Université de Montréal

No smoking! A critical examination of how Quebec tobacco control discourse may affect social inequalities in smoking

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No smoking! A critical examination of how Quebec tobacco control discourse may affect social inequalities in smoking

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RÉSUMÉ

Au Canada, la prévalence du tabagisme a diminué de façon significative. Ce succès est attribué aux politiques populationnelles de lutte contre le tabagisme telles que les campagnes anti-tabac, les interdictions de fumer, les hausses de taxation et les restrictions sur la vente des produits tabagiques. Néanmoins, les inégalités sociales en matière de tabagisme s'accroissent; la prévalence de tabagisme demeure élevée au sein des groupes défavorisés, notamment ceux ayant un faible statut socio-économique (SSE). Malgré la recherche existante qui porte sur les effets des politiques de lutte contre le tabagisme selon le SSE, *comment* ces politiques affectent ces inégalités est peu documentée. Ainsi, dans le contexte où le Québec s'est engagé dans une lutte contre le tabagisme avec l'adoption d'une politique populationnelle en 2015, « Loi visant à renforcer la lutte contre le tabagisme » (L44), et le développement d'une stratégie populationnelle en 2020 qui priorisent la réduction des inégalités sociales en matière de tabagisme, cette thèse aborde une question de grande pertinence pour la santé publique : comment les politiques publiques populationnelles, telles que L44, pourraient-elles affecter les inégalités sociales de la santé?

Cette thèse explore cette question de recherche par l'entremise de trois articles : un article conceptuel et deux articles empiriques. L'article conceptuel présente l'intérêt de la théorie de l'intersectionnalité pour la recherche sur les inégalités sociales de la santé, particulièrement lorsque cette recherche intègre les deux principes de l'intersectionnalité : le principe soulignant le rôle des structures sociales dans la reproduction d'inégalités sociales étant souvent négligé pour privilégier le principe faisant valoir les expériences des groupes sociaux défavorisés. Cet article permet donc d'encadrer cette thèse afin qu'elle considère les politiques de lutte contre le tabagisme et les pratiques des praticiens en lutte contre le tabagisme (PLT) comme étant des facteurs structuraux qui influencent les inégalités sociales en matière de tabagisme.

Guidés par un devis qualitatif basé sur l'analyse critique du discours, les deux articles empiriques (articles 2 et 3) examinent le discours des politiques de lutte contre le tabagisme comme un mécanisme reliant ces politiques et les pratiques des PLT aux inégalités sociales en matière de tabagisme. D'abord, l'article 2 applique l'analyse poststructuraliste de Bacchi aux transcriptions des consultations parlementaires pour le projet de loi L44 avec des acteurs québécois de lutte

contre le tabagisme. Cette analyse démontre que L44 renforce et avance des discours problématisant « le fumeur » comme groupe moralement déviant et duquel les non-fumeurs doivent être protégés. Il y est discuté la façon dont cette problématisation concrétise les relations de pouvoir entre les non-fumeurs et les personnes qui fument, ce qui donne le « droit » aux non-fumeurs de réguler ces dernières personnes. Il apparaît ainsi que L44 renforce l'identité sociale du fumeur qui se retrouve aux intersections du SSE, du genre, ou de la race. En employant un tel discours, il est soutenu que L44 pourrait perpétuer les inégalités sociales en matière de tabagisme.

L'article 3 emprunte le concept poststructuraliste des « pratiques discursives » afin d'analyser des entrevues faites avec des PLT au Québec. Cet article illustre comment leurs pratiques sont issues de discours sur la prévention du risque et le changement de comportement. Ces pratiques favorisent les interventions visant la réduction de la prévalence du tabagisme auprès de groupes « à risque » au détriment d'interventions ciblant les facteurs structuraux inéquitables dont découlent les inégalités sociales en matière du tabagisme. Toutefois, les PLT qui travaillent avec des personnes défavorisées qui fument, contrairement à ceux qui travaillent en prévention du tabagisme, tiennent un discours plus nuancé qui attribue une importance à l'amélioration des conditions sociales liées au risque de fumer. Cet article suggère que d'élargir les discours dominants en santé publique, notamment en intégrant l'expérience vécue des groupes défavorisés, a le potentiel de produire des discours et des politiques axés vers la promotion de l'équité en santé.

Bien qu'ancrée dans le contexte de la lutte contre le tabagisme, les connaissances générées par cette thèse pourront éclairer d'autres discours et politiques de santé publique. En utilisant une approche critique et théorique novatrice, l'importance d'adopter une perspective réflexive envers les connaissances, présuppositions et valeurs qui sous-tendent la problématisation d'un phénomène de la santé (p.ex. le tabagisme), est établie. Cette recherche démontre également qu'il est impératif d'intégrer l'expérience vécue dans l'élaboration de politiques publiques, de cibler les déterminants structuraux ainsi que d'engager les praticiens en santé publique dans le travail intersectoriel afin de réduire les inégalités sociales de la santé.

Mots-clés : inégalités sociales en matière de tabagisme; politiques de lutte contre le tabagisme; discours de politiques publiques; perspectives critiques en santé publique; Québec;

ABSTRACT

Significant reductions in smoking prevalence in Canada are attributed to population-level tobacco control policies, such as media campaigns, smoke-free policies, tax increases, and restrictions on the sale of tobacco products. Despite this public health success, social inequalities in smoking have been increasing, with smoking prevalence remaining high in certain socially disadvantaged groups, notably those of low socio-economic status (SES). Although research investigates potential effects of tobacco control policies across SES groups, evidence on *how* such policies come to have these inequitable effects is lacking. With Quebec's implementation of a 2015 population-level tobacco control policy, An Act to Bolster Tobacco Control (L44), and a 2020 strategy addressing the reduction of social inequalities in smoking, this thesis attends to a pressing public health question: how might population-level policies, such as L44, impact social inequalities in health?

To answer this question, the thesis is comprised of one conceptual article and two empirical articles. The conceptual article discusses the important insights that can be gained from using intersectionality theory when researching social inequalities in health, notably when examining both tenets of intersectionality – the tenet highlighting the role of intersecting social structures in the reproduction of social inequalities is often neglected to privilege the tenet underlining the experiences of intersecting social identities – to better understand the complexity of such inequalities. This article led the thesis to focus on tobacco control policies and practices of tobacco control practitioners (TCP) as structural factors influencing social inequalities in smoking.

Using a qualitative critical discourse analysis design, the two empirical articles (articles 2 and 3) critically examine tobacco control discourse as a mechanism linking tobacco control policies and TCP practices to social inequalities in smoking. Article 2 applies a Bacchian post-structuralist approach to policy discourse analysis to documents detailing L44 parliamentary consultations with Quebec tobacco control policy stakeholders. This article demonstrates that L44 reinforces and advances anti-smoking discourses by problematising "the smoker" as a distinct morally deviant category of people from which non-smokers need to be protected. This problematisation is further shown to reify power relations between non-smokers and people who

smoke, providing non-smokers the "right" to regulate people who smoke. It appears that by subjectifying and regulating people who smoke, L44, via its discourse, contributes to anchoring smoking status as a social identity intersecting with other social identities such as SES, gender, and/or race. In this way, it may contribute to perpetuating social inequalities in smoking.

In article 3, the post-structural concept of "discursive practices" is used to analyse interviews with Quebec TCP. This article illustrates how their practices are shaped by discourses of risk prevention and behaviour change. This was observed through their practices, which reproduced stigmatising representations of "the smoker" (echoing findings from article 2) and supported interventions targeting reductions in smoking prevalence for "at-risk" groups, rather than those addressing inequitable structural determinants of smoking. However, TCP working directly with socially disadvantaged people who smoke, compared to those working in policy, held comparatively more nuanced discursive practices, leading to reduced stigma and attention to the social conditions placing their patients at greater risk of smoking. This article concludes that broadening dominant public health discourses to integrate the lived experiences of socially disadvantaged people who smoke will likely produce more inclusive discourses and favour social policies that reduce social inequalities. This in contrast to risk prevention and behaviour change discourses that may entrench such inequalities.

The insights from this thesis can be applied to the relationships between a range of public health policies and social inequalities in health. By offering a critical perspective on tobacco control discourse through a novel theoretically-combined approach, this thesis ultimately aims to inform public health policy design by demonstrating strategies to reduce social inequalities in health and promote health equity. Chiefly, it underlines the importance of questioning unexamined knowledge, assumptions, and values shaping conceptualisations of health problems (e.g., smoking) and policy responses (e.g., tobacco control policies). It also demonstrates the importance of integrating lived experience in policy design and for public health practitioners to work intersectorally in order to achieve reductions in social inequalities in health.

Keywords: social inequalities in smoking; tobacco control policy; policy discourse; critical public health; Quebec

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LIST OF ABBREVIATIONS

ACPHHS	Advisory Committee on Population Health and Health Security
CERB	Canadian Emergency Response Benefit
CDA	Critical discourse analysis
CDC	Centers for Disease Control and Prevention
CIHR	Canadian Institutes for Health Research
DRSP-M	Direction régionale de santé publique de Montréal
FCTC	Framework Convention for Tobacco Control
HiAP	Health in All Policies
IBPA	Intersectionality-Based Policy Analysis
L44	An Act to Bolster Tobacco Control
LAA	Legislative Assembly of Alberta
MSSS	Ministère de la santé et des services sociaux
PHIR	Population health intervention research
QLP	Quebec Liberal Party
QNA	Quebec National Assembly
SDH	Social determinants of health
SES	Socio-economic status
SHS	Second-hand smoke
TCP	Tobacco control practitioners
THS	Third-hand smoke
VANDU	Vancouver Area Network of Drug Users
WHO	World Health Organisation
WPR	What's the problem represented to be?

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CHAPTER 1. INTRODUCTION

This thesis examines the relationship between tobacco control policies and social inequalities in smoking, yet my interest in pursuing a Ph.D. extends beyond these concepts. As a scholar, my work has been driven by the need to better understand how and why social inequalities persist, with the ultimate goal of using this knowledge to orient social and health policy design towards reducing such inequalities and promoting health equity.

I came to the field of health promotion as a social worker, having worked with different socially disadvantaged groups, notably people experiencing homelessness and women who had survived violence. While social workers often intervene at the individual level, it is understood in social work that individual problems are structurally produced; upstream social factors, or structural determinants (e.g., policies and social norms), shape the functioning of society, trickling down to shape our everyday lives (Bhuyan et al., 2017; Carniol, 1992; Link & Phelan, 1995; Moreau, 1979; WHO, 2008). Therefore, inequalities between social groups are not the result of strengths nor weaknesses within a particular group, but of inequitably distributed resources due to fallible social structures (Carniol, 1992; Link & Phelan, 1995; Moreau, 1979; WHO, 2008). These inequalities are thus not inherent, but discriminatory, as they are based on political, economic, social, and cultural decisions that privilege certain groups over others (Carniol, 1992; Crenshaw, 1989, 1991; Link & Phelan, 1995; Moreau, 1979; WHO, 2008). As such, social inequalities can be ameliorated.

As a social worker, I intervened at the individual level, but knowing that the social barriers individuals experienced were preventable left me wanting to better understand how policy, as a structural determinant, functions to impact social inequalities. Social inequalities in health, that is, social differences in mortality, morbidity, health behaviours, and access to health care services, are a prime and continual example of the effects of inequitable policies, often meant to improve population health (Frohlich & Potvin, 2008; Lorenc et al., 2013; Marshall-Catlin et al., 2019; Phelan et al., 2010; Phelan & Link, 2005; WHO, 2008). Indeed, research has demonstrated that some public health and health promotion interventions can inadvertently perpetuate or even increase social inequalities in health (Chaufan et al., 2015; Frohlich & Potvin, 2008; Lorenc et al., 2013; Phelan et al., 2010; Phelan & Link, 2005; Williams, 2017). These unintended consequences are of particular concern for the field of health promotion, as they challenge a fundamental health

promotion goal: promoting health equity (McQueen, 2001; WHO, 1986). Health promotion is thus the ideal terrain for investigating the relationship between policy and social inequalities, as it can benefit from knowledge on how interventions come to intentionally and unintentionally affect social inequalities in health to design policies that reduce those inequalities and promote health equity.

1.1. How might policies best reduce social inequalities in health?

There has been a longstanding debate among public health and health promotion researchers and practitioners regarding how to best intervene to reduce social inequalities in health (Douglas, 2016; Galea & Vaughan, 2021; Lambert et al., 2014). Much of this debate is focused on determining the best targets for intervention (Galea & Vaughan, 2021). McLaren and colleagues (2010) argue that this question reflects the much-contested question of whether human behaviour is the result of individual agency or societal structures and that public health interventions must act on the continuum between agency and structure in order to have an impact on population-level behaviour. This is well represented by the social determinants of health (SDH) approach, often used to examine public health intervention (Solar & Irwin, 2010; WHO, 2008). The SDH approach positions various determinants of health in relation to their influence on health. Those that directly affect health are referred to as proximal determinants and include health behaviours and biological dispositions. Intermediary determinants, including living and working environments, and socio-economic status (SES; i.e., income, education, and employment), are a step removed from health but exert influence either directly on health or by shaping proximal determinants. Lastly, structural determinants, such as social norms, politics, economic structure, and culture, are positioned farthest from health but their effect on health is nevertheless important as they shape intermediary determinants, which in turn shape proximal determinants that directly affect health.

Although the SDH approach demonstrates how different determinants affect health, it does not explicitly illustrate how these determinants come to produce social inequalities in health (Graham, 2004a, 2009). As such, many scholars cite Link and Phelan's "theory of fundamental causes" (Link & Phelan, 1995; Phelan et al., 2010; Phelan & Link, 2005) to fill this explanatory gap and elucidate how policy might intervene to redress these inequalities (Cerdá et al., 2014; Douglas, 2016; Graham, 2004a; Mackenbach, 2012; McCartney et al., 2013, 2021; McLaren et al.,

2010). In essence, Link and Phelan argue that dramatic increases in population health over the 20th century were mainly due to important advances in knowledge and technology pertaining to disease control. Use of these resources was limited to those with the means to access and mobilise them, resulting in increased social inequalities in health. To reduce these inequalities, policy interventions are most effective and create more lasting change when targeting structural determinants – referred to as "fundamental causes" – as they address the inequitable social, economic, and political contexts shaping the social distribution of health-related resources. Furthermore, focusing on structure allows interventions to attend to multiple health problems simultaneously, rather than intervening on problems or behaviours one at a time (i.e., solely focusing on smoking). Thus, intervening at the level of proximal determinants may improve population health. Yet if structural determinants are inequitably distributing resources, intervening on proximal determinants will only improve the health of those who possess and/or have the agency to mobilise those resources, thereby perpetuating or increasing social inequalities in health (Adler & Newman, 2002; Benach et al., 2013; Capewell & Graham, 2010; Chaufan et al., 2015; Galea & Vaughan, 2021; Lambert et al., 2014; Link & Phelan, 1995; Lorenc et al., 2013; McCartney et al., 2013; McLaren et al., 2010; Phelan et al., 2010; Phelan & Link, 2005; Whitehead, 2007; Whitehead & Dahlgren, 2006; Williams, 2017).

