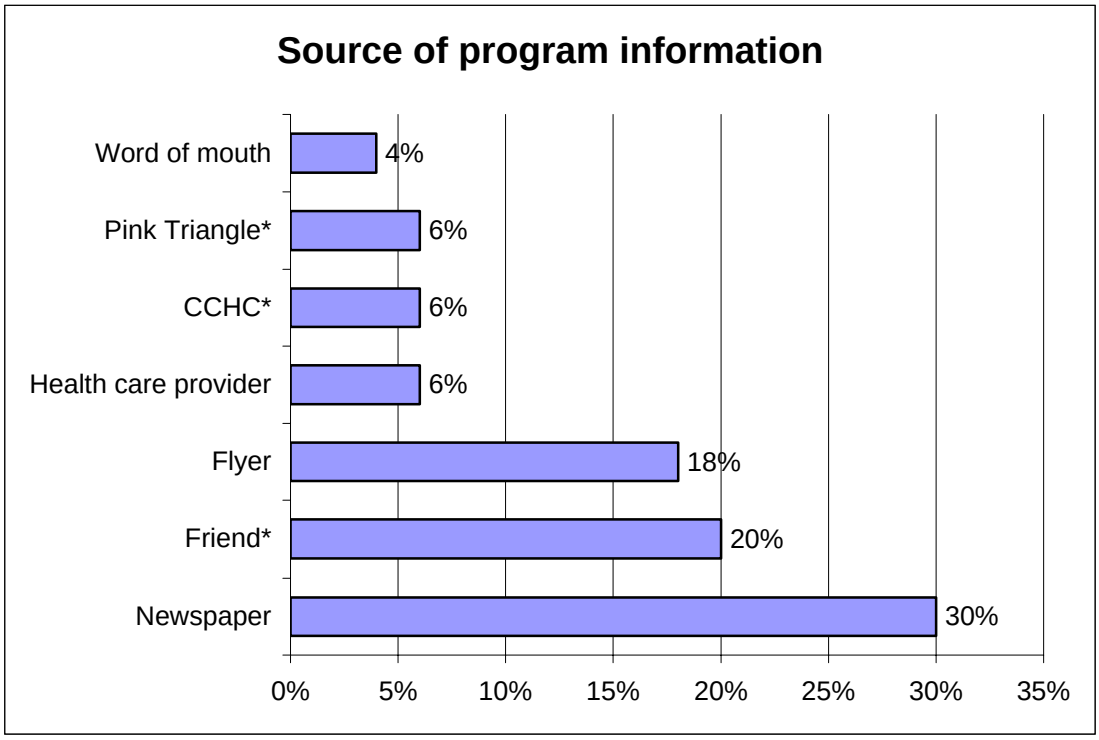
Table 4 – Where did program participants hear about the program?

Source	**#**	**%**
Newspaper (Capital Xtra)	15	30%
Friend*	10	20%
Flyer	9	18%
Health care provider	3	6%
CCHC*	3	6%
Pink Triangle*	3	6%
Word of mouth	2	4%
Radio	0	0
Public Health Info line*	0	0
TV	0	0
Other	6	11%

*this item was not included in all surveys as a choice

Other sources mentioned were: email (3 times); attending the program for the second time; and le Bras (Bureau regional action sida)

Figure 2



Changes: Dropped the advertisements in mainstream papers; began advertising campaign during Pride Week; lots of repetition; involved graphic designer to create GLBT tag-line and identity.

Intake/Registration

CCHC provided a telephone line for registration, which was successfully used for all programs. Potential participants were offered confirmation that the program was for the GLBT community at this time.

Changes: A waiting list was set up to deal with over-registration for the first groups.

Number of participants

A total of 47 GLBT persons registered for the five cessation groups. Enrolment was set at a maximum of 14 and minimum of 8 participants per group, consistent with other smoking cessation programs. Half of the participants attended male-only groups; one quarter attended a co-ed group, and 21% were in a female group.

Section 7. provides more details on participants.

Changes: Actual numbers of participants per group (based on intake questionnaires) were within these ranges with the exception of the second gay male English group, which had only 5 participants.
A waiting list was developed for when interest exceeded maximum numbers for Group 1. This was not necessary for subsequent groups.

Materials/Resources

The Program Facilitator searched for cessation materials and resources that were GLBT-specific, and found a very limited number. This lack was anticipated. Most of the materials for this program were adapted by the PF from a number of other sources, often informally or on an 'as needed' basis. This included adapting and translating cessation materials into French, which also was anticipated: " Part of her job as a facilitator was to adapt the existing program." (AC2)

Content

The content and flow of the sessions closely followed a standard plan for an 8-week cessation program.

The 8 'core' sessions were:
Smoking cessation tools

1) Addiction and smoking cessation process
2) Quitting- a healthy perspective
3) Coping strategies
4) Nutrition and exercise
5) Letting go - relapse prevention
6) Staying quit- the industry and GLBTQ community
7) Emotions. Evaluation. Celebration.

'Standard' content included nutrition, physical activity, breathing, relaxation, triggers - common for all cessation programs.

A number of themes specific to the GLBT community were identified, and addressed during the group discussions. These included:

- Isolation and loneliness
- Image is not everything
- Lifestyle changes
- Need for positive support
- Importance of negotiating support from friends, partners
- Feeling 'part of one big family", comfort level in being able to talk bout life stresses, triggers related to smoking (e.g., sex; disagreement with partner) without having to hide sexual orientation
- No judgment.

Follow-up contacts were planned for one month and six month after the end of the 8 week sessions. The groups were offered to the possibility of a face-to-face session for the one month follow-up, instead of a telephone call by the facilitator as per the six month follow-up. For each of the follow-up contacts, a follow-up questionnaire was filled. All the groups agreed to have a face to face meeting. These meetings were very well attended. Most of the participants who finished the 8 week sessions attend the one-month follow-up session. The ones who could not attend were contacted by phone or by e-mail by the facilitator.

***Changes*:** Most of the modifications were as anticipated, with some exceptions, such as the high interest in health issues and the importance of negotiation skills in relation to smoke-free homes. Details on program modifications are presented in Section 6., below.

Overall approach to cessation

The facilitator described the program's overall approach to cessation as follows:

- participants should understand their smoking behaviours, why they smoke
- what works for one participant doesn't work for another necessarily
- each participant develops her/his own plan
- recognize barriers to accessing services for target population
- encourage sharing experiences in the group about what works, what they have tried
- information about local resources provided (e.g., facilitator encourages participants to visit the PTS library, meet PTS staff; CCHC AC representative presented information about ACESS and CCHC services available)
- build up self-esteem of participants
- address issues of isolation and loneliness
- address issues related to lifestyle, couple relationships
- encourage development of mutual support and exchanges within the group
- cover all material, but with some flexibility.

Linking to local resources was an important component for this population: they identified a lot of isolation and loneliness, and also need links in relation to addressing other health concerns.

Facilitation

The Program Facilitator had previous experience working closely with the GLBT community, facilitating groups, delivering healthy sexuality programming, and had received PTCC cessation group training. AC members interviewed were unconditionally positive about the Program Facilitator, and attributed the perceived success of the program to this particular facilitator's skills and experiences. For example:

> "We moved into the other areas because we were so fortunate to find a facilitator with the skills and the background. She has a high degree of comfort with the gay male culture, and to be quite frank particularly with the sexual aspect. She's not

> fazed by any of this, and she works in the healthy sexuality program, that's her day job. So that was really a bonus, that she was fluently bilingual. We didn't announce for that, I guess we said it would be an advantage. …we managed to get just an outstanding person." (AC1)

The Program Facilitator describes her role in this program as follows:

> "I was there to help them figure out what types of smokers they were, what would best work for them in order to be able to stop smoking… I was facilitator, enabler, brought them resources they were missing." (PF)

Being an ex-smoker, the Program Facilitator also shared her own experiences around smoking, dealing with cravings, and success with cessation strategies.

> " I keep saying when I did counselling with abused women, and people would say you can't understand, you were never abused. But you can. The same thing, if you smoke, it's an extra bonus, but if you don't, that's okay." (PF)

The Program Facilitator commented on the additional comfort level of participants when the facilitator is also a member of the target population:

> "How important is it to be Francophone and gay? I'm not sure. I think there's a comfort level. If you can make yourself understood and understand what they're talking about, that's good…. I'm lucky enough to be immersed in both cultures. Bi-cultural. The same in the gay community. I've been in it all my life, there's a comfort level." (PF)

Identification as a member of the GLBT population was seen to supersede gender as a key characteristic of the facilitator:

> "As a woman facilitating a gay group, I wasn't too sure at first, but it was no problem at all. I felt comfortable. I'm not sure I can see someone from the mainstream population doing a male only gay group. People might not understand the jokes and the comments. People talk about going to bathhouses, people wouldn't know. " (PF)

The facilitation style used in the five groups was flexible and participatory. The Program Facilitator encouraged group dynamics to lead where the participants want to go; created a relaxed atmosphere where participants could have fun, and was responsive to participant needs, including a willingness to shift agenda items to accommodate discussions and interests of participants:

> "Session two was session two, but I might postpone some activities to a later date. That's my style. You need the flexibility to move with the program, not be too rigid. You're talking about people's smoking habits, that's so linked to lifestyle. You have to be flexible… there's a lot of issues that come up." (PF)

The Program Facilitator pointed out that

> "There's more than having a program in a binder to facilitate a group; you need skills and comfort level and knowledge about your group to be able to facilitate it."

The following qualities were identified by AC members and the PF as important for the facilitation of this program:

- being non-judgmental
- group facilitation skills
- sensitivity to supporting people who face multiple barriers
- experience in tobacco cessation
- familiarity with the vocabulary of GLBT participants
- being fully bilingual
- knowledge of the local venues for socializing (e.g., bathhouses, bars, clubs)
- awareness of GLBT cultures(styles, music, image, etc)
- high degree of comfort with talk about sex
- ability to ask the right questions and not make assumptions about people's gender, partners, or relationships
- having a sense of humour and high level of comfort with GLBT humour.

Evaluation component

The originally planned evaluation activities consisted of a number of participant surveys.

Since this was the first time GLBT-specific cessation programs were being delivered in the Ottawa area**,** there was considerable interest in assessing the success of the approach. As a consequence, a multiplicity of written tools, from diverse sources and with different purposes, were administered to participants. Two of the partners in this initiative (CCHC and ACESS) collect participant data routinely, for any of program, which they fund or sponsor. ACESS also carries out a separate evaluation of the facilitators in all their groups, which was done for two of the groups:

> "How it works, I go to the last session and I administer an evaluation form, so they have an opportunity to give feedback about [PF] as a facilitator, so I administer those evaluation forms and then I summarize the results and I give them to [PF]."

In addition, the Program Facilitator undertook the following evaluative activities specific to Stop Dragging Your Butt:

- in consultation with the City of Ottawa Program Planning and Evaluation Team, developed a participant evaluation questionnaire specific to Stop Dragging Your Butt, which was administered to all groups in the final session.
- participant feedback sheets at the end of each session for Group 1; open-ended replies summarized and analyzed by the City of Ottawa
- one-month follow-up survey, administered by the Program Facilitator during a group meeting (all groups for the exception of the English Gay Men Spring group)
- one-month follow-up telephone survey, administered by the Program Facilitator (administered to those unable to attend the one month follow-up meeting- six-month follow-up survey developed by ACESS was administered by the facilitator to the initial gay men's group of the fall of 2003. As of the date of this report, the follow-up has not yet been done with the other groups.

Changes: Consultants (authors of this report) were contracted to conduct a post-hoc analysis of available participant data, based on survey questionnaires administered during the program sessions (pre- and post-program questionnaires), supplemented by document review and interviews with key informants.

The ACESS intake questionnaires for smoking cessation programs were administered to participants in the two groups funded by ACESS (Groups 1 and 5). The CCHC intake questionnaire, which generates demographic information, was only administered for Group 1. Only two items from the intake questionnaires (from ACESS and Stop Dragging Your Butt tools) were repeated in the post-program evaluation questionnaires, limiting comparison of pre- and post-program scores.

As described in an earlier section (Method), relatively few post-program questionnaires were collected from participants. The facilitator explains that only those who completed all sessions were administered the questionnaire, because

> "I wasn't clear on my understanding - the post was only for people who finished, I thought. It would have been nice to send it out to get their feedback, but I didn't get it done."

The facilitator did, however, maintain telephone contact with group members, and has obtained/will obtain information on mid-term (at six months) smoking/cessation status.

Given the exploratory nature of the program, the multiplicity and inconsistency of pre- and post- tools, and the variations introduced for different target groups, we added formative evaluation questions, documenting implementation, identifying lessons learned, and formulating recommendations to improve eventual program evaluability.

5. Were there any barriers to implementation?

A number of barriers were identified in implementing various components.

As is often the case, limited funding is seen as an overall barrier:

> “It's always the funding. It comes down to that. The whole community is supportive, everybody thinks it’s a great idea, but it’s always a money thing.” (PF)

Lack of understanding about the need for GLBT-specific programming among some partner organizations:

> "Initially there was some very small resistance, just some kinds of questions around: 'Well, why do we need to have another population specific group? And why can't they just come to a general group? I had to do some pretty strong lobbying at that level, and then people decided to go for it. It was worth it and I'm glad that I persevered and that the committee was open minded." (AC2)

Barriers related to advertising and recruitment included:

- insufficient budget for the ideal advertising campaign
- small number of venues for advertising

- reluctance on the part of some individuals, organizations, or businesses to carry GLBT-specific advertising (" I'm not the only one who has difficulty recruiting…not everybody wants to put up that poster, not everybody's out.")
- difficult to reach segments of the GLBT population who don't frequent traditional socializing environments (bathhouses, bars).

There were some delays in recruiting the Francophone population. This is considered typical for the Ottawa region, in which it generally requires longer for 'the word to get out' that this is a good and trustworthy program.

6. How did the program change over subsequent iterations?

The GLBT Cessation Program was delivered to five groups between Fall 2003 and Fall 2004, as summarized below. The program was adapted and modified each time, based on learnings from the prior iteration, and on the needs of each of the specific sub-target groups.

Timeline for implementation

Group 1 - Fall 2003 - Anglophone gay men - Funded by ACESS
Group 2 - Spring 2004 - Anglophone gay men - funded by Health Canada
Group 3 - Spring 2004 - Anglophone lesbian and bisexual women - funded by Health Canada
Group 4 - Fall 2004 - Francophone gay men- funded by Health Canada
Group 5 - Fall 2004 - Anglophone co-ed (men and women) - Funded by ACESS

Process for extending to different target groups

After the program for men was proposed (Group 1), questions were raised about why women were not also targeted, especially given the very high smoking rates among lesbians: US figures show that the gay community smokes more than the mainstream; and that women smoke more than men in the gay community. The first adaptation, however, was for francophone gay men, since

> "we know Francophones smoke more, and it was a normal, natural flow for us." (PF)

The fact that the Program Facilitator was fully bilingual and bicultural was a factor, and that additional money might be available for bilingual programming, were factors in deciding to expand to the Francophone GLBT community.

Thus, following this initial pilot group, PTCC sought Health Canada funding to continue the work already started with the gay men's population. Funding was received to continue the work with the English-speaking gay male population in Ottawa, in addition to extending to lesbians and francophone gay men.

Recruitment for Group 1 generated a waiting list; therefore, a second Anglophone gay men's group (Group 2), and a group for lesbians and bisexual women were implemented in the spring of 2004 (Group 3).

The Francophone gay men group (Group 4) ran in the Fall of 2004 along with a co-ed group (Group 5) as a trial

> "My sense, because funding is scarce, is to find out what would happen if we tried it together. What would be the differences in dynamics, in how people express themselves. Plus, everyone else [in cessation] does co-ed…in the States they do co-ed." (PF)

Since the program materials are not yet gathered into a comprehensive manual, the Program Facilitator's perceptions are the most direct and useful source to understand how the content was adapted and the group process changed for each of the target groups. Overall, the PF found that:

- women were less focused on the image piece
- isolation was a stronger issue for men
- lifestyle and support issues were as or more important for the women
- male groups focused more on HIV/AIDS
- co-ed group: reviewed all health issues, but less time spent on sex-specific health concerns
- women focused more on breast and ovarian cancer.

The following table summarizes the Program Facilitator's perceptions of how the content was adapted and the group process changed for each of the five groups.

Table 5 Adaptation from mainstream cessation group

	Content adapted	Group process
Anglophone gay men (Groups 1&2)	Component on grieving emphasized (original source: It's Time – smoking cessation program – Meloche 1996) Emphasis on particular health issues: focus on HIV/AIDS with men. Acknowledgement of the role that cigarettes have played in the gay culture, in the coming out process, in the bar scene, especially for older people. Developing and practicing negotiation skills: e.g., negotiating smoke-free space at home when partner smokes; in other person's homes (e.g. dinner parties), and among groups of friends who socialize together: " We always associate with people who are like us, so when they go to bars, they all go out together and smoke. People are afraid to be left behind in the bar when everyone else goes outside, so they'll go along. They don't want to be left inside by themselves, so they go outside with their friends and they light up." Industry targetting to specific consumers, examples provided of targetting to gay community. "People are really amazed and surprised. They really appreciate that, they're being targeted, they hadn't noticed and now they know. "	Very supportive, friendly atmosphere quickly created both times. Some participants know each other previously. Participants develop social links with each other outside the group sessions.

Table 5 continued

	Content adapted	Group process
Francophone gay men population (Group 4):	No different components or materials introduced. Existing materials translated by facilitator.	High level of comfort due to speaking in own language. More humour. Atmosphere very fraternal, supportive, and honest.
Lesbian and bisexual women (Group 3)	More information about health issues of concern to women, especially cancer. Find it harder to negotiate smoke-free spaces with partners, need more skills practice.	Less camaraderie overall. Less mutual support. Participants did not create social links beyond the group.
Co-ed GLBT group (Group 5)	Cover both types of health issues, but less in-depth.	Took longer to get the group to interact with each other. After two weeks, the group jelled, and supported each other. Women tended to become more 'maternal' and look after the male participants. Women felt they were not being judged by anyone. "Everybody there was very open and non-judgmental, which was key. They all say the same thing, that they're with their peers makes such a big difference. To be able to talk about what's going on in your life, and not to have to hide the sex of your partner."

7. Were the target groups reached successfully?

The target group was characterized by three descriptors: self-identification as a member of the GLBT community; age 25+; and smoking status. It was also expected that participants would have some motivation to want to quit smoking.

Reach to the entire GLBT community

A total of 47 GLBT-self-identified individuals participated in the five cessation groups.