Evidence demonstrating the effectiveness of structural-based interventions at reducing social inequalities in health is, however, limited (Bambra et al., 2010; Korpi & Palme, 1998; McAllister et al., 2018; Phelan & Link, 2005; Thomson et al., 2018). Existing research demonstrates that countries that spend greater amounts on social services and redistributive policies tend to have better population health outcomes (Dutton et al., 2018; Liu & Dutton, 2020; McAllister et al., 2018; Rubin et al., 2016). More specifically, research highlights that policies investing in housing, work environments, unemployment security, retirement, and public transportation have positive health equity impacts (Bambra et al., 2010; Blair et al., 2019; Rubin et al., 2016). Socially disadvantaged people, notably low SES individuals, benefit the most from increased such interventions (Liu & Dutton, 2020). Arguments in favour of structural intervention do not imply, however, discarding proximal-focused interventions, but rather promoting a balance between both structural and proximal-focused interventions (Phelan et al., 2010).

Scholars have also argued that targeted interventions, i.e., interventions addressing a specific social group or community seen as socially disadvantaged or at high-risk of health issues, may maintain or increase social inequalities in health (Benach et al., 2013; Cerdá et al., 2014; Frohlich & Potvin, 2008; Rose, 1985, 1992; Williams, 2017). In the short term, they may help reduce risk factors and improve health for the targeted group. However, their tendency to neglect the structural determinants that led to elevated risk in the first place may render them inefficient in preventing this high-risk population, or another sub-population, from becoming high-risk in the future (Benach et al., 2013; Frohlich & Potvin, 2008; Rose, 1985, 1992; Williams, 2017). Sir Michael Marmot (2015) expressed succinctly this problem when he wrote: "Why treat people and send them back to the conditions that made them sick?" (p. 1). Further, as social inequalities in health are found across the social gradient – affecting multiple social groups simultaneously and differently (Graham & Kelly, 2004; Marmot, 2010) – targeted interventions cannot effectively reduce social inequalities in health because they target one social group at a time, thus neglecting the other social groups affected. Targeted interventions have also been found to unintentionally generate stigma toward the targeted social group as they may become singled out and associated with unhealthy behaviours, such as smoking or unhealthy eating (Cerdá et al., 2014; Douglas, 2016; Lorenc & Oliver, 2014; McLaren et al., 2010).

Notable public health scholars, such as Geoffrey Rose (1985, 1992), contend that to reduce social inequalities in health, public health interventions must target the entire population. However, population-level interventions were also found to inadvertently maintain or increase these inequalities (Cerdá et al., 2014; Frohlich & Potvin, 2008; McLaren et al., 2010). Frohlich and Potvin (2008) posit that this adverse effect occurs because socially disadvantaged groups in a population need more or different resources than are provided by population-level interventions. Therefore, while this type of intervention tends to benefit the majority of the population, socially disadvantaged segments are left behind (Frohlich & Potvin, 2008). As a result, modified versions of the population-level model have been proposed, such as the targeted population-level model (i.e., targeted universalism) or the proportionate universalism model (Benach et al., 2013; Carey et al., 2015; Frohlich & Potvin, 2008; Marmot, 2010). The former consists of a population-level intervention with additional resources for a socially disadvantaged group; the latter tailors the scale and intensity of the population-level intervention to the needs of all groups along the social

gradient (Benach et al., 2013; Carey et al., 2015; Frohlich & Potvin, 2008; Marmot, 2010). However, some scholars, like McLaren and colleagues (2010), argue that the shortcomings of population-level interventions are explained not necessarily by *who* is targeted, but rather by *what* (Benach et al., 2013; Cerdá et al., 2014; Whitehead, 2007; Williams, 2017). That is, population-level interventions addressing proximal determinants, such as anti-smoking media campaigns, tend to maintain or increase social inequalities in health. Those that act upon structural determinants, for instance free or accessible public transportation, are more likely to reduce these inequalities (Benach et al., 2013; Blair et al., 2019; Cerdá et al., 2014; Whitehead, 2007; Williams, 2017).

Over the last forty years, the World Health Organization (WHO) has published numerous strategies to reduce social inequalities in health by addressing inequitable structural determinants, including Health for All by the Year 2000 (1981) and Closing the Gap in a Generation (2008). Of particular note, Health in All Policies: Framework for Country Action (2014) detailed the Health in All Policies (HiAP) approach to intersectoral collaboration in policy processes (de Leeuw & Peters, 2014; Hall et al., 2016; Kickbusch, 2010; Ollila et al., 2013; WHO, 2014). HiAP is based on the premise that structural determinants lie mostly outside of the scope and expertise of the health and public health sectors (de Leeuw & Peters, 2014; Hall et al., 2016; Kickbusch, 2010; Ollila et al., 2013; WHO, 2014). Intersectoral collaboration between public health and other sectors (e.g., agriculture, transportation, education, and justice) is thus required for designing and implementing policies to improve population health and reduce social inequalities in health (de Leeuw & Peters, 2014; Hall et al., 2016; Ollila et al., 2013; WHO, 2014). This involves embedding these health-related objectives within policies in other sectors to ensure those policies do not negatively impact health or social inequalities in health (Kickbusch, 2010; Ollila et al., 2013; WHO, 2014). HiAP also promotes collaboration between government structures often characterised by "silo culture": where sectors keep to themselves (de Leeuw & Peters, 2014; Hall & Jacobson, 2018; Ollila et al., 2013). Thus, actors from different sectors must actively dismantle institutional barriers to achieve HiAP goals (de Leeuw & Peters, 2014; Hall & Jacobson, 2018; Ollila et al., 2013; WHO, 2014).

In response to WHO recommendations, many high-income countries and regions developed intersectoral health equity strategies focusing on both structural and proximal

determinants (Fisher et al., 2017; Gagnon et al., 2008; Graham, 2004a, 2009; Lynch, 2017; Raphael & Bryant, 2016; Storm et al., 2011; van Eyk et al., 2017). Yet these strategies and associated policies have tended towards reducing or preventing health problems by focusing on proximal determinants, a phenomenon known as "the lifestyle drift" (Baker et al., 2017; Cohen & Marshall, 2016; Dahlgren & Whitehead, 1991; M. Douglas, 2016; Galea & Vaughan, 2021; Graham, 2009; Lynch, 2017; Morrison et al., 2014; Orton et al., 2011; Smith et al., 2018; van Eyk et al., 2017). Further, many policies steer away from health equity to focus intervention goals on general health improvement (van Eyk et al., 2017). For instance, in 2005, Canada adopted the Pan-Canadian Integrated Healthy Living Strategy, which aimed to "improve overall health outcomes and reduce health disparities" (ACPHHS, 2005, p. 2). Although this strategy acknowledges the importance of acting on structural determinants to reduce social inequalities in health, suggested policy actions are limited to improving healthy eating, promoting physical activity, and increasing resources and opportunities to access healthy foods and physical activity (ACPHHS, 2005; Graham, 2009). This strategy contains limited reference to addressing the structural determinants reproducing these social inequalities in the first place.

Public health practitioners and policy makers privilege policies addressing proximal determinants because they provide concrete and measurable short-term outcomes (Benach et al., 2013; Montini & Bero, 2001; Morrison et al., 2014; Orton et al., 2011; Smith et al., 2018). They further contend that the logistics of policies aiming to reduce social inequalities in health by acting on structural determinants are too complex, difficult to evaluate, time consuming, and politically contentious (Baker et al., 2017; Blackman et al., 2009, 2012; Douglas, 2016; Hall & Jacobson, 2018; Lynch, 2017; Smith et al., 2018; van Eyk et al., 2017). Research has also underlined some of the many challenges to intersectoral collaboration, notably convincing other sectors to prioritise health and health equity in policy design (Gagnon et al., 2008; Greer & Lillvis, 2014; Hall & Jacobson, 2018; Smith & Weinstock, 2019; van Eyk et al., 2017). Indeed, equity is not necessarily a nonpartisan political value, and consequently, some sectors give it a low to no priority (Hall & Jacobson, 2018; van Eyk et al., 2017). Similarly, decision makers vary in their understandings of health, with some fostering more behavioural perspectives over structural ones (Fisher et al., 2017). It is also a given that sustained collaborations may be challenged by government structure that fluctuates in response to shifts in political power (Greer & Lillvis, 2014).

As an important and current example of both social inequalities in health and population-level policy responses, I would be remiss to not acknowledge the COVID-19 pandemic during which this thesis was written. The spread of the virus has exposed and exacerbated the severity of existing social inequalities in health, even in a high-income country like Canada (Bambra et al., 2020; Khare et al., 2020; McCready et al., 2021; Tircher & Zorn, 2020). Those hit hardest by the virus and the population-level measures to prevent its propagation are the most socially disadvantaged, including women, the elderly, people with chronic health conditions or disabilities, racialised groups and people who are unemployed or with precarious employment (Bambra et al., 2020; Tircher & Zorn, 2020). Unfortunately, and problematically, only sparse data has been collected in Canada regarding social inequalities of COVID-19 cases and associated mortality (Blair et al., 2021). However, one example of such data is found in neighbourhood-stratified data collected in Montreal: as of March 30, 2021 (just over a year since the first lockdown measures in Quebec), there had been 8266 cumulative cases in one low SES, predominantly immigrant neighbourhood, compared with 656 cumulative cases in a wealthy, predominantly white neighbourhood (DRSP-M, 2021).

The dire consequences of the pandemic on people's livelihoods exposed the need for structural policies to protect those most affected (Bryant et al., 2020; McCready et al., 2021). Canada's federal and provincial governments adopted social protection policies to alleviate those consequences. For example, the Canadian Emergency Response Benefit (CERB), which provided rapid financial support for a six-month period (March 15 to September 26, 2020) to Canadians who had lost their employment due to COVID-19 (Bryant et al., 2020; Government of Canada, 2020). It has since been integrated in Canada's Employment Insurance program. However, COVID-19 relief policies have not accounted for the particular needs of socially disadvantaged groups, nor the unintended consequences of policies on those groups (Khare et al., 2020; McCready et al., 2021; Mykhalovskiy et al., 2020; Mykhalovskiy & French, 2020). The lack of data on social inequalities in health contributes to erasing the needs of socially disadvantaged groups, and thus exacerbating social inequalities in health (Bambra et al., 2020; Blair et al., 2021). This global crisis clearly illustrates the need for structural policies to protect the population, specifically those who are socially disadvantaged. Policy makers must also consider the potential and actual unintended consequences of their policies as well as needs of socially disadvantaged

groups (Bryant et al., 2020; Khare et al., 2020; McCready et al., 2021; Mykhalovskiy et al., 2020; Mykhalovskiy & French, 2020; Tircher & Zorn, 2020).

1.2. Why study tobacco control policies and social inequalities in smoking?

This thesis specifically investigates the relationship between tobacco control policies (e.g., smoke-free policies and restrictions to tobacco industry products, including graphic health warnings on tobacco-related products) and social inequalities in smoking. Tobacco control policies – that aim to improve population health by preventing smoking initiation, protecting people from second-hand smoke (SHS), and encouraging cessation – tend to intervene at a population-level and focus on intermediary determinants (e.g., smoke-free environments) and structural determinants (e.g., changing smoking norms; Gore & Kothari, 2013; Whitehead, 2007). In Canada, and other high-income countries, tobacco control policies prevail as public health's most lauded and championed intervention due to their success in smoking denormalisation and their association to significant reductions in smoking prevalence (CDC, 2011; Levy et al., 2004; Warner & Mendez, 2010). Yet, as population-level smoking prevalence significantly decreased, social inequalities in smoking increased and persist, despite continued tobacco control efforts (Corsi et al., 2014; Warner & Mendez, 2010). It is troubling that tobacco control policies, meant to protect the entire population, may be benefiting more privileged social groups than socially disadvantaged groups. Additionally, as some of these policies are structural, this outcome contradicts much of the literature advocating for structural-focused interventions to reduce social inequalities in health. Faced with this paradox, this thesis aims to better understand how tobacco control policies might affect social inequalities in smoking by examining the Quebec tobacco control policy context, where smoking is highly regulated and denormalised, and where significant social inequalities in smoking have been observed (Gagné et al., 2020; Généreux et al., 2012; Lasnier et al., 2019). This in turn may contribute to informing and untangling the relationship between other public health policies and social inequalities in health.

1.3. A novel theoretical approach to study social inequalities in health

Many public health and health promotion scholars have advanced the importance of theoretically-based research on social inequalities in health to facilitate new insights and a deeper understanding of how they are reproduced (Øversveen et al., 2017; Whitehead, 2007). In this

thesis, this issue is considered using an under-utilised theoretical perspective merging two theoretical approaches: intersectionality and Bacchian post-structuralism. Although these two approaches differ in various ways, their respective limitations are in part addressed by combining them. Intersectionality, with structuralist roots, focuses primarily on the reproduction of intersecting social inequalities by intersecting structural forces (Collins & Bilge, 2016; Crenshaw, 1989, 1991). The past decade has seen growing usage of intersectionality in social inequalities in health research (Bowleg, 2012; Hankivsky, 2014; Hankivsky & Christoffersen, 2008; Heard et al., 2020; Lapalme et al., 2020). The emphasis on the intersecting effects of race, gender, and/or SES, has brought greater attention to the influence of structural determinants on social inequalities in health and therefore, the need to address their inequitable distribution. However, intersectionality has primarily been employed to explore the health outcomes and experiences of disadvantaged social groups who are subject to intersecting forms of oppression from structural determinants, with little research focusing on how intersecting structural determinants come to reproduce these social inequalities in health (Gkiouleka et al., 2018; Lapalme et al., 2020).

Bacchian post-structuralism offers an analytical framework for understanding how policies, which determine how resources are distributed (WHO, 2008), function to produce certain outcomes (Bacchi, 2009). More specifically, Bacchi (2009) examines policy discourse as a mechanism to explain policy effects. Her framework involves unpacking the "problematisation" that drives specific policy – that is, what knowledge, assumptions, beliefs, and values are involved in transforming a social phenomenon, for instance smoking, into a policy problem (Bacchi & Goodwin, 2016). Post-structural concepts like normalisation and subjectification (i.e., the changing of social norms through dominant discourses) elucidate how policy discourse shapes perceptions and the regulation of certain social phenomena as well as the construction and reinforcement of social hierarchy (Bacchi, 2009; Bacchi & Goodwin, 2016). As a result, power relations shaped by, and recursively, shaping and reinforcing policy discourse can also be identified to further illuminate the reproduction of social inequalities. Bacchi's theoretical concepts are thus particularly useful in highlighting how discourse shapes tobacco control policies to affect social inequalities in smoking in Quebec. Intersectionality complements Bacchi's framework by paying particular attention to the production of diverse social identities, and importantly, how they may intersect to form specific experiences of privilege and/or oppression.

Further, intersectionality sheds light on the structural determinants involved in reproducing social inequalities by examining which dominant discourses shape policy, how they do so, who they affect differently, and which discourses are silenced.