Participants were not asked to indicate their sexual orientation on the written surveys. However, according to the PF, all who attended stated that they were GLBT either when they phoned to inquire about the program, or during the program sessions.

Language

The program made special efforts to reach the Francophone GLBT community. Key informants and the PF feel that outreach to the Francophone GLBT population took a longer time and required considerable word of mouth. This is not considered unusual:

> "I know she had to cancel her Francophone group a couple of times, and that's just par for the course with francophone groups. It takes a long time to get those going. You always have to have a couple of runs at the francophone population to get them to come out." (AC2)

One way to assess the reach to the Francophone community is to examine the mother tongue of program participants.

Almost one third (34%) of program participants across all five groups indicated that their mother tongue was French. This percentage is considerably greater than the percentage of Francophones in the Ottawa area (20%).

Two thirds (60%) of the participants indicated that their mother tongue was English, and 34% that it was French.

Table 6 Mother tongue

	Frequency	Percent
English	28	60%
French	16	34%
Other	3	6%
Total	47	100.0

Based on the above, the program appears to have very successfully reached both Francophone and Anglophone gay men, requiring waiting lists after the first session.

Although the impression of key informants is that it took several attempts to reach Francophone gay men, in fact half of the participants with French mother tongue attended one of the other groups. The Francophone group included one participant with English as a mother tongue.

It did take longer to recruit individuals to participate in a French-language group; or, perhaps, since the French-language group was not offered right away, many bilingual Francophones chose to attend an English group.

Gender

Fewer lesbian/bisexual women were reached overall. A total of 12 persons who identify as female filled out intake questionnaires.

Across all five groups, three quarters of the participants were male, and one quarter was female, as shown in the table below.

Table 7 Gender

	Frequency	Percent
Male	34	72%
Female	12	26%
N/A	1	2%
Total	47	100%

Although a 2:1 ratio of gay men to lesbian respondents in research studies is not unexpected, the ratio in this case is almost 3:1. This might be a consequence of the marketing/recruitment strategies used, rather than an indicator of lack of need among lesbian/bisexual women: the original focus group that helped determine the style and emphasis of the advertising strategy was held with gay men; and the Gay Men's Wellness Initiative was a key partner. It might be useful to consider whether the same campaign style and activities that successfully reach gay men appeal to lesbian and bisexual women.

Ethnic diversity

As illustrated in Table 6, above, only 6% or three participants reported a non-official language as their mother tongue.

Questions about ethnicity and place of birth were included only on surveys for 26 respondents.

Of those who were asked these questions:

- 23 were White; 3 were Aboriginal or Native.
- 21 were born in Canada, 3 in the US; 2 in another country.

In comparison, respondents to the 2001 GLBT Wellness Survey were from considerably more diverse origins: 13% were born outside Canada, including UK, Northern Europe, US, China, Eastern Europe, India/Pakistan, Middle East, African/Caribbean countries, and South America.

These figures suggest that the program may not have reached the full cultural, ethnic, and linguistic diversity within the community. On the other hand, it is worth noting that smoking rates in the mainstream population do vary with immigration status and ethnic identity. Uneven reach to this population may be due to both a lesser need and an insufficiently targeted marketing/recruitment campaign. Without further investigation, no conclusions can be drawn.

Income

Income is an important variable in relation to smoking prevalence in general. The reach of this program to lower income groups was a concern for AC informants:

> "And we always forget in the gay community, that we've kind of put ourselves in a marketing niche, as having huge disposable incomes, that there are a lot of gay men who are living in rooming houses, who literally can't afford to go to bars. And my guess is probably are likely to be addicted in large ways, including tobacco." (AC1)

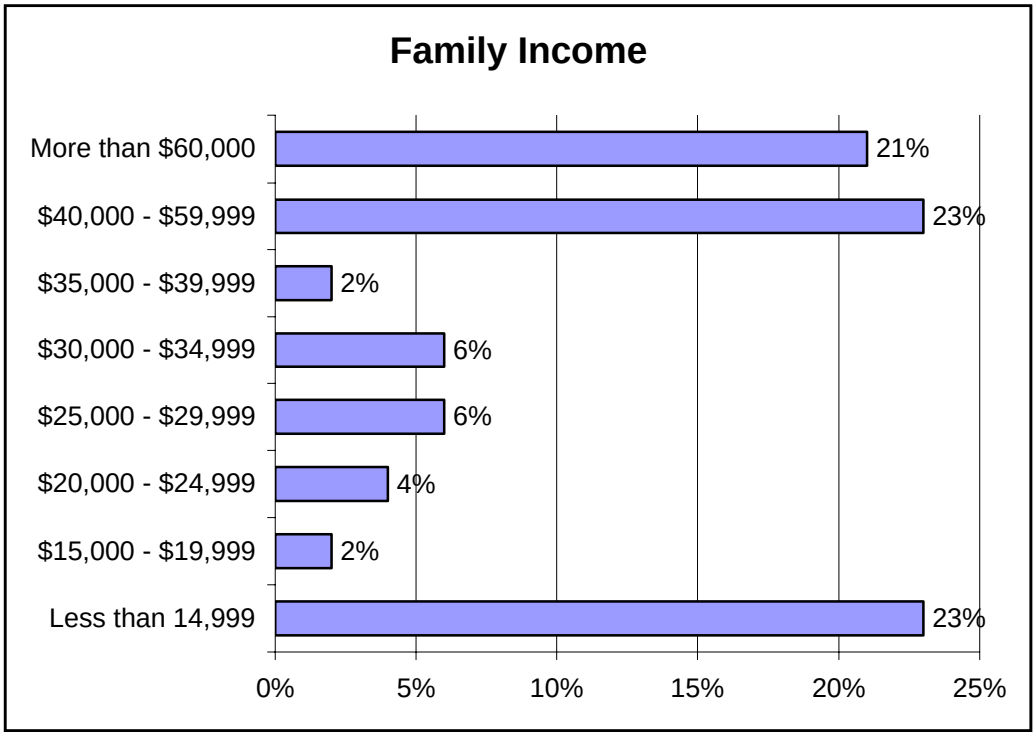
Survey questions asked for family income. Note: The GLBT Wellness Survey (Social Data Research et al, 2001) findings suggest that family income may provide a less accurate measure of economic well-being than personal or individual income for this population.

Family income varied considerably, with concentrations at both extremes. Almost a quarter (23%) of participants was living on less than 15,000 a year, whereas one in five (21%) reported a family income of more than $60,000. Another quarter (23%) had a family income between $40,000 and $60,000.

Table 8 Family Income from all sources

	Frequency	Percent	Cumulative Percent
Less than 14,999	11	23%	23%
$15,000 - $19,999	1	2%	26%
$20,000 - $24,999	2	4%	30%
$25,000 - $29,999	3	6%	36%
$30,000 - $34,999	3	6%	43%
$35,000 - $39,999	1	2%	45%
$40,000 - $59,999	11	23%	68.%
More than $60,000	10	21%	89%
N/A	5	11%	100.0
Total	47	100%	

Figure 3



Key informant concerns about not reaching the lower income population don't appear to be justified from the survey data.

According to the results of the GLBT community needs survey, 8% of the GLBT 25+ population have a household income lower than $20, 000/year. In contrast, 25% of program participants were in this income category. At the highest income bracket, program participants and GLBT Wellness Survey respondents also appear to differ: while only 10% of the program participants had family incomes above $60,000, 64% of the Ottawa GLBT population falls in this income bracket.

Education

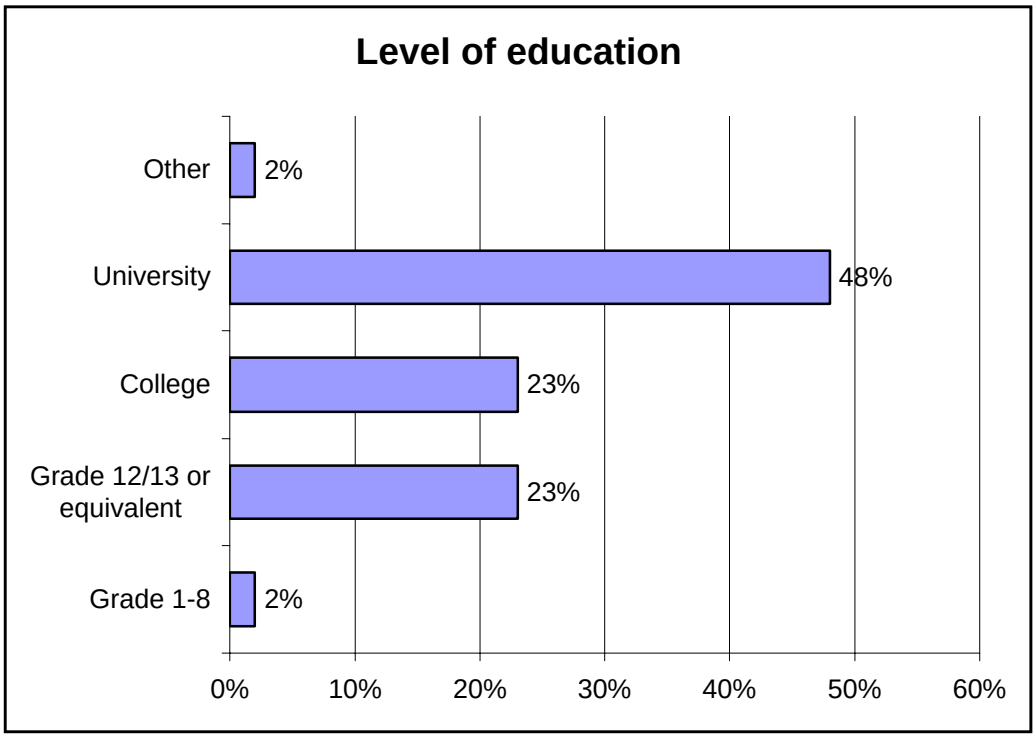
Participants' level of education was high, with almost half (48%) having completed university and another quarter (24%) college. Another quarter reported to have completed grade 12 or 13. Only one person had fewer years of education.