Combining the different theoretical perspectives of intersectionality and Bacchian post-structuralism brings unique insights to research pertaining to the relationship between social inequalities in smoking and tobacco control policies. More specifically, by unpacking the problematisation underlying tobacco control policy discourse, namely the possibly reductive representations of smoking and of being a "smoker" versus a "non-smoker" (Bell et al., 2010; Dennis, 2013, 2015; Frohlich et al., 2012; Poland, 2000), Bacchian post-structuralism permits to identify the frameworks shaping these problematisations and their limitations in constructing a more complex understandings (Bacchi, 2009). This is different than other theoretical perspectives that do not question problematisations, that is that they take for granted that a social phenomenon is indeed a problem (Bacchi, 2009). On the other hand, intersectionality, as a contemporary theoretical perspective informed by the experiences of disadvantaged populations, ensures that unpacking tobacco control policy discourse considers how power relationships are reproduced and reinforced and how these power relations might affect certain social groups differently, especially those that tend to be overlooked in research (Collins & Bilge, 2016; Crenshaw, 1989, 1991).

This combined approach does have limitations. Although some of the concepts of interest (e.g., normalisation, subjectification, power relations, social identities) for intersectionality and Bacchian post-structuralism overlap, some concepts may receive more analytical attention than others. This may be especially true since Bacchi has developed an explicit analytical framework incorporating post-structural concepts (Bacchi, 2009), while there is yet to be a common framework from which to apply intersectionality (Abrams et al., 2020; McCall, 2005). It may thus be challenging to apply intersectionality, chiefly to examine how intersecting macro structural determinants shape tobacco control policy discourse to inequitably affect different social groups. Despite these limitations, a combined intersectional and Bacchian post-structural approach is not only novel for research on social inequalities in smoking and tobacco control policy, but can also contribute to developing a more complex and thorough understanding of this thesis' objective, that

is, of the ways in which population-level tobacco control policies affect social inequalities in smoking.

1.4. Structure of the thesis

For the purposes of transparency, I acknowledge that I experience many privileges and, in some cases, disadvantages, as a result of the intersecting identities that form who I am and how I experience the world. I am a white, middle-class woman with a high-level of education, with a background in social work, and experience with a mental health-related disability. I am a citizen of a high-income Western country and a Francophone who spent my childhood in a Francophone-minority context. With regard to smoking, I have smoked occasionally as a teenager and young adult, but never enough to consider myself "a smoker". These identities have, intentionally or not, shaped my perspectives on and approaches to my research for this thesis. I have done my best to remain aware of the potential influence of my background on this research, sought to understand perspectives different from my own by reading qualitative research on experiences of socially disadvantaged people who smoke and by participating in conducting qualitative research (see Appendixes I and II), as well as employed a reflexive journaling approach while collecting and analysing data.

This thesis is comprised of six chapters, including this introduction and three scientific articles. Chapter 2 explores the literature on social inequalities in smoking, tobacco control policy in Canada and Quebec, and the relationship between these policies and social inequalities in smoking. I drew on conceptual and empirical literature from a variety of disciplines to provide an overall understanding of this relationship. This literature review also details the underpinnings of the combined theoretical approach used to guide this thesis and its relevance to the project. In particular, Article 1, the first thesis article, demonstrates the importance of intersectionality in social inequalities in health research and discusses how it could be better used to advance this field of research. This chapter concludes with the thesis research question and objectives. Chapter 3 outlines the study design taken in this thesis and details the insights and limitations of the different data collection methods (i.e., parliamentary transcriptions and TCP interviews) and those of the two Bacchian approaches employed to discursively analyse these data.

Chapter 4 presents the thesis findings in the form of two empirical articles: articles 2 and 3. Article 2 highlights the findings of the critical discourse analysis, based on transcripts from parliamentary commission discussions with various tobacco control stakeholders and legislators related to a 2015 Quebec tobacco control policy. Article 3 shifts the attention from a specific policy to the practices of tobacco control practitioners in Quebec who have been working with new governmental priorities to reduce social inequalities in smoking. Chapter 5 contextualises the findings from these articles in relation to conceptual and empirical findings in the literature, namely, relating to moral regulation, stigma, and power relations in policy development. This discussion of the thesis findings addresses the thesis question and objectives, and additionally explores insights regarding potential directions for equitable policy design. The concluding Chapter 6 focuses on the contributions of this thesis to the public health policy and social inequalities in health literature and identifies future directions for research and practice.

CHAPTER 2. LITERATURE REVIEW

Gaining a comprehensive understanding of the relationship between tobacco control policies and social inequalities in smoking requires knowledge from empirical and conceptual literature derived from various disciplines, including epidemiology, social epidemiology, health promotion, and sociology. In some ways these perspectives complement each other by filling gaps left by others; in other ways, contrast ensues when different conclusions are drawn. In this chapter, the concepts relating to the relationship between tobacco control policies and social inequalities in smoking are detailed using the large array of available scientific literature, highlighting their convergences, divergences, as well as residual gaps in knowledge. The two theoretical approaches guiding this thesis, Bacchian post-structuralism and intersectionality, are also used to complement the empirical literature and to add greater depth to the concepts discussed. Finally, the research question and research objectives of the thesis are presented.

2.1. The different meanings of smoking

Smoking is a social phenomenon that has held, and continues to hold, various social meanings (Rudy, 2005). In Canada, during the 19th and early 20th centuries, smoking was viewed as a symbol of wealth and social privilege and was thus reserved for men, particularly those who were wealthy and white (Collishaw, 2009; Rudy, 2005). However, some groups, notably Christian women's organisations, denounced smoking as a morally abject practice, and viewed second-hand smoke (SHS) as bothersome (Bell, 2011; Rudy, 2005). With the expansion of cigarette production at the end of the First and Second World Wars, smoking became increasingly available to the general public (Collishaw, 2009; Rudy, 2005; Warner & Mendez, 2010). Indeed, smoking became a common, everyday social practice in the 1950-60s, as approximately 50% of the population smoked (Corsi et al., 2014; Reid et al., 2014). Thus, the social meaning of smoking was transformed; rather than distinguishing social hierarchy, as it once did, smoking became a reflection of social conformity (Brandt, 1998; Rudy, 2005). The social acceptability of smoking was also supported by tobacco industry marketing (Rudy, 2005).

Around the same time, in the early 1950s, clinical and epidemiological research on the harmful effects of smoking was making headway (Collishaw, 2009). The publication of studies, notably by Wynder and Graham (1950) as well as Doll and Hill (1950) first alerted the public to the effects of smoking on lung cancer (Collishaw, 2009). It was, however, the Surgeon General's

Report of 1964 (U.S. Department of Health and Human Services, 1964), informed by the latest developments in clinical and epidemiological research, that mobilised the Canadian government to begin protecting the public from tobacco products (Collishaw, 2009; Stuber et al., 2008). Henceforth, there was an increased development of various tobacco control policies, with a priority on transforming the social acceptability of smoking (i.e., denormalising smoking) in order to reduce smoking prevalence (Collishaw, 2009; Lavack, 1999). In parallel, smoking prevalence gradually decreased (Corsi et al., 2014), and by 2019, only 14.8% of adult Canadians smoked (Statistics Canada, 2021). Smoking prevalence has since plateaued, with only slight decreases observed over the last four years (Statistics Canada, 2021). This observation holds true in Quebec. Furthermore, significant reductions in smoking prevalence have been reported in Quebec notably since 2000, when smoking prevalence was about 29.5%, and then declined to 17% in 2019 (Statistics Canada, 2021). It has, nonetheless, hovered between 18.6% and 17% between 2015 and 2019 respectively (Statistics Canada, 2021).

As smoking prevalence decreased, smoking was increasingly viewed as a threat to health, principally due to clinical and epidemiological evidence (Collishaw, 2009; U.S. Department of Health and Human Services, 1964). In essence, this research substantiates that cigarette smoking is a leading preventable cause of mortality (Doll et al., 2004), responsible for 21% of mortalities in Canada (Généreux et al., 2012; Jones et al., 2010). Indeed, those who smoke are at a higher risk of contracting smoking-related illnesses, including various cancers as well as cardiovascular and respiratory diseases (Doll et al., 2004; Fielding, 1985; Liang et al., 2009). Further, it is not only the person who smokes who is subject to a higher risk of morbidity and early mortality, but those exposed to second-hand smoke (SHS), particularly indoors or in enclosed spaces, are also vulnerable (Cao et al., 2015; Fielding, 1985; Heiss et al., 2008; Pope et al., 2001). Non-smokers exposed to SHS have a higher risk of developing lung cancer, cardiovascular and respiratory diseases, and of aggravating pre-existing respiratory illnesses (Cao et al., 2015; Fielding, 1985; Heiss et al., 2008; Pope et al., 2001). In sum, the heavy burden smoking poses on population health and the health care system has made smoking a priority issue for public health (Health Canada, 2017; MSSS, 2020; Tessier et al., 2013).

Critical scholarship from the social sciences have brought forth different perspectives on smoking, SHS, and more recently third-hand smoke (THS, i.e., the chemical residue of smoke absorbed by indoor surfaces) than mainstream public health perspectives principally informed by clinical and epidemiological evidence (Bell, 2011, 2014; Dennis, 2013; Mair & Kierans, 2007). Mairs and Kierans (2007) importantly contextualise tobacco research as aligned with tobacco control objectives of protecting non-smokers, preventing smoking, and encouraging cessation. This research therefore seeks to better understand smoking prevalence by social groups, varying levels of smoking risk for different social groups, and individual and environmental factors influencing smoking risk (Mair, 2011; Mair & Kierans, 2007). This evidence is then used to inform and justify tobacco control measures (Bell, 2011; Mair & Kierans, 2007). Research that reproduces certain public health values and assumptions is what Mykhalovskiy and colleagues (2019) refer to as research "in" public health, or in this case "in" tobacco control. This opposes research "of" tobacco control, which does not serve to inform the tobacco control agenda of ending smoking, but offers a critical perspective of tobacco control. Critical scholars argue that research "in" tobacco control reproduces understandings of smoking that are limited to considering smoking as health threat. Consequently, smoking is viewed as irrational and morally condemnable, and thus, people who smoke are depicted as irresponsible, lacking self-control, and/or addicted (Mair & Kierans, 2007). Developing a more complex understanding of smoking, namely as a social phenomenon embedded in social, cultural, historical, and political contexts, is therefore challenging for research "in" tobacco control.

Studies positioned outside of tobacco control, or "of" tobacco control, have shed light on the gaps in mainstream tobacco control understandings of smoking. For instance, some qualitative research has uncovered some of the complexity of smoking, describing it beyond its health effects, but more so as a social practice that may also incite pleasure, allow reflection, diffuse anxiety, and facilitate social interactions (Antin et al., 2017; Bell, 2013; Dennis, 2013; Glenn et al., 2017; Hoek & Smith, 2016; Moore et al., 2009; Peretti-Watel & Constance, 2009; Sanders et al., 2019; Siahpush et al., 2006; Thompson et al., 2007; Triandafilidis et al., 2017a). Moreover, Bell's work (Bell, 2011, 2014) importantly underlines that mainstream tobacco control understandings of smoking are not solely based on clinical and epidemiological evidence, but also on moral views of smoking, and in particular, SHS. Indeed, tobacco control measures targeted SHS, and

increasingly THS, before evidence of their health effects was available. While such evidence has been developed in recent years, this evidence presents some limitations because of the complexity inherent to studying the health effects of SHS and THS, especially regarding outdoor exposure. Therefore, the moral character of SHS and THS, whereby people who smoke bother non-smokers with smoke, cannot be detached from our understandings of these phenomena and corresponding tobacco control measures. As Bell states (2011, p. 49): "… the subjectively experienced abjectness of cigarette smoke far more than the 'objectively' demonstrable harms to health it causes ultimately explains both popular and public health responses to the substance."

2.2. Social inequalities in smoking

Although the significant decline in smoking prevalence in Canada and other high income countries has been celebrated in the public health sphere, this decline does not reflect differences experienced by social groups, with some groups displaying higher smoking prevalence than others (Amroussia et al., 2020; Barbeau et al., 2004; Barnett et al., 2004; Bauld et al., 2007; Corsi et al., 2014; Généreux et al., 2012; Giskes, 2005; Graham et al., 2006; Hiscock et al., 2012; Jones et al., 2010; King et al., 2019; Lasnier et al., 2019). Some research – principally interdisciplinary scholarship at the intersection of the social sciences and public health, such as social epidemiology, health promotion, and health sociology – uses the term "social inequalities in smoking" to denote these differences, as is the case in this thesis. The intent of using this term is to underscore that these inequalities do not represent random differences in the population, but rather, are the result of inequitable distribution of structural determinants (e.g., access to education, income, employment, health and social services, and safe and secure housing) that place those with lesser means at a higher risk of smoking than those with more privileged (Adler & Newman, 2002; Frohlich et al., 2010; Goldberg, 2014; Graham et al., 2006; Poland, 2006).

Social inequalities in smoking are often studied in relation to individual-level characteristics, namely, SES, gender, age, race, sexual identity, as well as mental health and disability (Agrawal et al., 2008; Amroussia et al., 2020; Barbeau et al., 2004; Barnett et al., 2004; Corliss et al., 2014; Corsi et al., 2014; Généreux et al., 2012; Graham, 1994, 1996; Graham et al., 2006; Hiscock et al., 2012; Jefferis et al., 2004; Jones et al., 2010; King et al., 2012; King et al., 2019; Sanders et al., 2019). Much of the literature, however, examines social inequalities in

smoking according to SES, with steeper smoking prevalence observed among low SES groups as compared with high SES groups (Agrawal et al., 2008; Amroussia et al., 2020; Barbeau et al., 2004; Corsi et al., 2013; Généreux et al., 2012; Hiscock et al., 2012; King et al., 2019). For example, in 2015-2016, 12.9% of people who smoked in Quebec had a university degree while 24.8% had not completed a high school education (Lasnier et al., 2019). Low SES individuals also tend to start smoking at younger ages, smoke more cigarettes per day, and have lower cessation rates (Agrawal et al., 2008; Barbeau et al., 2004; Généreux et al., 2012; Giskes, 2005; Green et al., 2016; Hiscock et al., 2012; Jefferis et al., 2004; Jones et al., 2010; King et al., 2019; Maralani, 2013; Reid et al., 2010; Siahpush et al., 2006; Tjora et al., 2012). They are additionally exposed to more SHS than higher SES individuals (Chu et al., 2019; Gagné et al., 2020; Kuntz & Lampert, 2016; Lasnier et al., 2012; Max et al., 2009; Montreuil et al., 2017). For instance, socially disadvantaged non-smoking youths and adults in Montreal are more likely to be exposed to SHS in private vehicles than those from more privileged groups (Gagné et al., 2020; Lasnier et al., 2012, 2019; Montreuil et al., 2017). This evidence demonstrates that social inequalities in smoking translate to social inequalities in health such that these socially disadvantaged groups carry a disproportionately heavier burden of smoking-related illness (Kulik et al., 2013; Mackenbach et al., 2004).