Table 9 Level of Education

	Frequency	Percent	Cumulative Percent
Grade 1-8	1	2%	2%5
Grade 12/13 or equivalent	11	23%	26%
College	11	23%	50%
University	22	48%	98%
Other	1	2%	100%
N/A	1	2%	
Total	47	100%	

The educational level of program participants is higher than that of the general population aged 25 and over in Ottawa, in which 51% have completed a college or university degree (Statistics Canada, 1996). It is, however, a little lower than that of the Ottawa 25+ GLBT community as surveyed in 2001: 75% of that age group reported having completed a university or college degree, and none had less than secondary education.

Figure 4



Household composition

We were unable to determine the living situation or household composition from survey data. The different intake questionnaires used for the various programs did not ask this question consistently, and individual respondents provided contradictory answers across different instruments.

Other comments on program reach to the GLBT community

Since the program encouraged self-identification as a member of the GLBT community (through advertising, location, and at intake/registration), it may not have reached members who are not 'out'. In addition, the marketing campaign, which focused on social venues (bars, bathhouses) may not have reached all sectors of the community.

> "I would say, this was a very ‘out’ in your face program. My guess is that there are scores and scores of gay men who maybe don't even know about this, who are not closeted, but they're not accessible thorough he gay newspaper or whatever. But you know we had to start somewhere." (AC1)

> "People with low incomes are invisible in our community, as are people with AIDS. The thing is that, the people in our community who are visible are a very narrow band. The elderly are invisible as well. The handicapped are invisible." (AC1)

Reach to the GLBT population 25 or older

The target group was defined as over 24. The program deliberately set out to reach the adult GLBT population, and based many program adaptations (bar culture strategies, specific fitness and health information, dealing with loss and grieving) on the realities of this age group.

> "We weren't necessarily out there to stop young kids from smoking. We thought the life experience of a gay man in his late thirties, mid forties is a world of difference from that of a seventeen year old. It's essentially, your own mortality is beginning to close in around you. " (AC)

In terms of age, the target group was successfully reached.

The age of participants ranged between 22 and 72, with an average age of 42.7 years. Only one participant was younger than 25.

Reach to individuals who smoke

Intake questionnaire data suggest that the program did successfully reach GLBT smokers. Overall, the participants in **Stop Dragging Your Butt/Fierté sans fumer** cessation programs seem to be heavier smokers than the general population. They smoked more cigarettes on average, and a greater percentage smoked their first cigarettes within 30 minutes of waking up. The program also reached a majority of

individuals who had previously tried to quit (81%) unsuccessfully, many of them more than once. Four of 26 who were asked had previously attended an ACCESS cessation program.

Smoking status at program entry

Almost all participants (94%) indicated that they were smokers at program entry. Only 6% (3 individuals) indicated that they were smoke-free.

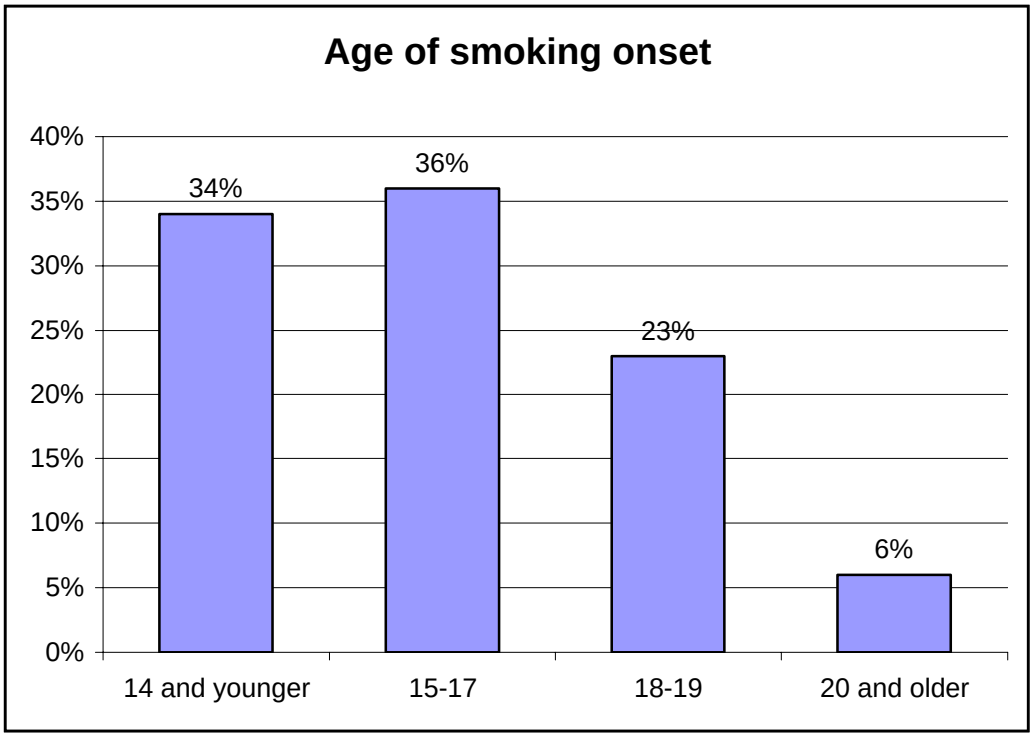
Age of smoking onset

The average age of smoking onset was 15.4, ranging between 10 and 20. 70% of the participants had started to smoke before age 17.

Table 10 Age of smoking onset

	Frequency	Percent	Cumulative Percent
14 and younger	16	34%	34%
15-17	17	36%	70%
18-19	11	23%	94%
20 and older	3	6%	100.0
Total	47	100%	

Figure 5



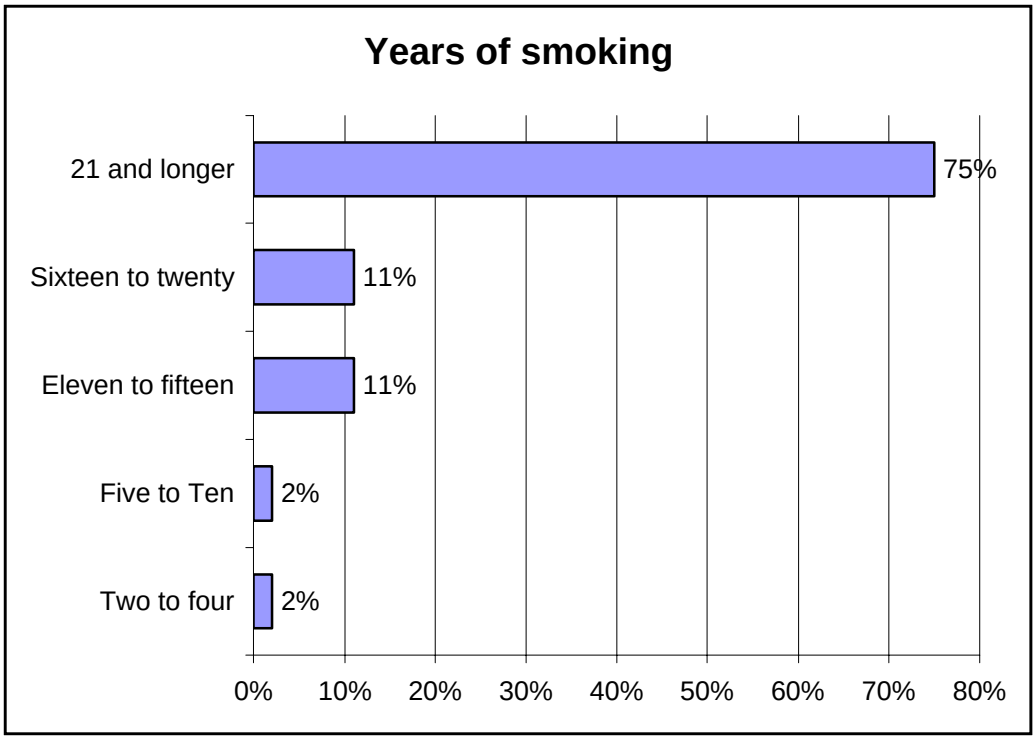
Number of years being a smoker

Participants had smoked between 4 and 50 years, with and average of 25.5 years of having been a smoker. Three quarters (75%) indicated to have smoked longer than 21 years.

Table 11 Years of smoking

	Frequency	Percent	Cumulative Percent
Two to four	1	2%	2%
Five to Ten	1	2%	4%
Eleven to fifteen	5	11%	15%
Sixteen to twenty	5	11%	26%
21 and longer	35	75%	100%
Total	47	100%	

Figure 6



Average number of cigarette smoked daily

Of the 42 people who were smoking daily, the average cigarette consumption per day was 19.6, ranging between 2 and 50. Only one person said that he or she was an occasional smoker, and 3 were smoke-free. The average cigarette consumption of the

general Canadian population 25 years and older was 16.5 cigarettes per day (Canadian Tobacco Use Monitoring Survey, CTUMS, 2003).

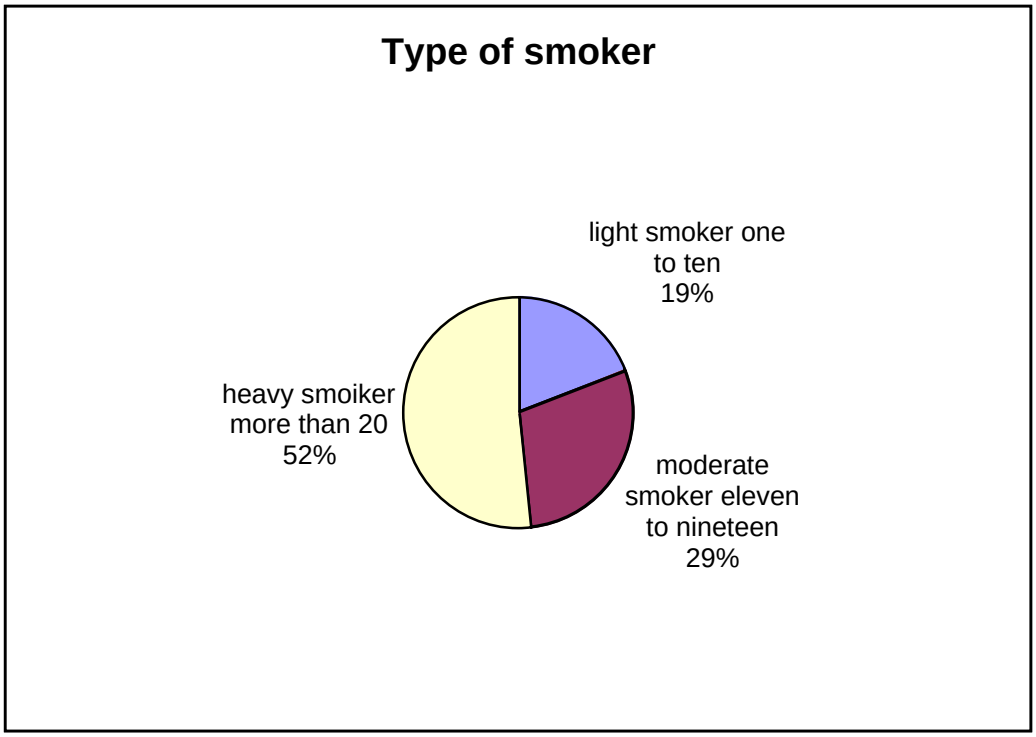
According to CTUMS terminology, about half of the smokers (52%) can be classified as heavy smokers, given the fact that they were smoking 20 cigarettes daily or more. A third (29%) were moderate smokers, smoking between 11 and 19 cigarettes daily, and only one in five (19%) could be classified as a light smoker, who smoked less than 10 cigarettes daily.

Table 12 Number of cigarettes smoked

	Frequency	Percent	Valid Percent
1 to 10 cigarettes (light smoker)*	8	17%	19%
11 to 19 (moderate smoker)*	12	26%	29%
20 and more (heavy smoker)*	22	47%	52%
N/A	5	11%	
Total	47	100.0	

*CTUMS terminology

Figure 7



Smoking dependency

CTUMS classifies smoking dependency according to how soon after waking someone smokes their first cigarette. Almost three quarters (72%) reported that they smoked within 30 minutes of waking up, compared to 63% of the smokers in the general Canadian population 25 years and older (CTUMS, 2003).

Half of the smokers can be classified as heavy smokers, smoking more than 20 cigarettes daily.

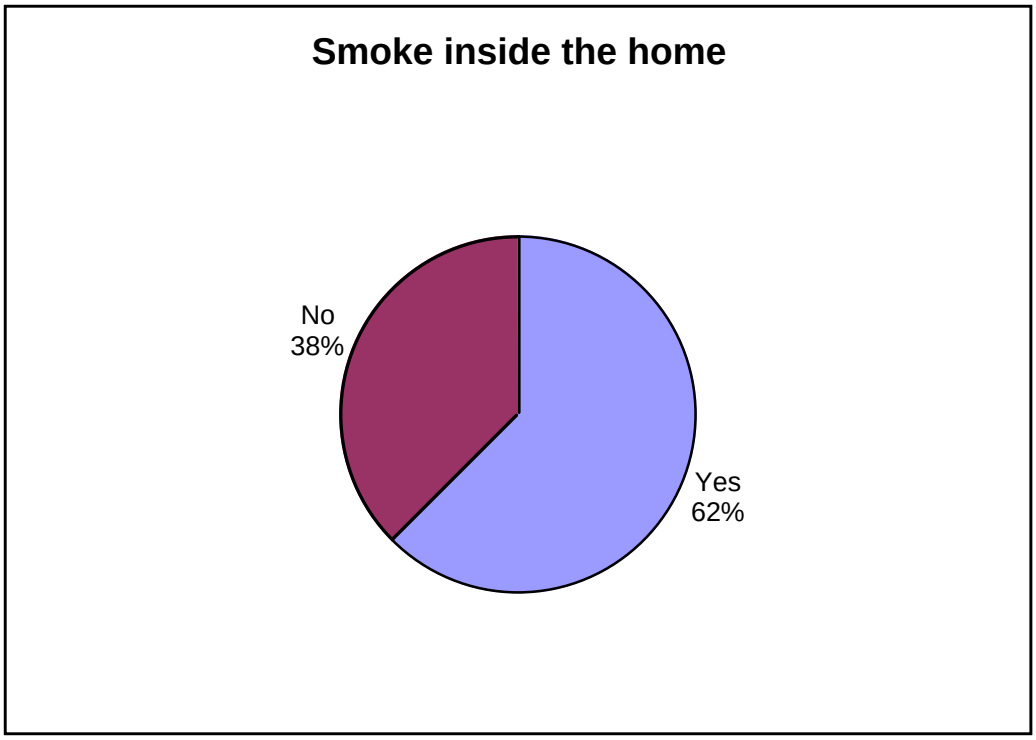
Smoke in home

About two thirds (70%) indicated that they were smoking inside their home, whereas one third (36%) did not. Not all participants were asked at intake whether or not they were living with a smoker. However, of those who were asked, 7 indicated that they did live with a smoker.

Table 13 Smoke inside home

	Frequency	Percent
Yes	28	60%
No	17	36%
N/A	2	4%
Total	47	100%

Figure 8



Nicotine Replacement Therapy (NRT)

Almost three quarters (72%) had used nicotine replacement before attending the program, and 9% were currently doing so. Half (50%) had used Zyban before.

Reasons for relapse

The majority of participants had quit smoking before. 81% provided at least one reason why they had started smoking again after having quit previously. Many of the reasons mentioned by participants that made them smoke again were very similar, having to do with stress, the social scene, use of alcohol, boredom and loneliness:
“End of a relationship; went out drinking with friends and started up again”.
“The bars, hanging out with majority smokers”.

The most common reason provided by 53% (20) of the respondents for relapse was stress, followed by 40% (15) who mentioned that they started again because they were socializing with people who smoked, their friend smoked, their friend had started smoking again, they had a new boyfriend who smoked. Smoking in bars and alcohol as a trigger, or playing pool was mentioned by 16% (6) of the respondents. Being bored or having something to do was provided as a reason by 13% (5). A few mentioned that they had been overconfident, thinking that they were able to have a drag and not realizing how easy it was to fall back into the habit of smoking. Others simply stated that they liked the taste or that they were addicted.

Motivation to join the program

The majority of respondents joined the program to receive support to quit smoking (85%), or support to stay smoke-free 40%. Many respondents checked both options, likely in anticipation that they will need support to maintain their smoke-free status once they had been able to quit.

13% wished to receive subsidized NRT (6, 13%). However, this question was only included in 26 of all of the questionnaires, of these 23% joined the program also to get subsidized NRT.

The majority of respondents checked that they were seriously thinking of quitting, 90% wished to do so in the next month, and 30% within the next 6 months. A number of respondents checked both options, either they were unsure if they would be able to do it within the next month, or because they did not read the question carefully.

8. What were the immediate, shot-term outcomes of the program? Any spin-offs, unanticipated effects?

A total of 20 participants filled out a survey at program end, 17 men and 3 women.

Short term quit rates

Almost half of the participants (45%) indicated at program end that they had quit completely, and a quarter (25%) had been able to stay smoke free for longer than one week. Only 3 respondents (15%) had only been able to smoke free for a few hours, and 2 had stayed smoke-free for a time period between 2 and 6 days.

Table 14 Longest time without smoking

	Frequency	Percent	Cumulative Percent
A few hours	3	15%	16%
2-6 days	2	10%	26%
Longer than one week	5	25%	53%
I quit completely	9	45%	100%
N/A	1	5%	
	20	100%	

We did not detect any specific patterns or differences across the different program constellation when looking at the length of time participants were able to stay smoke-free.