Although much research has focused on the individual-level characteristics of social inequalities in health, substantial quantitative and qualitative research has also documented contextual factors that shape social inequalities in smoking, namely physical and social environments (Antin et al., 2017; Bernard et al., 2007; Caryl et al., 2020; Frohlich et al., 2002; Généreux et al., 2012; Glenn et al., 2017; Haines-Saah et al., 2013; Kravitz-Wirtz, 2016; McCready et al., 2019; Paul et al., 2010; Pearce et al., 2012; Stead et al., 2001; Thompson et al., 2007). For example, studies demonstrate that people with a low SES tend to inhabit and access low SES environments that are often characterised by high smoking prevalence and permissive smoking norms (Caryl et al., 2020; Frohlich et al., 2002; Généreux et al., 2012; Glenn et al., 2017; McCready et al., 2019; Stead et al., 2001; Thompson et al., 2007). As such, people with a low SES are frequently exposed to smoking, including from friends and family, as well as tobacco products and retailers (Caryl et al., 2020; Glenn et al., 2017; McCready et al., 2019; Stead et al., 2001; Thompson et al., 2007). People with a low SES have also reported greater pressure to smoke and

less encouragement to quit (Frohlich et al., 2002; Giskes, 2005; Glenn et al., 2017; Kravitz-Wirtz, 2016; Paul et al., 2010; Pearce et al., 2012; Stead et al., 2001). Even when they did want to quit, low SES people who smoke have expressed a lack of access to resources to help them quit and/or deter them from initiating (e.g., knowledge, social connections, and support), while higher SES individuals have greater access to such resources (Hoek & Smith, 2016; Honjo et al., 2006; Siahpush et al., 2006).

Research "of" tobacco control (i.e., research that does not serve tobacco control objectives) has played an important role in highlighting the limits to tobacco research understandings of social inequalities in smoking. First, much clinical and epidemiological research examines the relationship between smoking and health without considering how inequitably distributed social factors, such as SES, race, and/or gender, may compound and/or exacerbate the health effects associated to smoking. Second, some research "of"' tobacco control has demonstrated that tobacco control policies can contribute to increasing and/or maintaining social inequalities in smoking (Frohlich et al., 2010, 2012; Gilbert, 2008; Guillaumier et al., 2015a; Sanders et al., 2019; Thompson et al., 2007). This type of inquiry would not likely be possible for research "in" tobacco control. Indeed, some critical tobacco control scholars have been accused of working in service of the tobacco industry because their research critically examined tobacco control policies (Bell, 2013; Dennis, 2013; Mair & Kierans, 2007). However, better understanding how social inequalities in smoking are reproduced is key to improving the health and well-being of populations living in disadvantage, which includes critically exploring the relationship between tobacco control policies and social inequalities in smoking. As Bell (2013, p. 39) states: "There must also be a place for research that challenges taken-for-granted perspectives embedded in tobacco control (and not just so that tobacco control can operate more effectively)."

2.3. Tobacco control policies

Tobacco control policies consist of various population-level public health interventions that aim to reduce smoking prevalence, prevent smoking uptake, and protect the population from the harms of smoking and SHS in order to reduce smoking-related morbidity and mortality in the population (CDC, 2014; WHO, 2003). To this end, tobacco control policies seek to change social, physical, and economic environments to prevent smoking and reduce smoking prevalence

(Thomas et al., 2008). In Canada, tobacco control policies are implemented through federal, provincial, or municipal legislation, depending on the type of intervention (Collishaw, 2009). They are supported by public health institutions as well as federal, provincial, and municipal advocacy groups, such as the Physicians for a Smoke-Free Canada, the Canadian Cancer Society, the Non-Smokers' Rights Association, the Canadian Public Health Association, and particularly in Quebec there is notably the Quebec Coalition for Tobacco Control and the Conseil québécois sur le tabac et la santé.

In Canada, the tobacco control movement was spearheaded by Christian groups at the end of the 19th century, notably the Women's Christian Temperance Union (Collishaw, 2009; Rudy, 2005). They perceived smoking as a moral vice and advocated to eradicate smoking from public social life with policies like increased taxation of tobacco products and smoke-free trams in Montreal (Collishaw, 2009). However, these policies had modest effects on smoking prevalence, as the popularity of smoking grew during the mid 20th century to become common social practice (Collishaw, 2009; Rudy, 2005). Although mounting clinical and epidemiological evidence of the negative consequences of smoking on health in the 1950-1960s did foster some tobacco control policies in Canada, these were limited to taxation measures (Collins & Procter, 2011). It was the accumulated clinical and epidemiological evidence of the association between SHS and lung cancer in non-smokers, followed by the Surgeon General's 1986 report asserting this association (U.S. Department of Health and Human Services, 1986), that prompted the Canadian government to intervene on smoking beyond taxation measures (Collins & Procter, 2011).

The end of the 20th century was marked by the implementation of many tobacco control policies in multiple high-income countries, including Canada. In 2003, the WHO developed the Framework Convention for Tobacco Control (FCTC; WHO, 2003) to guide the international community in implementing tobacco control policies. The framework outlines key tobacco control strategies, subdivided by The International Tobacco Control Evaluation project (ITC Project, 2013) in five categories. The following descriptions of each of these policies also includes their development in Canada and, where relevant, Quebec (see Figure 1, p.39-40 for a timeline of tobacco control policy development in Canada and Quebec):

1) Health warning labels and packaging descriptors depict, textually and/or pictorially, the health risks of smoking on cigarette packages. These warnings are designed to inform the public, especially people who smoke, of these dangers in the hopes of motivating cessation and preventing initiation (ITC Project, 2013). The Tobacco Products Control Regulations of 1989 was the first Canadian regulation of this kind and mandated the inclusion of text-only health warnings on all cigarette packaging (Collishaw, 2009; ITC Project, 2013). In 2001, Canada was the first country to introduce pictorial warning labels, which were required to cover 50% of the front and back of product packages (Collishaw, 2009; ITC Project, 2013; Reid & Hammond, 2015). This was expanded to 75 % coverage in 2012 with information on cessation resources included (Reid & Hammond, 2015). Australia was the first country to implement plain packaging in 2012 (WHO, 2016). Plain packaging policy prohibits all branding on cigarette packages and standardises their size and colour (ITC Project, 2009). In Canada, plain packaging was officially adopted in 2019 under the Tobacco and Vaping Products Act (formerly The Tobacco Products Act; Government of Canada, 2018b).

2) Pricing and taxation of tobacco products aim to prevent smoking uptake and promote cessation by rendering cigarettes less affordable (ITC Project, 2013; Tessier et al., 2013; WHO, 2015). In Canada, cigarettes are subjected to two federal taxes (i.e., federal excise tax and goods and services tax) and one provincial excise tax (MSSS, 2020; Reid & Hammond, 2015). Tax fluctuations have been observed in Canada since the 1870s, with notable increases in the 1950s and the 1980s as well as a rollback in 1994 (MSSS, 2020; Reid & Hammond, 2015). Since 2000, taxes have only increased (Collishaw, 2009; ITC Project, 2013; Reid & Hammond, 2015), though in Quebec, increases have stagnated since 2014 (MSSS, 2020). Regarding the legal purchasing age of tobacco products, Quebec's 1998 Tobacco Act proscribed minors (i.e., <18 years of age) from such purchases (MSSS, 2020).

3) Tobacco advertising and promotion restrictions attempt to reduce tobacco visibility, particularly for youth, by limiting tobacco industry marketing and reducing in-store visibility of cigarettes (ITC Project, 2013). In Canada, the 1997 Tobacco Act aimed to regulate the manufacture, sale, and promotion of tobacco products (Collishaw, 2009; ITC Project, 2013; Reid & Hammond, 2015). The Cracking Down on Tobacco Marketing Aimed at Youth Act, passed

federally in 2009, prohibited print advertising of tobacco products as well as flavourings in cigarettes (except menthol) to deter youth from smoking (Non-Smokers' Rights Association, 2011). Nonetheless, exposure to cigarette marketing persists through other media, notably movies and television, not covered by this legislation (Collishaw, 2009; ITC Project, 2013). In Quebec, the 1998 Tobacco Act prohibited tobacco industry marketing during public events, and a 2005 amendment proscribed point-of-sale tobacco products displays (MSSS, 2020; Reid & Hammond, 2015).

4) Smoke-free legislation prohibits smoking in specific locations, notably in indoor public spaces, some indoor private spaces (i.e., vehicles), and in some outdoor public spaces. Such legislation aims to protect non-smokers from SHS exposure and to reduce the visibility of smoking (Collins & Procter, 2011; Hyland et al., 2012; Tessier et al., 2013; WHO, 2003). In Canada, smoke-free policies are legislated provincially and municipally, although at the federal level, Canada passed the Non-Smokers' Health Act in 1988 prohibiting smoking in all government workplaces, banks, and inter-provincial public transportation (Reid & Hammond, 2015). Additionally, in 2008, federal prisons became smoke-free (Reid & Hammond, 2015). Quebec passed its first smoke-free policy, An Act to Protect Non-Smokers in Certain Public Places, in 1986, prohibiting smoking in certain public places, notably government workplaces and institutions (e.g., hospitals and schools; MSSS, 2020). The policy was amended in 1998 (renamed the Tobacco Act) to include additional smoke-free spaces, with a notable amendment in 2005 proscribing smoking in all indoor workplaces and public spaces including restaurants, bars, bingo halls, bowling alleys, and casinos (MSSS, 2020; Smoking and Health Action Foundation, 2015).

5) Education and support for cessation include mass media campaigns to educate the public about the health effects of smoking, the benefits of cessation, and the tobacco industry's tactics to encourage smoking (ITC Project, 2013; Tessier et al., 2013; WHO, 2003). Such campaigns also disseminate messages depicting smoking as unattractive to prevent initiation and promote cessation (Haines-Saah et al., 2015; Montreuil, 2017). In Canada, there were 15 separate national mass media campaigns between 2001 and 2006 as a part of the federal tobacco control strategy (ITC Project, 2013). Notable among these was the Heather Crowe Campaign, from 2002 to 2004, featuring testimony by a non-smoking waitress who was dying of lung cancer as a result of SHS

exposure (Lovell, 2003). Since 2010, decreased federal funding for these campaigns has led to their reduced visibility (ITC Project, 2013; Non-Smokers' Rights Association, 2011). Mass media campaigns have also been broadcasted in Quebec, namely since 2001, by the Ministry of Health and Social Services (MSSS) and by community organisations (Montreuil, 2017; MSSS, 2018). Many of these campaigns are targeted to preventing youth smoking, such as "*Y'a rien de plus dégueu qu'une cigarette*" (2011-2012) and "*Magane pas tes organes avec la boucane*" (2013-2014; Montreuil, 2017).

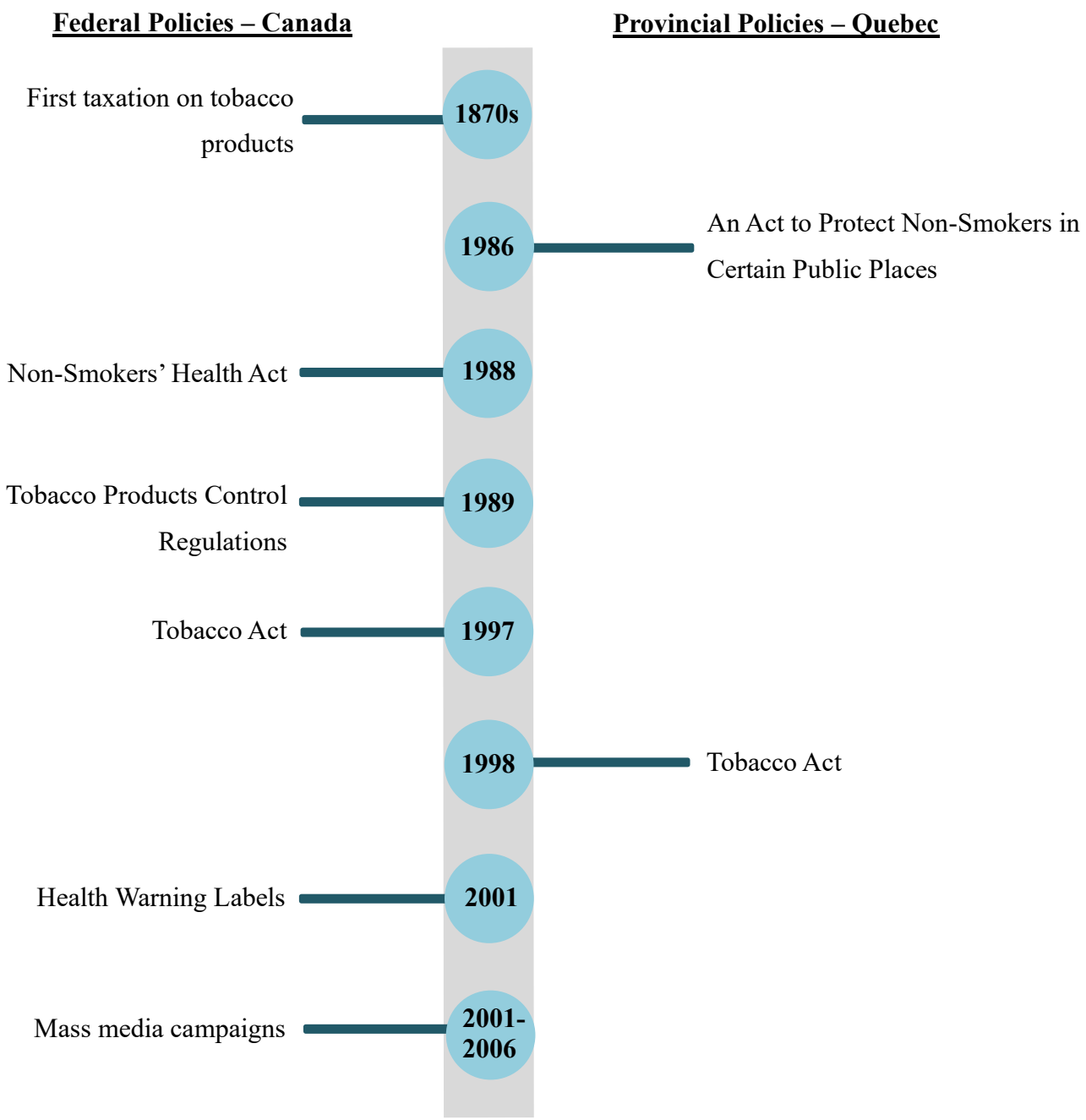
Beyond these tobacco control policy categories, the Canadian government as well as some provincial governments, develop tobacco control strategies to guide their next steps. At the federal level, Canada updated the Canada Federal Tobacco Strategy in 2017, setting priorities for future tobacco control interventions and goals for smoking prevalence reduction (Health Canada, 2017). Notably, this document details Canada's "tobacco endgame", an internationally used strategy aiming to significantly reduce smoking prevalence. Canada's endgame is to achieve a less than 5% smoking prevalence by 2035. To do so, the strategy prioritises improving access to smoking cessation and harm reduction resources (including electronic cigarettes), updating their mass media campaigns to inform the public of the harms of smoking and tobacco-related products, as well as adopting plain packaging (achieved in 2019). The strategy further notes the importance of increasing targeted tobacco control programs for disadvantaged and Indigenous populations deemed at a high risk of smoking.