Figure 9

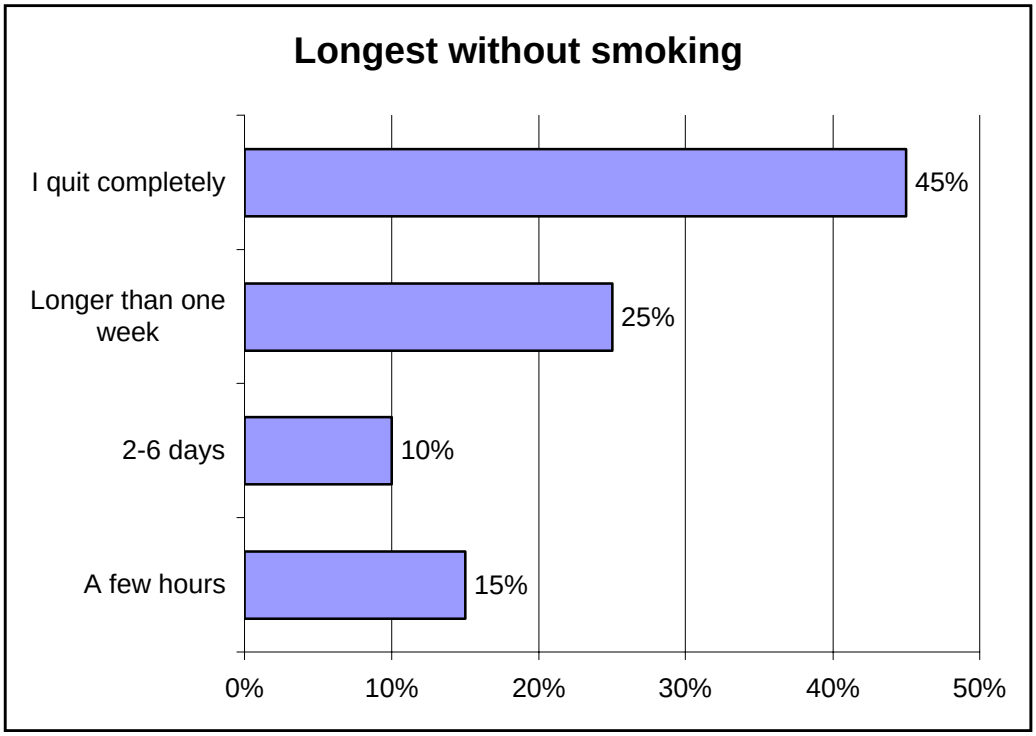


Table 15 Longest time without smoking and group composition

	Longest time without smoking				Total
Type of group attended	A few hours	2-6 days	Longer than one week	I quit completely	
Male only	1	2	3	5	11
Female only	1			1	2
Co-ed	1		2	3	6
	3	2	5	9	19

How soon do respondents smoke their first cigarette? Pre and post surveys compared

Two thirds (65%, 13) of the respondents who provided pre and post surveys indicated in the pre program survey, that they were smoking within 30 minutes of waking up. At program end, this number had gone down to 15% (3) of the respondents, a reduction of 50%.

Table 16 Smoke first cigarette within 30 minutes of waking: Pre and post

	Yes	No or N/A	Total
Pre program	13	7	20
Post program	3	17	20

The three respondents who indicated at the end of the program that they were smoking their first cigarette within 30 minutes of waking up were distributed evenly across the different types of groups.

Figure 10

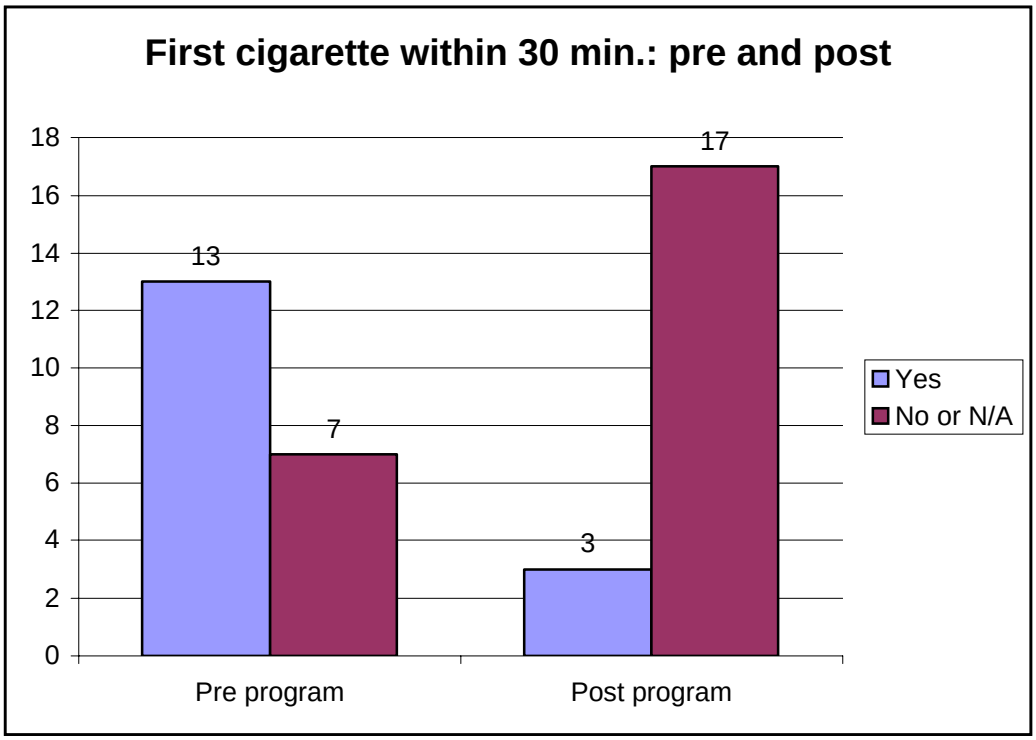


Table 17 Smoke first cigarette within 30 minutes of waking up: Across groups

Type of group attended	Yes	No	Total
Male only	1	10	11
Female only	1	2	3
Co-ed	1	5	6
	3	17	20

Long-term quit rates

Long-term quit rates were not systematically collected for all groups. However, according to the program facilitator after a year one male from the first fall male cessation group was still smoke-free in December of 2004. Three of the first Fall 2003 group had signed up for a second time to attend the fall group in 2004.

9. How satisfied were participants with the program?

Program satisfaction was measured in a number of different ways. Participants were asked to report of an increase in learning on specific items; rate the degree of helpfulness of the program in assisting them with certain skills related to quitting; evaluate organizational aspects of the program; assess certain program aspects and program usefulness; and, indicate whether or not they would recommend the program to a friend. In addition, open-ended questions were included to collect qualitative data about satisfaction with the program. Finally, participants were asked whether or not they would recommend the program to a friend.

Self-reported learnings

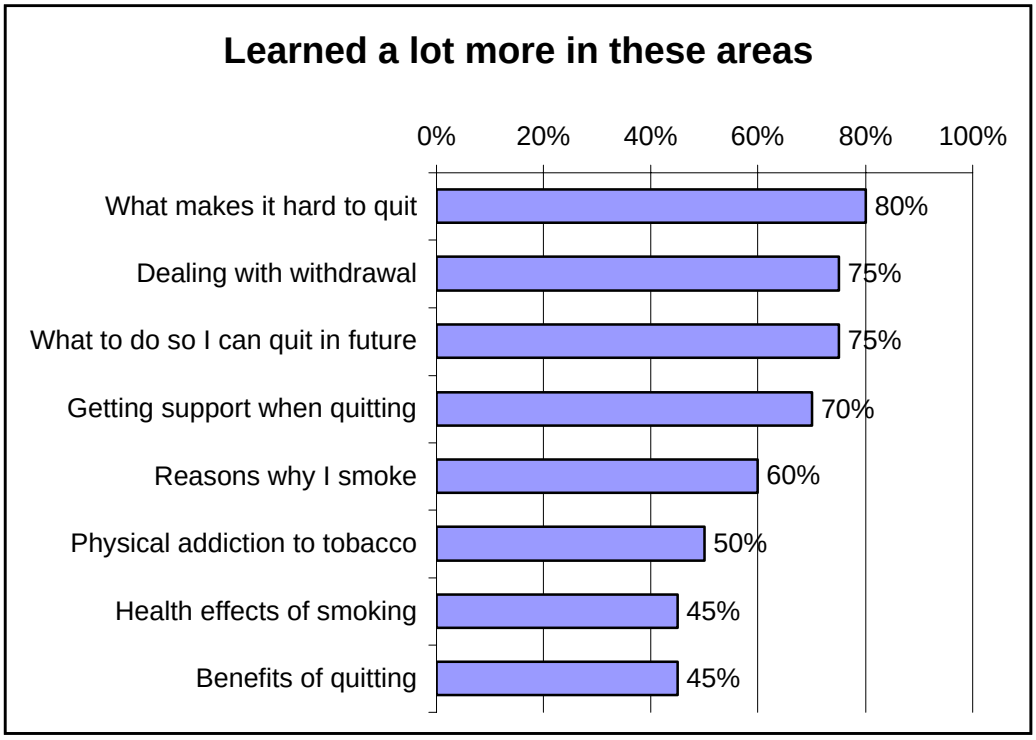
After completing the program participants were asked to rate on a 3-point scale (1=nothing more; 3=a lot more) how much more they knew now about smoking and quitting. On average, almost two thirds (63%) rated that they knew a lot more, and another third (31%) that they knew something more. These high ratings are indicative of very high levels of satisfaction with having learned more during the program.

Most participants felt that they had learned more about what makes it hard to quit (80%), followed by dealing with withdrawal and what to do to quit in future (75%). Almost three quarters (70%) also felt that they had increased their knowledge a lot about getting support when quitting. Knowing more about reasons why one smokes (60%) and the physical addiction of tobacco (50%) was followed by learning more about the health effects of smoking and benefits of quitting (both 45%).