Although many high-income countries have observed reductions in smoking prevalence following the implementation of tobacco control policies, the FCTC and tobacco control advocates continue to campaign for increased smoking restrictions (Health Canada, 2017; MSSS, 2020; Warner & Mendez, 2010; WHO, 2019). Heeding these calls, Quebec amended the Tobacco Act in 2015 (last amendment in 2005) renaming it An Act to Bolster Tobacco Control (L44[1]; QNA,

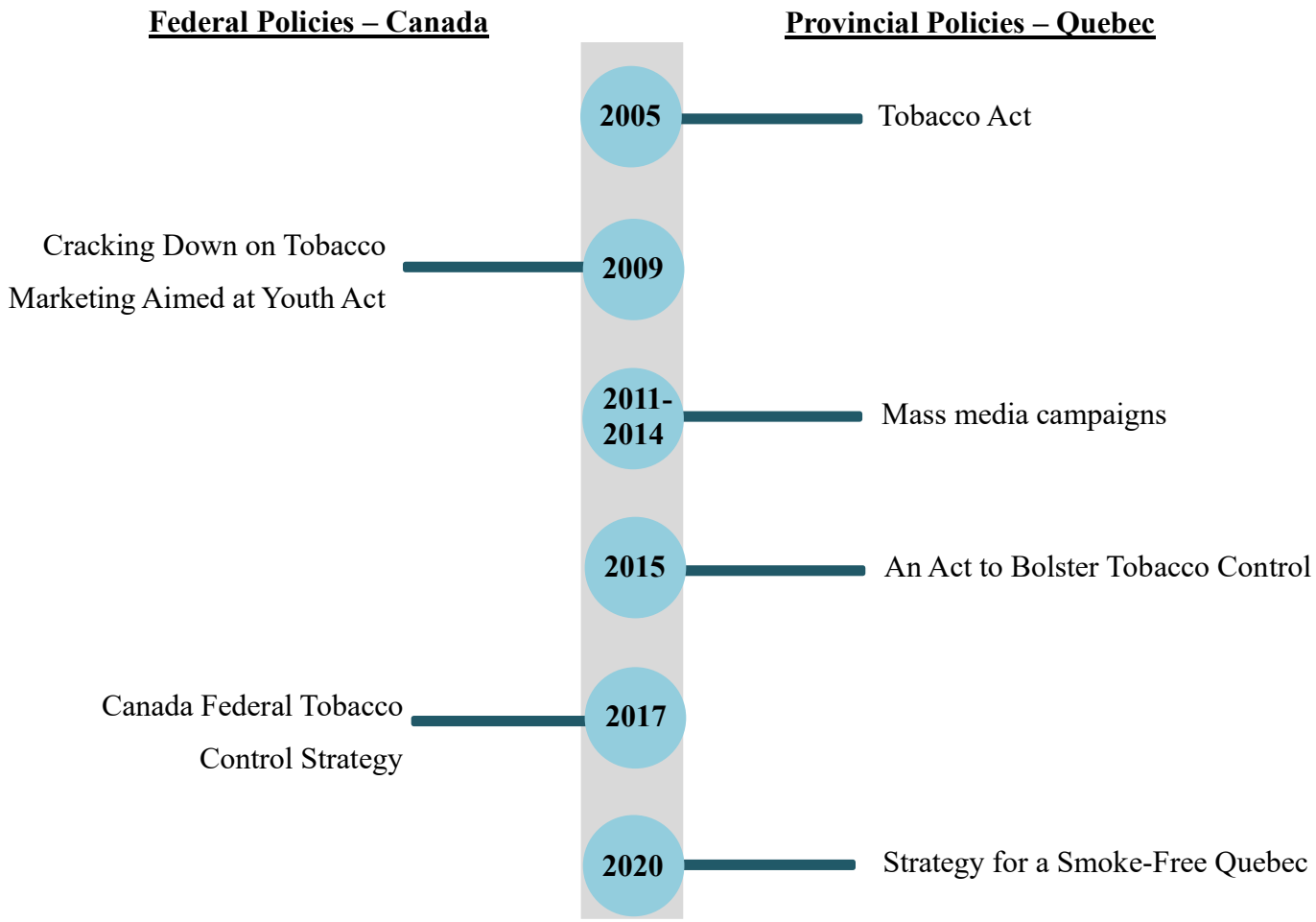
[1] In this thesis, An Act to Bolster Tobacco Control is abbreviated to "L44". When this law was proposed to the Quebec National Assembly it was attributed the number 44 and became referred to as Bill 44 (B44). Once bills are passed into law, their number is dropped and they are officially known under their title. However, as the title for this law is quite long, this thesis continues to use the number 44 with the letter "L" representing law rather than the letter "B" for bill.

2015). Amendments to this law were designed to respond to three objectives: 1) prevent youth smoking initiation; 2) protect non-smokers, especially children and youth, from SHS exposure;

Figure 1. Timeline of Tobacco Control Policies in Canada and Quebec[2]



[2] It is important to note that the first tobacco control law in Quebec was adopted in 1986 (An Act to Protect Non-Smokers in Certain Spaces) and all subsequent laws are amendments of the amended law that preceded them.



and 3) encourage people who smoke to quit. To achieve these objectives, L44 notably prohibits smoking on restaurant and bar terraces, in playgrounds, nine meters from any door or window that opens, in vehicles with children under 16 years present, and obliged health and social service institutions to be equipped with a smoke-free policy. Further, electronic cigarettes were officially designated as a tobacco product, thus subjecting them to the same smoke-free restrictions as cigarettes. L44 also proscribed all flavoured cigarettes, enlarged warning messages on cigarette packages, and increased fines for individuals who do not respect these rules.

Since the implementation of L44, Quebec has been considered as having some of the most restrictive tobacco control measures both in Canada and internationally (MSSS, 2020). Nevertheless, this did not prevented the Quebec government from updating their tobacco control strategy in 2020, namely setting a provincial tobacco endgame to reduce smoking prevalence to 10% or less in Quebec by 2025 and placing a specific priority on reducing social inequalities in

smoking (MSSS, 2020). To this end, proposed interventions focus on further denormalising smoking, preventing youth from using tobacco products (including electronic cigarettes), encouraging smoking cessation, and strengthening prevention of SHS and THS. Examples of favoured interventions include increasing tobacco product prices, raising the legal purchasing age for tobacco-related products to 21 years, reducing the density of tobacco-related product retailers, disseminating more youth-targeted awareness campaigns on the harms of smoking cigarettes and electronic cigarettes, improving access to smoking cessation services, and creating additional smoke-free spaces (e.g., beaches, outdoor public events, and hotel rooms).

2.3.1. Smoking denormalisation: a key strategy for tobacco control policies

Although the different types of tobacco control policies have their own ways of regulating smoking or tobacco products, they all contribute to denormalising smoking (Chapman & Freeman, 2008; Hammond et al., 2006; Lavack, 1999; Voigt, 2013). This strategy acts upon social norms related to smoking, transforming them from acceptable to unacceptable (Bayer, 2008; Bell, Salmon, et al., 2010; Chapman & Freeman, 2008; Graham, 2012; Hammond et al., 2006; Kelly et al., 2018; Kim & Shanahan, 2003; Lavack, 1999; Ritchie et al., 2010; Stuber et al., 2008; Voigt, 2013). This strategy is based on the assumption that social norms significantly influence behaviours and beliefs; individuals would rather belong to society than experience the consequences of deviating from normative behaviour, such as stigmatisation and marginalisation (Bayer, 2008; Collins & Procter, 2011; Durkin et al., 2021; Kelly et al., 2018; Kim & Shanahan, 2003; Voigt, 2013). In this way, denormalising smoking can contribute to reducing smoking prevalence. As such, government institutions, public health associations and advocacy groups are explicit that their tobacco control policies intend to denormalise smoking (Americans for Nonsmokers' Rights, 2009; Canadian Public Health Association, 2011; Health Canada, 2017; MSSS, 2020), as affirmed by the Americans for Nonsmokers' Rights (2009, p. 1): "One of the most successful strategies however, was something tobacco control advocates stumbled onto about 30 years ago: encouraging society to view tobacco use as an undesirable and anti-social behaviour".

Tobacco control policies denormalise smoking by conveying the message that smoking is socially unacceptable. The ways in which this message is conveyed, however, differ. For instance,

smoke-free policies and tobacco product regulations denormalise smoking by rendering public smoking and tobacco products increasingly invisible and by sending the message that smoking is harmful to the population (Alesci et al., 2003; Brown et al., 2009; Chapman & Freeman, 2008; Hammond et al., 2006; Kelly et al., 2018; Moore, 2005; Voigt, 2013). Such policies have further contributed to transforming social representations of smoking, and by extension, people who smoke as aberrant and unacceptable (Alesci et al., 2003; Brown et al., 2009; Chapman & Freeman, 2008; Collins & Procter, 2011; Moore, 2005; Voigt, 2013). As a result, public spaces where smoking continues to be acceptable, such as parking lots and alleys, are often perceived as bleak and inhospitable, especially if one must smoke in adverse weather conditions. This reinforces the rhetoric of smoking and people who smoke as disdainful (Collins & Procter, 2011). Health warnings on tobacco products and mass media campaigns also denormalise smoking but through graphic imagery used to communicate the negative health consequences of smoking (Amonini et al., 2015; Amos et al., 2011; Gilbert, 2008; Noar et al., 2016). This imagery relies on eliciting emotions to decrease smoking's allure like disgust, discomfort, fear, regret, guilt, and shame in the hopes of motivating people to quit (Amonini et al., 2015; Durkin et al., 2021; Haines-Saah et al., 2015; Lupton, 2015; Noar et al., 2016; Thompson et al., 2009).

Some tobacco control research asserts that smoking denormalisation has successfully contributed to reducing smoking prevalence (Alamar & Glantz, 2006; Amonini et al., 2015; Azagba & Sharaf, 2013; Bala et al., 2013; Hammond, 2011; Hammond et al., 2006; Kelly et al., 2018; Kim & Shanahan, 2003; Noar et al., 2016; Wakefield et al., 2010). By portraying smoking as harmful and undesirable, studies, such as Hammond's (2011), found that anti-smoking messages helped motivate cessation, and Durkin et al.'s (2021), reported that perceiving anti-smoking attitudes from family and friends can also encourage cessation. Growing anti-smoking norms in the broader population have also increased social support for further implementation of tobacco control policies, which in return, strengthen anti-tobacco messages or "discourses" (Hammond et al., 2006; Voigt, 2013). However, other research suggests that the impact of smoking denormalisation on reducing smoking prevalence may only be observed in the short-term, as relapses and delayed smoking initiation are not considered (Sandoval et al., 2018). It is thus important for research to consider the long-term effects of smoking denormalisation to more accurately portray its impact on smoking. Much tobacco control research similarly neglects the

potential unintended consequences of anti-smoking messages, notably regarding the stigmatisation of those who continue to smoke and their impact on social inequalities in smoking (Bell, Salmon, et al., 2010; Chapman & Freeman, 2008; Haines-Saah et al., 2015; Voigt, 2013).

2.4. Tobacco control policies and social inequalities in smoking

Evidence of tobacco control policies' equity impact remains inconclusive: policies have been found to increase, decrease, or have no effects on social inequalities in smoking (Amos et al., 2011; Borland, 2006; Brown et al., 2014; Eek et al., 2010; Hill et al., 2014; Hiscock et al., 2012; Lorenc et al., 2013; Main et al., 2008; Mons et al., 2013; Schaap et al., 2008; Thomas et al., 2008). For example, smoke-free policies have been found to reduce population-level SHS exposure, smoking prevalence, and smoking-related illnesses (Akhtar et al., 2010; Been et al., 2015; Fowkes et al., 2008; Frazer et al., 2016; Gagné et al., 2020; Hargreaves et al., 2010; Hoffman & Tan, 2015; Kelly et al., 2018), but to increase, decrease, or have no effect on inequalities (Akhtar et al., 2010; Amos et al., 2011; Borland, 2006; Brown et al., 2014; Gagné et al., 2020; Greaves & Hemsing, 2009; Hill et al., 2014; Kuntz & Lampert, 2016; Lorenc et al., 2013; Mons et al., 2013; Moore et al., 2012; Sandoval et al., 2018). Research indicating that smoke-free policies decrease social inequalities in smoking attribute this finding to the success of smoking denormalisation, particularly its effects on preventing smoking initiation and motivating smoking cessation (Borland, 2006; Kelly et al., 2018; Mons et al., 2013).

Studies demonstrating that smoke-free policies increase or have no impact on social inequalities in smoking suggest various reasons for this outcome. Some found that in low SES environments, smoke-free policies are found to be generally ignored by residents (McCready et al., 2019; Moore et al., 2009; Pederson et al., 2016). In McCready et al.'s (2019) study, participants living in a low SES neighbourhood reported that residents respected smoke-free regulations only once their neighbourhood was gentrified. In this way, smoke-free policies in public spaces may be displacing smoking in the home rather than motivating people who smoke to quit (i.e., "the displacement hypothesis"; Bell, McCullough, et al., 2010; Gagné et al., 2020; Ho et al., 2010; Kuntz & Lampert, 2016). As a result, the harms of SHS exposure are heightened for both those who smoke and their families (Gagné et al., 2020; Ho et al., 2010; Kuntz & Lampert, 2016). This seems particularly true for low SES families, with some research reporting that social inequalities

in smoking and in exposure to SHS in the home have persisted or even increased since the implementation of smoke-free policies in public spaces (Gagné et al., 2020; Greaves & Hemsing, 2009; Ho et al., 2010; Kuntz & Lampert, 2016; Moore et al., 2012). Other studies have observed that social inequalities in smoking and in SHS exposure *outside* the home have also persisted or increased post-enactment of smoke-free policies (Akhtar et al., 2010; Greaves & Hemsing, 2009; Sandoval et al., 2018). In these cases, smoke-free policies have the unintended consequence of defeating their own purpose: to protect non-smokers from SHS.

Regarding mass media campaigns, research has found that the impact of anti-smoking messages on social inequalities in smoking is dependent on how audiences perceive the relevance of the message (Amos et al., 2011; Brown et al., 2014; Gilbert, 2008; Hill et al., 2014; Hiscock et al., 2012; Levy et al., 2004; McCullough et al., 2018). Messages perceived as relevant among socially disadvantaged groups have been observed to decrease social inequalities in smoking, whereas messages deemed irrelevant have been associated with increases in these inequalities (Amos et al., 2012; Brown et al., 2014; Hill et al., 2014; Hiscock et al., 2012; Levy et al., 2004; McCullough et al., 2018). However, a systematic review by Lorenc et al. (2013) reported that media campaigns tended to increase social inequalities in smoking irrespective of the message's perceived relevance. Restrictions over cigarette marketing have been reported with mixed results for both reductions in smoking prevalence and social inequalities in smoking (Amos et al., 2011; Hoffman & Tan, 2015). Negative equity impacts have been observed in relation to graphic health warnings on packages, as they tend to reduce smoking among high SES groups but less so among those of low SES (Guillaumier et al., 2015b; Hammond et al., 2006; Mead et al., 2015). In particular, Guillaumier et al. (2015b) found that low SES participants felt desensitised to these messages and generally avoided them, while Haines-Saah and Bell (2016) reported their low SES participants did not tend to smoke commercial cigarettes and were therefore not regularly exposed to health messages found on cigarette packaging.