Table 18 Knowing more about smoking and quitting

	A lot more		Something more		Nothing more	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
What makes it hard to quit	16	80%	4	20%	0	0
Dealing with withdrawal	15	75%	5	25%	0	0
What to do so I can quit in future	15	75%	3	15%	1	5%
Getting support when quitting	14	70%	6	30%	0	0
Reasons why I smoke	12	60%	7	35%	1	5%
Physical addiction to tobacco	10	50%	6	30%	4	20%
Health effects of smoking	9	45%	8	40	3	15%
Benefits of quitting	9	45%	11	55%	0	0
Average	12.5	63%	6.25	31%	1	0.5%

Figure 11



Perceived helpfulness of the program

Participants were asked on a scale of 4 (1=not at all helpful, 4=very helpful) to rate how helpful the program was to help them with certain things. Since nobody chose the "not at all helpful" category for any of the items, this scale item is not included in the table below.

Overall, participants rated that the program had been either very helpful or somewhat helpful on almost all items. On average, 73% rated the items as very helpful and 16% as somewhat helpful, indicating a very high degree of program satisfaction.

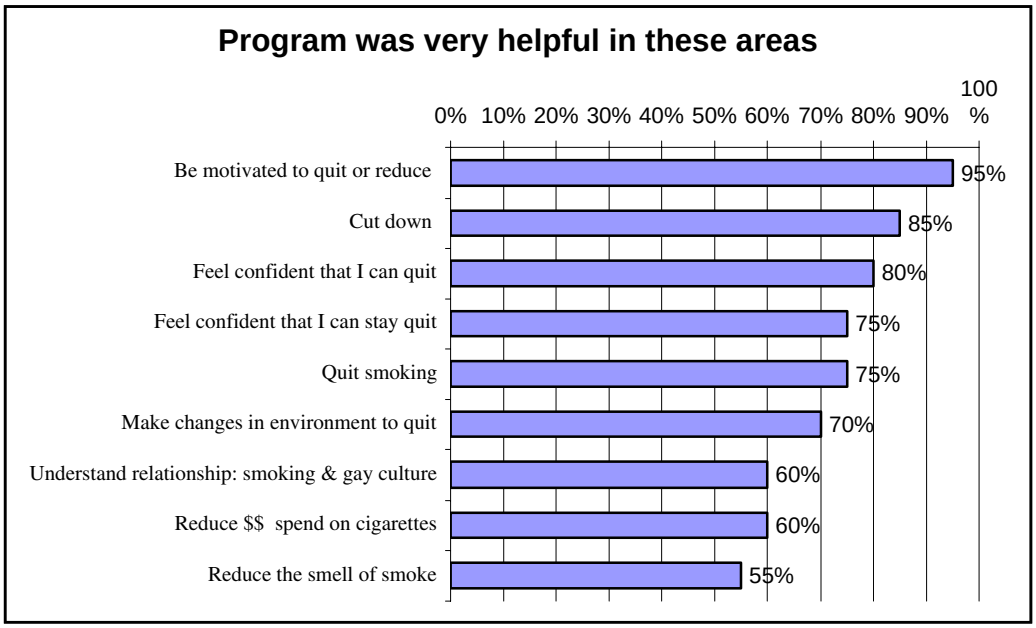
The majority (95%) of participants found that they had received the most help with "being motivated to quit or reduce smoking". 85% also found that the program had been very helpful to assist them with cutting down the number of cigarettes they smoked, and 80% felt that the program had helped them to make them feel confident that they would be able to quit or remain smoke free after quitting (75%). Three quarters (75%) found the program very helpful to assist them with quitting, 10% found it somewhat helpful and one person not very helpful. 70% indicated the program had helped them a lot to make changes to their environment, and 60% understood the relationship much better between smoking and the gay culture. 60% felt very much helped with reducing the money they were spending on cigarettes and just over a half (55%) with reducing the smell of smoke.

Table 19 How helpful was the program for you in the areas listed below?

	Very helpful		Somewhat helpful		Not very helpful		Can't really say	
Skills	#	%	#	%	#	%	#	%
Be motivated to quit or reduce smoking	19	95%					1	5%
Cut down on the number of cigarettes I smoke	17	85%	2	10%			1	5%
Feel confident that I can quit	16	80%	4	20%				
Feel confident that I can remain smoke-free after quitting	15	75%	3	15%			2	10%
Quit smoking	15	75%	2	10%	1	5%	2	10%
Make changes in my environment to help me quit	14	70%	6	30%				
Better understand the relationship between smoking and the gay culture	12	60%	7	35%	1	5%		
Reduce the money I spend on cigarettes	12	60%	4	20%	3	15%	1	5%
Reduce the smell of smoke	11	55%	4	20%	2	10%	3	15%
Average	14.6	72.8%	3.3	16.7%	.8	.4%	1.4	5.5%

Participants also provided additional comments, about what they found most and least helpful as part of the program.

Figure 12



Many respondents appreciated that the groups were targeted at the GLBT community, which facilitated sharing of experiences and provided a great level of support to group members. Other comments focused on the facilitator's skill and knowledge level and her positive way of group facilitation. Some reported that they found specific parts of the program particularly useful, e.g. dealing with triggers, or learning about various coping strategies. One commented that he or she knew how to quit in future.

When asked what they did not find helpful, many mentioned that they were unaware of anything. A number of respondents would have liked follow-up sessions to be offered.

Comments:

- Being in a group of my peers
- Sitting with other gay men wishing to stop smoking; discussion about what as a gay men are our triggers
- GLBT specific focus
- Group support, info packages, facilitator experience
- Weekly support and discussion.
- The group discussions involving sharing of experiences
- I am not ready yet, but through this program, Christianne and group, along with the discussions and handouts perhaps I will be successful when the time is right
- The fiery, good natured, intelligent informed attitude knowledge and skill of the facilitator
- Learning how to deal with triggers

- It wasn't just one thing - the great teacher with the good tools, the access to cheaper patches (even they should be free) the wonderful GLBT group members
- The various coping strategies; the various stages one goes through
- Carbon monoxide testing.

Not helpful

- The group discussions involving sharing of experiences
- Not that aware of
- Don't know
- Yes, more willpower and determination
- A follow-up "step 2" kind of group, i.e., some kind of structured relapse prevention group
- The start time of 6pm is difficult; 7 or 7:30 would have been better
- Not that I can think of
- A 30-day residential program just like for other addicts
- No
- Maybe if a suggested method of quitting were provided as well

Key informants offered the following additional observations about program satisfaction:

- Connections and networks created among participants in several groups ("That strength could also be a weakness, because if you come two or three friends together, then one starts to smoke, all will relapse together too".)
- A lot of mutual support and exchange of ideas, suggestions around living with HIV.
- Isolated people who were not involved in the bar scene were able to meet others, make friends.
- Participants learned more about resources available to the GLBT community: e.g., Pink Triangle Services, CCHC, recreational clubs- especially beyond the bathhouse and bar scene.

Would recommend program to a friend

All respondents would recommend the program to a friend, and some commented that they already done so.

Comments
- … and have done to many of my friends
- I already have
- I tried to get buddies to join me, but they have to be ready and willing
- Very helpful

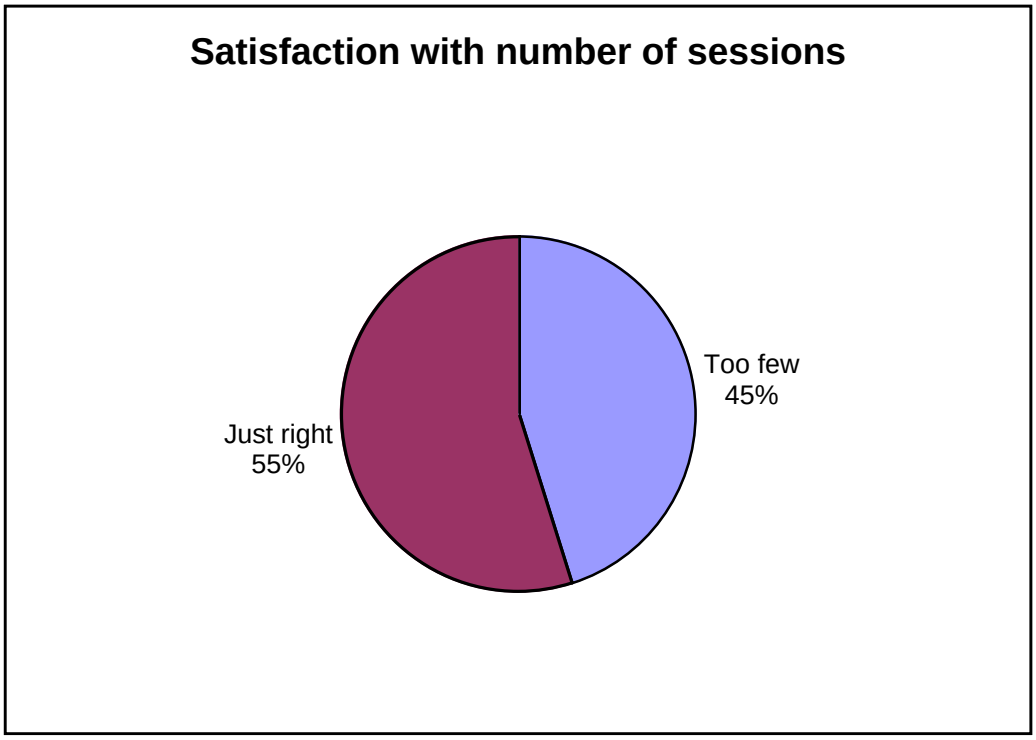
Satisfaction with organizational aspects of the program

While over half of the respondents (11, 55%) felt that the number of sessions provided as part of the program were just right, 45% (9) felt that there had been too few sessions. Participants' comments focused mostly on the need for more sessions, the benefits of ongoing or follow-up sessions, or a second stage program.