On the subject of price increases, there is agreement in much of the literature that they reduce both population-level smoking prevalence and social inequalities in smoking (Amos et al., 2011; Brown et al., 2014; Hill et al., 2014; Hiscock et al., 2012; Hoffman & Tan, 2015; Levy et al., 2004; Lorenc & Oliver, 2014; Thomas et al., 2008; Wilkinson et al., 2019). Nonetheless, some

scholars suggest that increasing tobacco prices may have negative impacts on equity (Blakely & Gartner, 2019; Franks et al., 2007; Hirono & Smith, 2018; Peretti-Watel & Constance, 2009; Thomas et al., 2008). While it may motivate cessation amongst socially disadvantaged people who smoke, these effects may be short-lived as this group is vulnerable to relapses (Blakely & Gartner, 2019; Peretti-Watel & Constance, 2009). Other studies have found that when faced with price increases, socially disadvantaged people who smoke turn to cheaper, sometimes contraband, cigarettes or sacrifice living necessities to pay for cigarettes rather than quit (Guillaumier et al., 2015a; Hirono & Smith, 2018; Hoek & Smith, 2016; Peretti-Watel & Constance, 2009; Warner & Mendez, 2010). Further, some low SES people who smoke perceive tax increases as judgemental of, or a punishment for, smoking, especially when taxation is not accompanied by cessation resources (Hoek & Smith, 2016). These inconsistencies in the literature reflect the limited equity assessments of tobacco control policies and warrant systematically including an equity lens in tobacco control policy research (Amos et al., 2011; Hirono & Smith, 2018; Hiscock et al., 2012).

2.4.1. How tobacco control policies may affect social inequalities in smoking

Research on the equity effects of tobacco control policies rarely considers *how* these policies come to affect social inequalities in smoking. Existing studies have identified smoking denormalisation messages employed by tobacco control policies as a potential key factor in explaining how these policies affect social inequalities in smoking (Frohlich et al., 2012; McCready et al., 2019; Poland, 2000; Thompson et al., 2007; Voigt, 2013). It has been found that smoking denormalisation not only negatively portrays smoking, but also people who smoke, who tend to be of low SES and/or living in other disadvantaged circumstances (Bayer & Stuber, 2006; Brandt, 1998; Collins & Procter, 2011; Frohlich et al., 2012). Negative perceptions of people who smoke are upheld by the view that smoking is an act of volition, and thus, that people who smoke are uniquely responsible for their behaviour and any health impacts – on themselves, others, and their environment (Adler & Newman, 2002; Bain et al., 2017; Brandt, 1998; Dennis, 2013; Diprose, 2008; Frohlich et al., 2012; Lupton, 2015; Moore, 2005; Roberts & Weeks, 2017; Stuber et al., 2008; Voigt, 2010, 2013). This notion of individualism is reinforced by smoking denormalisation messages. As smoking is increasingly viewed as socially abnormal and deviant, those who defy the changing norms by continuing to smoke are perceived to do so by choice, purposively courting preventable health risks for themselves and others (Bell, McCullough, et al.,

2010; Brandt, 1998; Burris, 2008; Chapman & Freeman, 2008; Dennis, 2013, 2015; Farrimond & Joffe, 2006; Frohlich et al., 2012; Gilbert, 2008; Lupton, 2015; Sanders et al., 2019; Triandafilidis et al., 2017a). Thus, smoking becomes an issue of morality, where non-smokers are viewed as morally observant victims of the harmful effects of people who smoke, who are seen as immoral and deviant (Bell, McCullough, et al., 2010; Brandt, 1998; Burris, 2008; Chapman & Freeman, 2008; Dennis, 2013, 2015; Farrimond & Joffe, 2006; Frohlich et al., 2012; Gilbert, 2008; Lupton, 2015; Sanders et al., 2019; Triandafilidis et al., 2017a). Brandt (1998) clearly illustrates the moral perception of people who smoke: "Not only has the meaning of the cigarette been transformed but even more, the meaning of the smoker … [who] has become a pariah in a powerful tale of risk and responsibility – the object of scorn and hostility" (p. 176).

Considering the inequitable social distribution of smoking, low-SES people who smoke are more likely to be associated with this volitional perspective, thus reinforcing existing similar perspectives of people living in poverty or in other disenfranchised circumstances (Frohlich et al., 2012; McCormack, 2004). Further, these representations of people who smoke discount the inequitable social conditions that shape the risk of smoking (Frohlich et al., 2012; Haines-Saah et al., 2015; Phelan et al., 2010; Voigt, 2010, 2013). A study by Haines-Saah et al. (2015) substantiates this claim. They found that graphic warning messages on cigarette packages conveyed specific representations of people who smoke, generally as ill, victims of addiction, and irresponsible. This in turn reflects a narrow and simplistic understanding of people who smoke and ignores structural social determinants of smoking, such as SES (Brandt, 1998; Frohlich et al., 2012; Haines-Saah et al., 2015; Phelan et al., 2010; Voigt, 2010, 2013).

Research has found that the attribution of individual responsibility as conveyed by smoking denormalisation messages has stigmatising effects on people who smoke (Antin et al., 2017; Bain et al., 2017; Bell, McCullough, et al., 2010; Frohlich et al., 2012; Hefler & Carter, 2019; Hirono & Smith, 2018; Lipperman-Kreda et al., 2019; McCready et al., 2019; McKie et al., 2003; Moore, 2005; Poland, 2000; Ritchie et al., 2010; Sanders et al., 2019; Thompson et al., 2009; Triandafilidis et al., 2017a; Voigt, 2013). Moore (2005) found that the stigmatisation of people who smoke has a "master status" effect (a concept notably discussed by Hughes, 1971), suggesting that negative perceptions of people who smoke are attributed to their overall identity, disregarding their non-

smoking-related traits. As a result, people who smoke can experience status loss (Bell, McCullough, et al., 2010; Goffman, 1963; Hefler & Carter, 2019; Ritchie et al., 2010; Thompson et al., 2007). Indeed, in a study by Bell and colleagues (2010), smoking participants reported that their personal identity was reduced to "the smoker" label, which they felt equated to being a "bad" person. In other words, people who smoke tend to self-stigmatise and even reproduce that stigmatisation on other people who smoke (Bell, McCullough, et al., 2010; Hefler & Carter, 2019; McCready et al., 2019; Ritchie et al., 2010; Thompson et al., 2007). Stigmatisation may manifest as comments, insults, or non-verbal actions to communicate the disapproval of smoking, for example, grimacing, staring, coughing, blocking the nose, covering the face, waving hands to clear air of smoke (Bell, McCullough, et al., 2010; Bell, 2013; McCready et al., 2019; Poland, 2000; Triandafilidis et al., 2017a).

Despite research pointing to the negative effects of stigmatisation, some scholars and public health practitioners justify its use as a tobacco control tool as it has demonstrated the potential to help people who smoke to quit (Bayer, 2008; Evans-Polce et al., 2015; Kim & Shanahan, 2003; Stuber et al., 2008). Others have strongly objected to the use of stigmatisation because of its inequitable effects (Bell, Salmon, et al., 2010; Fielding-Singh et al., 2020; Triandafilidis et al., 2017a; Voigt, 2013). That is, as smoking is increasingly considered a marker of disadvantage, stigmatisation of people who smoke disproportionately affects socially disadvantaged individuals who smoke (Bayer & Stuber, 2006; Frohlich et al., 2012; Lipperman-Kreda et al., 2019). Some research has demonstrated the negative health effects of smoking stigma not only on the general smoking population (Burris, 2002; Link & Phelan, 2001, 2006; Puhl & Heuer, 2009), but particularly on low SES people who smoke (Farrimond & Joffe, 2006; Fielding-Singh et al., 2020; Triandafilidis et al., 2017a). For instance, Farrimond and Joffe (2006) found that high SES people who smoke tend to challenge smoking-related stigma, while their low SES counterparts internalise stigma and as a result, are more likely to feel unmotivated to quit. Yet, other research has observed that low SES people who smoke experience less stigmatisation or are less aware of this stigma than higher SES people who smoke (Stuber et al., 2008), possibly due to the permissive smoking environments that low SES people tend to frequent (Glenn et al., 2017; McCready et al., 2019; Thompson et al., 2007). Smoking stigma has also been reported to limit access to employment and health care for people who smoke because they are perceived as raising insurance premium costs

(Bell, McCullough, et al., 2010; McKie et al., 2003; Roberts, 2014; Stuber et al., 2008; Voigt, 2012). In this way, smoking denormalisation messages may exacerbate the effects of existing relative powerlessness and disadvantage for people who smoke and increase social inequalities (Antin et al., 2017; Frohlich et al., 2012; Frohlich & Potvin, 2008; Greaves & Hemsing, 2009; Sandoval et al., 2018; Thompson et al., 2007; Voigt, 2013). Indeed, Bell and colleagues (2010) challenge the use of the term "denormalisation", as it suggests a harmless process while concealing its stigmatising and discriminatory effects on people who smoke, especially those who are socially disadvantaged.

Some qualitative literature elucidates the inequitable effect of smoking denormalisation messaging and stigmatisation by demonstrating how they influence the development of uneven power relations between "the non-smoker" and "the smoker[3]", with the former having the moral upper hand (Bayer & Stuber, 2006; Bell, McCullough, et al., 2010; Brandt, 1998; Fischer & Poland, 1998; Frohlich et al., 2012; Link & Phelan, 2001; Poland, 2000; Ritchie et al., 2010). This leads to a greater informal surveillance and public regulation of people who smoke by non-smokers, which may be expressed as unsolicited comments about the unacceptability and dangers of smoking (i.e., educating people who smoke) and being told where one can or cannot smoke (i.e., informal "policing"; Bell, 2013; Bell, McCullough, et al., 2010; Brandt, 1998; Fischer & Poland, 1998; Poland, 2000; Tan, 2013). Indeed, designated smoke-free spaces and anti-smoking discourses encourage non-smokers to police people who smoke as they are confident that policies will support such actions (Bell, 2013). Whether such surveillance and regulation is performed consciously or not, the intent is to ensure that public spaces are free of moral deviancy and to privilege those who adhere to social and moral codes of conduct (Brandt, 1998; Diprose, 2008). As a result, non-smokers increasingly stake claim to public spaces, with or without policy to support them (Bell, McCullough, et al., 2010; Dennis, 2015). For instance, certain businesses have adopted their own smoke-free policy in lieu of government policy or ask employees to smoke away from their establishment since an association with smoking could cast them in a negative light and

[3] In this thesis, the term "smoker" is used only when referring to moral and stigmatising representations of people who smoke. In an effort to not reproduce these representations, the term "people who smoke" is employed. Quotation marks are used in the first iteration of this term and are then dropped to alleviate the text.

thus, negatively affect business (McCready et al., 2019; Moore, 2005). Although these power dynamics may motivate cessation in some cases, other research has found that people who smoke continue to do so but adapt their smoking practices when they are around non-smokers (e.g., smoking away from non-smokers) in order to avoid being regulated (Bell, 2013; Bell, McCullough, et al., 2010; McCready et al., 2019; Poland, 2000; Tan, 2013; Thompson et al., 2007).

Power relations between the non-smoker and the smoker reflect power relations between social classes, as non-smokers tend to represent the middle-class majority while those who smoke generally come from lower SES backgrounds (Dennis, 2015; Graham, 2012; Poland, 2000). It has therefore been argued that the regulation of smoking, and by extension of morality, often corresponds to high to middle SES people regulating low SES people, reinforcing social dominance by higher social classes (Dennis, 2015; Diprose, 2008; Poland, 2000). This relates to Link and Phelan's (2001) understanding of stigmatisation as being power contingent. Stigma resulting from the regulation of people who smoke contributes to reinforcing power relations by social class, moral adherence, and smoking status, creating a greater social distinction between "us" and "them". In return, these reinforced power dynamics further legitimise the regulation of low SES people who smoke, thus entrenching social class-based smoking stigma (Link & Phelan, 2001). Public spaces become increasingly smoke-free, homogeneous, and thus dominated by middle to high class social groups and devoid or "sanitised" of lower classes (Dennis, 2015; Fischer & Poland, 1998). The absence of low SES people who smoke from these public spaces obscures appreciation of the complexity of their lives and of the effects of smoking denormalisation (Poland, 2000).

2.4.2. The role of tobacco control practitioners

It is argued that policy makers and practitioners reinforce and perpetuate smoking denormalisation discourses that guide their work (Bacchi, 2009; Frohlich et al., 2012; Holmes et al., 2006). While there exists a body of research pertaining to TCP, this research primarily examines how TCP engage with tobacco control policies, namely how they perceive, develop, and advocate for them (Amri, 2020; Johnson et al., 2010; Montini & Bero, 2001; Ritchie et al., 2009; Ritchie et al., 2015; Smith et al., 2019, 2020; Thomson et al., 2010; Timberlake et al., 2020; Wilson & Thomson, 2011). Few studies seek to explore how TCP engage with smoking denormalisation

discourses (Frohlich et al., 2012). Nonetheless, a better understanding of TCP's relationship to tobacco control policies may help elucidate the connection between such tobacco control policies and social inequalities in smoking.

It is important to first clarify how TCP are defined. Frohlich et al. (2012) define TCP as "… any health professional or programme developer who had the prevention or cessation of … smoking as a major component to their job mandate" (p. 982). This broad definition encompasses the different types of professionals working in tobacco control, however, two main categories of TCP can be distinguished in the literature. The first is comprised of policy informers, policy makers, and advocates. These TCP tend not to work directly with communities, but rather participate in decision making, advocacy, or the development of tobacco control policies and smoking prevention programs (Frohlich et al., 2012). Additionally, they stay abreast of the latest evidence on smoking and tobacco control policy to inform policy decisions. These TCP often work in public health directorates, public health centers, or government institutions (Frohlich et al., 2012; Montini & Bero, 2001; Smith et al., 2019, 2020). In the second category, we find smoking prevention and cessation practitioners, who often work directly with people who smoke in settings such as public health centers or various health and social service institutions (e.g., hospitals, mental health centers, and youth centers; Frohlich et al., 2012). Their responsibilities generally involve regulating and monitoring smoke-free spaces and supporting people who smoke with smoking cessation (Johnson et al., 2010). These TCP often have different disciplinary and professional backgrounds from those who work in program and policy development: the former represent fields like public health, medicine, or social sciences, while the latter tend to have studied in nursing, social work, and health education (Ritchie et al., 2015). Although most studies focus on one of these TCP categories, some studies include participants from both (Frohlich et al., 2012; Ritchie et al., 2015; Timberlake et al., 2020).

The literature on TCP underscores their varied degrees of support for tobacco control policies (Johnson et al., 2010; Ritchie et al., 2015; Smith et al., 2019, 2020; Thomson et al., 2010; Timberlake et al., 2020; Wilson & Thomson, 2011). Some TCP, often those working at the policy level, perceive tobacco control measures as successful in denormalising smoking and reducing smoking prevalence (Amri, 2020; Cenko & Pulvirenti, 2015; Laird et al., 2019; Smith et al., 2019;

Thomson et al., 2010; Timberlake et al., 2020; Wilson & Thomson, 2011). To support their mandate to reduce, and in some cases eliminate, smoking prevalence, they advocate for additional policies to denormalise smoking (Amri, 2020; Cenko & Pulvirenti, 2015; Laird et al., 2019; Smith et al., 2019; Thomson et al., 2010; Timberlake et al., 2020; Wilson & Thomson, 2011). However, TCP do not advocate for all types of tobacco control policies equally, and have been found to privilege tobacco control policies that garner greater public support irrespective of the amount of scientific evidence pointing to their effectiveness (Blackman et al., 2012; Cenko & Pulvirenti, 2015; Ritchie et al., 2015; Smith et al., 2019; Thomson et al., 2010, 2010; Timberlake et al., 2020). TCP also underline that to achieve their smoking prevalence reduction goals, tobacco control policy advances should be paired with additional smoking cessation resources (Amri, 2020; Ritchie et al., 2015; Smith et al., 2020).

Other TCP, especially those working directly with people who smoke, express a fraught relationship with tobacco control policies. These TCP are in some cases required to enforce smoke-free regulations in institutions or organisations where they work and this unwelcome responsibility can create tension in their relationships with service users (Johnson et al., 2010; Ritchie et al., 2009). Indeed, the relationships that TCP cultivate with service users afford a more complex understanding of smoking, namely how the social context shapes smoking behaviour and the stigma experienced by people who smoke (Johnson et al., 2010; Ritchie et al., 2009; Ritchie et al., 2015; Smith et al., 2020). To achieve greater success among populations who continue to smoke, these TCP argue that tobacco control policies should adapt to the specific needs and realities of those who smoke (Ritchie et al., 2009), especially those from socially disadvantaged populations (Smith et al., 2020). This might be accomplished by involving TCP who work directly with people who smoke in the process of policy and program development, a collaboration that has yet to be implemented (Johnson et al., 2010; Smith et al., 2019).

Some research also explored the types of discourses that informed TCP tobacco control-related perspectives and practices (Frohlich et al., 2012; Mair, 2011; Montini & Bero, 2001; Ritchie et al., 2015). In many cases, TCP's perspectives are shaped by behavioural understandings of health, wherein the concepts of "risk" and risk prevention are of central importance (Frohlich et al., 2012; Mair, 2011; Montini & Bero, 2001; Ritchie et al., 2015). This has led some TCP to

view smoking as an individual choice, and therefore assign responsibility for the consequences of smoking to the individual (Frohlich et al., 2012). Mair (2011) demonstrates that evidence consulted by TCP may contribute to their behavioural perspectives of smoking. Such evidence is most often surveillance data that measure and monitor smoking prevalence and risk as well as create profiles of people who smoke. Importantly, these data tend not to capture the social and structural determinants that place certain people at a higher risk of smoking. As a result, TCP opt for interventions that focus on behavioural change or proximal determinants, for example, media campaigns and access to smoking cessation services (Mair, 2011; Morrison et al., 2014; Smith et al., 2018). Frohlich and colleagues (2012) underline that neglecting structural determinants of smoking may have consequential results, including increased stigmatisation and marginalisation of people who smoke, particularly those of low SES. These authors argue that interventions focused solely behavioural change are not effective at reducing smoking prevalence when they state: "By adopting such discourses tobacco control practitioners may, inadvertently, be reinforcing and creating the very phenomena they wish to remedy" (p. 990).

In some cases, TCP recognised the existence of social inequalities in smoking and the potentially stigmatising effect of tobacco control policies (Bisset et al., 2017; Frohlich et al., 2012; Ritchie et al., 2009; Smith et al., 2019). Yet they continued to favour these policies, especially targeted smoking prevention interventions, in the hopes of reducing social inequalities in smoking (Amri, 2020; Bisset et al., 2017; Frohlich et al., 2012; Laird et al., 2019; Ritchie et al., 2009; Smith et al., 2019, 2020; Timberlake et al., 2020; Wilson & Thomson, 2011). Some TCP do question the effects of tobacco control policies on low SES people who smoke, and consequently, do not support policies that risk harming this population (Timberlake et al., 2020; Wilson & Thomson, 2011). According to Smith and colleagues (2020), some TCP have proposed a bottom-up approach, notably involving disadvantaged communities in designing and developing tobacco control policies to mitigate these effects. They argue that if the voices of socially disadvantaged populations are persistently excluded from tobacco control discussions, these populations may resist tobacco control policies and thus, smoking prevalence will continue to stagnate.

Research to date has carved a path to better understanding how tobacco control policies may affect social inequalities in smoking. Key findings clarifying this relationship point to the role

of smoking denormalisation as a discourse shaping tobacco control policies as well as to the behavioural perspectives that shape TCP's perspectives and narrow understanding of the experiences of people who smoke. However, few studies deconstruct what other discourses may shape tobacco control policies and how they affect social inequalities in smoking. Further, although research has illuminated how TCP perceive tobacco control policies, few studies have explored how TCP may reproduce, adapt, and/or challenge tobacco control policy discourse. In order to achieve a more comprehensive understanding of how tobacco control policy discourse affect social inequalities in smoking, this thesis draws from two different, yet complimentary theoretical approaches: intersectionality and Bacchian post-structuralism.

2.5. Theoretical approaches

2.5.1. Intersectionality

Intersectionality, which originates from Black feminist theory and activism, was developed to better understand the complexity inherent to the reproduction of social inequalities (Anthias, 2012; Bilge, 2010; Bowleg, 2012; Brah & Phoenix, 2004; Collins & Bilge, 2016; Crenshaw, 1989; Gkiouleka et al., 2018; Hankivsky, 2014; Kapilashrami et al., 2015). This theoretical approach draws attention to the processes by which systems of power, such as patriarchy, white supremacy, capitalism, and cis-heteronormativity, socially construct social identities of privilege (e.g., white men) and of oppression (e.g., Black women; Crenshaw, 1989, 1991). What distinguishes intersectionality from other social theories is its focus. Intersectionality does not emphasise the relationship between a singular system of power and a singular social identity (e.g., patriarchal oppression of women), but on the intersections of multiple systems of power and their effects on multiple intersecting social identities (e.g., patriarchal white supremacist oppression of Black women; Bowleg, 2012; Brah & Phoenix, 2004; Collins & Bilge, 2016; Crenshaw, 1989, 1991; Gkiouleka et al., 2018; Hankivsky, 2014). Indeed, the underlying assumption driving intersectionality is that experiences of privilege and/or oppression are dependent on an individual's intersecting social identities (Crenshaw, 1989, 1991; Davis, 1981). For instance, Crenshaw (1989, 1991) argues that the oppression experienced by Black women is due to the intersection of patriarchy and white supremacy, a perspective not represented by feminist nor anti-racism movements. Therefore, examining social identities separately or adding them together (e.g., Black and women rather than Black women) fails to capture the specific experiences of oppression

occurring at the intersection of social identities (Bowleg, 2012; Brah & Phoenix, 2004; Collins & Bilge, 2016; Crenshaw, 1989, 1991; Davis, 1981; Gkiouleka et al., 2018; Hankivsky, 2014).

With regard to social inequalities in smoking, intersectional research broadens our understanding of their complexity (Amroussia et al., 2020; Corliss et al., 2014; Lipperman-Kreda et al., 2019). In the quantitative literature, for instance, Amaroussa et al.'s (2020) epidemiological study examines social inequalities in smoking at the intersections of sexual orientation and SES (i.e., education levels) in the US. They found that smoking prevalence among those who were "doubly disadvantaged" (i.e., sexual minorities without a high school degree) was lower than for "singly disadvantaged" populations, (i.e., either straight people without a high school degree or sexual minorities with a high school degree or higher). These findings suggest that the influence of education on smoking is contingent on sexual orientation. Thus, observing social inequalities in smoking at the intersection of SES and sexual orientation paints a more complex picture than observing these inequalities separately. Social inequalities in smoking at the intersections of gender, race, sexual orientation, age, and/or SES have also been studied (Corliss et al., 2014; Graham, 1994, 1996; King et al., 2012). For example, Corliss et al. (2014) measured the risk of smoking for adolescents at the intersections of sexual orientation, gender, and race in the US. Their findings indicate that Black, Asian American, and Pacific Islander LGBTQ youth, bisexual girls, and younger bisexual youth are at a greater risk of smoking than adolescents representing other intersections.

Intersectionality has also been applied to qualitative research examining social inequalities in smoking. Much of this literature concludes that smoking experiences vary by intersecting social identities, but that many participants had the common experience of smoking to deal with various forms of structural oppression (Antin et al., 2017; McCready et al., 2019; Sanders et al., 2019; Thirlway, 2020; Triandafilidis et al., 2017a, 2017b). For example, women, and racialised women in particular, have reported being treated more harshly when smoking than men, racialised men, and non-racialised women (Tan, 2013; Triandafilidis et al., 2017a, 2017b). In an Australian study, Triandafilidis and colleagues (2017a) found that it was not acceptable for Chinese and Indonesian women to smoke within their cultures, but it was acceptable for all men and non-Chinese or non-Indonesian women to do so. Participants reported feeling stress and frustration from restrictions

imposed by their families, based on the intersection of gender and culture. Additionally, qualitative research has found that the specifically stigmatising representation of "the bad mother" targets mothers who smoke, especially those of lower SES, highlighting the importance of studying the intersections of gender, parenting, SES, and smoking (Graham, 1987; McCready et al., 2019; Tan, 2013; Triandafilidis et al., 2017a).

Although intersectional research has advanced our understandings of social inequalities in smoking, the first paper of this thesis (see below) argues that intersectionality is not used to its full potential within social inequalities in health research. That is, most studies use it to understand the experiences of socially disadvantaged populations of intersecting oppressed social identities, but rarely does research empirically examine how structures of power intersect to (re)produce this oppression. The article concludes by demonstrating how this latter research perspective can be achieved through policy discourse.

Article 1. More than a buzzword: How intersectionality can advance social inequalities in health research

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Note regarding contributions to this article

This article is based in my interpretations of the state of social inequalities in health research using intersectionality. I conceived the argument and wrote the entire manuscript. Drs. Frohlich and Haines-Saah contributed to numerous discussions about the article's main argument and provided feedback on several drafts.

Abstract

Intersectionality is increasingly adopted in research to understand the complex ways that social inequalities shape health. Intersectional research thus explores how multiple forms of oppression intersect and shape how marginalised social groups experience health issues. Yet intersectionality research has often neglected to focus on the upstream structural factors that (re)produce social inequalities in health.

In this paper we argue that intersectionality can further advance social inequality in health research when it is used to understand more than just the multiplicity of socially marginalised groups' experiences and identities, but also on how interlocking social structures and power relations perpetuate social inequalities in health. We suggest that analysing policy with an intersectional lens is a key entry point to empirically explicate the underlying mechanisms that permit social inequalities in health to persist. To illustrate our argument, we use the example of how an intersectional perspective can be adopted to better understand the role of tobacco control policies in contributing to social inequalities in smoking.

Keywords: intersectionality; social theory; health inequalities; public policy

Introduction

There remains important limitations to our understanding of social inequalities in health, namely *why* and *how* these inequalities persist (Dunn, 2012). Although various social theories have revealed important insights, intersectionality theory has the potential to fill these explanatory gaps. Intersectionality sheds light on how power relationships (re)produce social inequalities (Anthias, 2012; Bilge, 2010; Bowleg, 2012; Brah & Phoenix, 2004; Collins & Bilge, 2016; Crenshaw, 1989; Gkiouleka, Huijts, Beckfield, & Bambra, 2018; Hankivsky, 2014; Kapilashrami, Hill, & Meer, 2015). In particular, intersectionality conceptualises these power relationships to be comprised of: 1) intersecting systems of power (e.g. heteropatriarchy, white supremacy, and/or capitalism) that shape social structures, such as health and social policies, and 2) intersecting social groups that experience privilege and/or oppression as a result of these social structures (Bilge, 2010; Bowleg, 2012; Brah & Phoenix, 2004; Collins, 1990; Collins & Bilge, 2016; Crenshaw, 1989; Gkiouleka et al., 2018; Hankivsky, 2014; Kapilashrami et al., 2015; López & Gadsden, 2016). Intersectional research has explored, for instance, how young, racialised women experienced smoking-related stigma based on their intersecting identities of gender, race, and social class (Triandafilidis, Ussher, Perz, & Huppatz, 2017). An intersectional approach can also provide a lens through which to focus further upstream by examining how the intersections of systems of power such as heteropatriarchy, white supremacy, and class privilege have shaped tobacco control policies to, consequently, affect the context of young women's experiences of smoking-related stigma.

What distinguishes intersectionality from other critical social theories is the emphasis on conceptualising power relationships beyond a single axis (e.g. the relationship between patriarchy and women's oppression) to prioritise power relationships between intersecting systems of power and intersecting social groups that are consequently privileged and/or oppressed (e.g. the

relationship between patriarchy *and* white supremacy and Black women's oppression; Brah & Phoenix, 2004; Collins & Bilge, 2016; Crenshaw, 1989; Gkiouleka et al., 2018; Hankivsky, 2014). As intersectionality emerged from Black feminist theory and activism of the 1960-1970s, it is also intended to serve as a heuristic and advocacy tool for redressing social inequalities (Collins & Bilge, 2016; Hankivsky & Christoffersen, 2008). This dual emphasis on theory and praxis is evidenced by the adoption of intersectionality by contemporary feminist advocates as a framework for action on gender oppression that simultaneously accounts for racism, homophobia, ableism, and classism.

Social inequalities in health research using an intersectional lens has focused chiefly on one dimension of the power relationship, that is, how intersecting social groups experience health issues such as HIV, obesity, and smoking (e.g. Ailshire & House, 2011; Barbeau, Krieger, & Soobader, 2004; Triandafilidis et al., 2017). Further consideration of how intersecting structural forces perpetuate social inequalities in health is missing from this research. This lack of attention to analysing power has been said to 'depoliticise' intersectionality, that is, limit its potential for substantial political change to reduce social inequalities (Bilge, 2013; Collins, 1990).

In this paper we argue that we can obtain a more comprehensive understanding of social inequalities in health if intersectionality is used to empirically examine both structural forces that perpetuate social inequalities in health and experiences of social groups that are affected by these structural forces (Bilge, 2013; Hancock, 2007). To illustrate our argument, we first explore how intersectionality is currently used in social inequalities in health research, and then examine how intersectionality could be used to provide a more comprehensive understanding of social

inequalities in health. We demonstrate this last point with an example of how an intersectional perspective can explore the role of tobacco control policies to better understand social inequalities in smoking.