Table 20 Satisfaction with number of sessions (8)

	Frequency	Percent
Too few	9	45%
Just right	11	55%
Total	20	100.0

Figure 13



Participants commented as follows about the number of sessions.

- I think a 13 week program with a commitment by participants would allow those having more difficulty to quit
- But I missed two of the night sessions
- Would appreciate stage 2 group
- Ongoing support would be beneficial
- May be too many sessions for the extent of the content, but that's not what the program is about. Need the time to explore and share with others in a semi

structured way to benefit fully; 8 sessions was good, although so many people are busy these days.
- I missed two of the night sessions
- Perhaps in future 10 weeks
- I'm getting to know everyone and am being inspired by the success of them and would like to continue with this program
- Longer could be better
- Could have been longer

Respondents from the co-ed group were the most likely to indicate that 8 sessions was not enough, as illustrated in Table 21 below.

Table 21 Satisfaction with number of sessions across type of program

	Satisfaction with number of sessions (8)		Total
Type of group attended	Too few	Just right	
Male only	4	7	11
Female only	0	3	3
Co-ed	5	1	6
	9	11	20

Only one person felt that the actual length of each session was too short. All other respondents found that the session length was just right (see Table 22 below). As one person commented: “Sessions were very interesting and time went by quickly. I think less than 1.5 hours would be too little”. Another participant was concerned about the scheduled starting time of the program. This person would have liked the starting time to be earlier. “I thought may be it should start a half hour earlier or an hour later (I finish work at 5pm so I had to hang around downtown for an hour”.

Table 22 Satisfaction with length of each session (1.5 hours)

	Frequency	Percent
Too short	1	5.0
Just right	19	95.0
Total	20	100.0

Satisfaction with specific program aspects

Respondents were asked to rate a number of different items on a scale of 1 to 4 (1=poor; 4=Excellent). Almost all items were rated as either “Excellent”, or “Good”, indicating very high levels of satisfaction among participants. None of the respondents rated any of the items as ‘poor’. Therefore this item is not included in the table below.

Table 23 Satisfaction with specific program aspects

	Excellent		Good		Fair		N/A	
	#	%	#	%	#	%	#	%
Overall program	17	85%	3	15%				
Handouts	12	60%	6	30%	1	5%	1	5%
Interaction with other participants	11	55%	8	40%			1	5%
Style of the program	10	50%	10	50%				
Assignments between sessions	4	20%	13	65%	2	10%	1	5%
Average	10.8	54%	8	40%	.6	.3%		

All respondents from the female and co-ed groups rated the program as excellent.

Table 24 Program rating across different group compositions

	Overall program		Total
Type of group attended	Good	Excellent	
Male only	3	8	11
Female only		3	3
Co-ed		6	6
	3	17	20

10. How did participants assess the usefulness of a GLBT-specific program?

Respondents were asked to rate on a scale of 1 to 5 (1=not at all useful; 5=very useful) how useful it was to offer a smoking cessation program tailored to the gay community (gay men, lesbians, etc.). 85% rated it as very useful and 10% as useful, amounting to an average rating of 4.9. Many respondents also commented about the usefulness of this type of program, pointing out the importance to have programs for GLBT community available to ensure that participants felt safe to discuss issues pertaining to their unique needs. One participant found it useful for having learned that many other participants had to deal with similar triggers. Another respondent found the handouts to be very useful and made suggestions regarding the format of the material to be compiled in one booklet.

Comments about GLBT-specific program

- You're in a safe environment and can express yourself
- Had this been a straight group I would not have quit, therefore would still be smoking
- Useful because there aren't a lot of other groups to join.
- Very helpful to be able to discuss gay issues and smoking
- It was easy to talk among other lesbians about the influences or impact our partners may, or may not have

- Yes as they have unique needs
- I found it useful for me is that I saw that many of my triggers were common to other participants (egg, hanging around bars, large % of friends who smoke, etc.)
- Yes I think it is very useful and there should be more awareness of it in the community
- Handouts helpful for exercises, wonder if they were booklets with all exercises, booklet towards gay audience would be ideal, seeing such high rates (stats).
- Je n'ai pas d'opinion.

11. How satisfied were the community advisory committee members with the program?

Advisory Committee members were very pleased with the success of the program, and with the participation of the community organizations that they represented.

They mentioned a number of benefits for their organizations arising from the program, including:

- opportunity to offer GLBT-specific programming as an example of what can be done
- increased exposure to the GLBT community
- increased credibility with the GLBT community
- increased awareness of organizations' programs by the GLBT community
- opportunity to meet client needs
- opportunity to offer services to clients who would not have participated in 'mainstream' groups.

They were willing to continue to be involved in the project and/or in similar programs. One AC member stated that their organization was so pleased with the program that they would be willing to continue offering at least one GLBT-specific cessation program per year, even if ACESS funding were no longer available.

AC members used the following indicators of success in assessing the program:

- a community coalition was established
- needs were clearly determined
- program design and advertising were congruent and showed integrity
- information was tailored to the community
- delivery was culturally competent and sensitive
- registration was high (waiting lists)
- attendance was high and consistent
- drop-outs were few
- cessation rates were high
- participant satisfaction was high (and clearly expressed).

12. What programming issues/ideas emerged?

In the process of implementing and delivering this program, additional information was identified about the needs of the GLBT community. Given the dearth of data about GLBT smoking and cessation issues, especially in Canada, the information may be of use not only for future cessation programming, but also for other health promotion and education programs directed at this target population. Key learnings include:

- A GLBT-specific group was key to attract and retain participants, who would not have signed up for 'mainstream' cessation programs.
- Offering groups at a GLBT-identified site, rather than a GLBT-friendly site, provides both comfort and additional benefits, in terms of linking with resources.
- Recruitment takes time, money, repetition, and multiple vehicles. I think we did great, but it meant lots of work. You have to keep pushing it. The longer you advertise the better it is."
- A minimum of two-months advertising is suggested prior to the launch of a new session/program. This leaves time for 'word of mouth' recruitment, which is especially effective in the Francophone community.
- Publicity that coincides with Pride Week works well. Well-designed graphics and 'catchy' tag lines help. "
- Although gay men, lesbians, and bisexuals all have unique needs, it is possible and workable to delivery programming in a co-ed setting.
- Not being judged by other participants; and feeling safe to share personal information about one's own lifestyle, are essential ingredients for a group program to work well with the GLBT population.
- Given the heavy emotional stress of living in a society that discriminates against and negatively judges GLBT people, an approach that is clearly non-judgmental, open, and accepting is important.
- Recognizing the importance of peers, peer pressure, group activities, and socialization is necessary to effectively plan and support interventions that target lifestyle changes.
- A high degree of comfort and familiarity with the GLBT community, as well as specific training to work with this community, are important requirements for effective facilitation with the community.
- The support and advice of recognized GLBT and GLBT-supportive community organizations, through an Advisory Committee, is key, especially in terms of understanding community needs, planning recruitment strategies, and bringing a sense of commitment to the project.

13. How can the program be improved?

Informants made the following suggestions for improving the program:

- Continue to offer the gay men program, and the co-ed program if funding is not available for separate program.
- Provide longer-term follow up sessions, drop-in or continuing supports for participants after the 8 weeks are finished.
- Advertise in mainstream papers with "nice, bright ads", to reach the population that does not frequent gay-specific venues or bars.
- Develop an integrated program manual:
    - collect all the materials that were used for each of the group variations
    - write up (in some detail) instructions, content, facilitation for adapted activities and components
    - work with graphic artist to design appropriate 'look' for program manual
    - include the logo and tag-line in the manual/binder, on all materials, and in all publicity.
- Provide training to potential facilitators/users of the program manual
- Approach Health Canada and Canadian Rainbow Health Coalition to market the program nationally (Toronto, Vancouver have shown interest)
- Continue to disseminate results of the program to both GLBT health-related and tobacco cessation audiences.

CONCLUSION

Based on the data available for this evaluation (keeping in mind the methodological and resource limitations mentioned above), we conclude that this program:

- reached a significantly under-serviced target group;
- was very successfully implemented;
- was positively perceived by key community partners;
- satisfied or exceeded participant needs;
- satisfied or exceeded community organization expectations;
- and shows great promise as a workable model for further development.

To strengthen the program prior to evaluating it for effectiveness (outcomes) we recommend:

- development of a comprehensive program manual, incorporating all the materials, resources, and activity instructions used by the facilitator of these five pilots
- development of standard intake and post-program evaluation tools, to be administered consistently to all group participants, including to drop-outs, whenever possible
- inclusion of cut-down, as well as cessation questions as indicators of success

- mid-term follow-up (telephone follow-up is a possibility) to determine continuing cessation rates
- repetition of program delivery to co-ed and women-only group, to permit assessment of program with a larger female population
- continuation of active Advisory Committee participation, with a focus on strategies for recruitment of the GLBT female population to future cessation groups (co-ed and/or women-only).

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