Intersectionality in social inequalities in health research

Social inequalities in health research using an intersectional lens tends to adopt what McCall (2005) labeled an 'intracategorical' approach, which focuses on specific health outcomes or health experiences of social groups experiencing multiple marginalities. For instance, Ailshire and House (2011) found that the BMI of low-income African American women tends to increase with age. Other intersectional research, referred to as 'intercategorical' (McCall, 2005), compares health outcomes or health experiences of intersecting privileged groups to intersecting marginalised groups. For example, Abichahine and Veenstra, (2016) compared physical activity for men and women of different ethnicities, social classes, and sexual orientations.

While valuable for underscoring the health-related experiences of social groups who are often neglected in research (Gkiouleka et al., 2018; Hancock, 2007), intersectional social inequalities in health research has been lacking the ability to delineate the distinct mechanisms by which intersecting structural forces' contribute to reproducing social inequalities in health and shape how people experience multiple oppressions (Bilge, 2013; Collins & Bilge, 2016; Gkiouleka et al., 2018). Intercategorical research could, in theory, reveal these structural forces by focusing on the social processes that have created and perpetuated relationships of inequality (Choo & Ferree, 2010; Kapilashrami et al., 2015; McCall, 2005). However, intercategorical social inequalities in health research has mostly continued to focus on differences between social groups

without empirically accounting for the social processes that have shaped these differences in the first place.

Understanding how structural factors (re)produce social inequalities in health is not a new concept for public health. Landmark documents such as the Ottawa Charter for Health Promotion (1986), the Black Report (1980), and the final report of the WHO's Commission on the Social Determinants of Health (2008), have highlighted the structural factors responsible for persisting social inequalities in health and the need for action at a structural level. Consequently, much research has been dedicated to understanding the impacts of social determinants of health on social inequalities in health with a strong emphasis on socio-economic status (SES; Bowleg, 2012; Gkiouleka et al., 2018; Kapilashrami et al., 2015). Yet, this singular focus runs the risk of homogenising social groups that are actually heterogeneous (Hankivsky & Cormier, 2011). An intersectional perspective permits researchers to unpack this heterogeneity by insisting on examinations of the multiple intersecting social determinants of health such as SES, gender, and race (Bowleg, 2012; Gkiouleka et al., 2018; Hankivsky & Christoffersen, 2008; Kapilashrami et al., 2015). Some research does measure social inequalities in health in different populations by intersecting social determinants of health (Axelsson Fisk et al., 2018; Bastos, Harnois, & Paradies, 2018), which has been useful in identifying some of the structural forces at play. However, this research has been limited in explaining how and why these forces perpetuate social inequalities in health (Hankivsky & Christoffersen, 2008).

Qualitative intersectional research that focuses on marginalised individuals' experiences of social inequalities in health often comes closer to explicating how and why structural forces

reproduce these inequalities. For example, through the experiences of disabled women living in India of different SES, Dean et al. (2017) demonstrated how sexism, ableism, and classism intersect and seep through relationships with family and medical professionals to hinder access to sexual and reproductive health care for these women. In this example, there are evident structural forces at play and an understanding of how and why these forces are integrated in these women's everyday lives become clearer. However, a piece of the intersectional puzzle is missing. Further empirical analyses of the structural forms that these dominant forces (i.e. sexism, ableism, and classism) bolster, such as sexual and reproductive health policies and social norms in relation to disabled people, poverty, and/or women, would allow for a more comprehensive understanding of the perpetuation of social inequalities in health for these women. This analysis may also reveal concrete paths for shaping future policy to redress social inequalities in health among this population.

There are a few intersectional studies that have sought to explore the processes by which structural forces exert their influence and, often unintentionally, reinforce social inequalities in health. These, mostly qualitative studies, generally focus on the places allocated to marginalised groups or social inequalities in health in specific policies. In this sense, policies are conceptualised as a medium by which intersecting social forces shape social norms and behaviours. For instance, Rudrum, (2012) critically analysed the discourse underlying policy recommendations for a maternal care policy in British Colombia (BC), Canada. More specifically, she aimed to understand how multiple marginalities associated with some social groups were represented in these policy recommendations, how they were framed, and how the maternal care context in BC shaped these policy recommendations. Rudrum was able to identify systems of oppression such as

patriarchy, colonialism, and class privilege and how they shape maternal care services for marginalised populations. Although this intersectional research is vital to better understand the ways in which structural forces reproduce social inequalities, these policy-oriented studies also leave out an important dimension of power relationships, that is, the experiences of marginalised populations. They often hypothesise the consequences that these policies will have on marginalised populations, but they cannot draw from empirical evidence. In this respect, Rudrum, could have interviewed marginalised women who were not represented by maternal policies in BC to better understand the impact of this policy.

In essence, we argue that in order to have a more comprehensive understanding of social inequalities in health, research should explore the dynamics between the two poles of power relationships, as conceptualised by intersectionality (i.e. structural and individual), rather than separating them. This would mean not only focusing on how multiple marginalities and health are experienced at the individual level. Researchers should broaden their understanding of these inequalities to include the ways in which structural factors might shape them (Else-Quest & Hyde, 2016; López & Gadsden, 2016). Understanding how these power relationships function is important to generate necessary evidence to challenge the status quo and redress social inequalities (Collins & Bilge, 2016; Crenshaw, 1989, 1991; Else-Quest & Hyde, 2016; Hancock, 2007; Hankivsky & Christoffersen, 2008).

How intersectionality can advance our understanding of social inequalities in health

For many researchers, how to operationalise power relationships remains unclear and ambitious. Although we sympathise with the grandeur of this feat, we suggest focusing on an intervention, such as a policy. Indeed, policies are a pertinent entry point, as dominant social forces

can influence their design, consequently shaping social norms and differential access to resources (Collins & Bilge, 2016; Crenshaw, 1991; Hankivsky & Cormier, 2011). In this sense, policies represent a mechanism by which structural forces express power (Crenshaw, 1991; Gkiouleka et al., 2018; Hancock, 2007; Hankivsky et al., 2012a; Hankivsky & Christoffersen, 2008). This is demonstrated by the few intersectional studies that have focused on policy analysis to better understand social inequalities in health (Hankivsky et al., 2012b).

An intersectional analysis of policy aims to understand how the policy in question might have differential effects and what groups are consequently affected (Hankivsky & Cormier, 2011; Hankivsky et al., 2012b). With this information, we can also come to explicate a policy's role in the reproduction of social inequalities in health (i.e. why). To do so, it is important to consider: who designed the policy, why it was designed, how the problem to be addressed by the policy and the people concerned are framed, why they are framed in this way, whose interests are represented and whose are omitted, and what potential impacts this inclusion and exclusion might have on various social groups' health (Bacchi, 2009; Gkiouleka et al., 2018; Hankivsky et al., 2012b). These questions serve to unpack both the assumptions underlying the policy design and the experiences of policy, which are critical elements to intersectional research (Bacchi, 2009; Hankivsky et al., 2012b).

Few studies have integrated both analysis of a policy itself and experiences of this policy. Clark (2012), for example, sought to better understand the root causes of violence in the lives of Indigenous women by analysing policies as well as the colonial and sexist contexts in which these policies were designed and continue to operate. Further, with a case study of an Indigenous young

woman who is a victim of sexual violence, Clark illustrates the shortcomings of these policies through the experiences of marginalised populations, thus paving the way for new conceptualisations of policies that would promote the health and safety of all girls and women, particularly those of marginalised intersecting identities. As there are few other examples of research that uses intersectionality so comprehensively, we provide an example of how social inequalities in smoking could be studied in the context of tobacco control policies.

Tobacco control policies and social inequalities in smoking

Since the implementation of tobacco control policies such as awareness campaigns, smokefree policies, and taxation increases, significant reductions in smoking prevalence have been observed in many high-income countries (Feliu et al., 2018; Hoffman & Tan, 2015). Despite this success, research has revealed increases in social inequalities in smoking (Barbeau et al., 2004; Corsi et al., 2014). Studies mainly stratify smoking by SES, but some research has also observed differences by gender and race (Barbeau et al., 2004; Corsi et al., 2014). For instance, in Canada, smoking prevalence among university educated women decreased from 45% in 1950 to 8% in 2011, whereas it decreased from 40% to only 33% for women with less than a high school education (Corsi et al., 2014). In the US, high prevalence of smoking was found at the intersections of race and SES, notably for Black, Indigenous, Latino and Asian people with low educational attainment (Barbeau et al., 2004).

The intersections of class, gender, and/or race (i.e. known determinants of smoking) not only represent different experiences of smoking and meanings of tobacco, but they also place individuals who are oppressed by these intersections at a disproportionately higher risk of smoking-related illnesses. Further, the health and social consequences of smoking stigma (e.g.

stress, limited access to health and social services; Hatzenbuehler, Phelan, & Link, 2013) may intensify the burden of oppression experienced from intersections of class, gender, and/or race.

From an intersectional perspective, explicating why social inequalities in smoking exist involves examining the relationship between tobacco control policy and various social groups. Framing the research problem to include both poles of power relationships entails: 1) what and how do intersecting structural forces marginalise and/or privilege social groups through tobacco control policy; and 2) what and how do intersecting social groups experience tobacco control policy differently, that is, how do they benefit from and/or suffer because of it (Crenshaw, 1989; Hankivsky et al., 2012b).

In relation to tobacco control policy as a structural factor, research investigating the differential effects of tobacco control policies on smoking is inconsistent; some studies suggest that they increase, decrease, or have no impact on social inequalities in smoking (Amos et al., 2011; Brown, Platt, & Amos, 2014; Hill, Amos, Clifford, & Platt, 2014; Sandoval et al., 2018). As this research is outcome-focused, we know little about *why* and *how* these policies might differently affect social groups that experience multiple marginalisation. To do so, researchers might explore the actors within tobacco control, who they represent, what are their interests, who is included and excluded from these interests, as well as their understandings and perspectives regarding social inequalities in smoking (Bacchi, 2009; Hankivsky et al., 2012b). It would also be important to critically reflect on smoking denormalisation approaches that tobacco control policies employ. How do they refer to different intersecting social groups (if at all)? More specifically, how are identities based on intersections of class, gender, and/or race discussed in relation to smoking

(if at all)? What intended and unintended effects might this denormalisation have on intersecting social groups? Has it created a new social identity category based on smoking status, for instance, that of 'the smoker' and 'the non-smoker'? How might these smoking status identities intersect with those of class, gender, and race (and/or others, if relevant)?

Better understanding how tobacco control policy might impact social inequalities in smoking is only one piece of the intersectionality-based research puzzle. This research would also seek to explore how different intersecting social groups experience tobacco control policies. How do they understand these policies to affect their lives and their smoking? What advantages and disadvantages do they experience because of these policies? Further, how discursive representations of smoking status according to class, gender, and race (emanating from policy, prevention programs, and/or media) affect people's smoking and everyday lives may also be explored. For instance, this could mean examining how representations of women smoking impacts the smoking experience and everyday lives of racialised women who smoke. Indeed, Triandafilidis et al. (2017) found that women of different ethnic backgrounds had distinct experiences of smoking-related stigma due to the intersection of their race/ethnicity and gender. Thus, analysing the policies and programs that contribute to these representations of women smoking could provide a more thorough understanding of these inequalities.

Conclusion

In order to achieve concrete reductions in social inequalities in health, we need to first better understand the mechanisms that contribute to their (re)production. Intersectionality is a novel theoretical addition to social inequalities in health research to achieve this end. Yet it is important to critically reflect on how we integrate this theory in social inequalities in health

research. In this paper, we argued that the focus has primarily been at the level of experiences of social inequalities in health with little empirical evidence of how intersecting structural forces shape these experiences of marginalisation and/or of privilege. We suggest using intersectionality to inform critical explorations of policies as a concrete entry point for analysing both structural forces and individual experiences of social inequalities in health. It is also important to not limit our use of intersectionality for research; its origins in Black feminist social movements make it a framework for action. Thus knowledge generated from intersectional research should be used to advocate for policies that aim to address social inequalities in health.

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2.5.2. Bacchian post-structuralism

Many studies in social science scholarship have examined policy discourse to better understand how policies function and how they come to have certain outcomes (Bacchi, 2000; Ball, 1993; Fairclough, 2013; Hawe et al., 2012; Wetherell, 2001). Indeed, discourse is so frequently studied that it may be perceived as a vague catch-all term (Howarth, 2010; Jørgensen & Phillips, 2002; Lupton, 1992). For many scholars, especially those who work in psychology and linguistics, discourse relates to language and communication patterns (Jørgensen & Phillips, 2002; Wetherell, 2001). Critical social scientists favour a different understanding of discourse, informed by a Foucauldian post-structural notion of discourse (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Bacchi & Goodwin, 2016; Jørgensen & Phillips, 2002). Indeed, the few studies examining the discourses underlying tobacco control policies have used a Foucauldian post-structural approach (Fernández, 2016; Frohlich et al., 2012; Gilbert, 2008; Poland, 2000; Thompson et al., 2007, 2009). In essence, Foucauldian post-structuralism understands discourse as a system of thought shaped by various knowledge, assumptions, values, and beliefs that collectively construct certain conceptualisations of social phenomena (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Bacchi & Bonham, 2014; Foucault, 1969; Howarth, 2010; Jørgensen & Phillips, 2002). In this way, discourse has been argued to be a social practice as it contributes to producing social phenomena and the social world in which we live, but is recursively produced by this same social world (Jørgensen & Phillips, 2002). In policy research, discourse informs policy and is also disseminated by policy (Bacchi, 2009). This approach to discourse primarily seeks to better understand how a given discourse becomes dominant by examining the factors or conditions that enabled it to become so (Bacchi & Bonham, 2014; Foucault, 1976; Negura et al., 2019). It also explores how discourse circulates in social life, and how it comes to affect the population in different ways (Foucault, 1976; Negura et al., 2019).

This thesis draws from critical political scientist Carol Bacchi's unique approach to Foucauldian post-structural understandings of discourse, specifically policy discourse (Bacchi, 2000, 2009; Bacchi & Bonham, 2014; Bacchi & Goodwin, 2016). According to Bacchi, policy discourse can be explored by deconstructing the policy's "problematisation" – the process by which policy makers and advocates construct social phenomena into problems. As such, problematisations are constructed from certain discourses comprised of dominant knowledges,

assumptions, values, and interests. This specific narrative of the problem is generally considered by the public to be "truth" or "fact", although many other perspectives may exist but get less traction. As a result, problematisations limit the understandings of, and solutions to, policy problems. This conceptualisation of policy discourse runs contrary to the commonly held assumption in policy studies that certain social phenomena (e.g., smoking) are inherently problematic and thus, policies are perceived as solutions to redress these problems.

Bacchi (2009) argues that "we are governed through problematisations" (p. 25). This central idea in her approach elucidates the ways in which problematisations shape individuals' beliefs and actions. By casting social phenomena in a specific light, problematisations shape social norms by reflecting ideal behaviours and values while discouraging others (i.e., normalisation; Bacchi, 2009; Bacchi & Goodwin, 2016; Foucault, 1975, 2004; Lupton, 1995). Various experts, including doctors, teachers, and scientists, reinforce these norms to the public through their expertise (Bacchi, 2009; Holmes et al., 2006; Schrecker, 2013). To fit in society, individuals respond by self-monitoring and self-regulating their own behaviours and beliefs in accordance with dominant social norms (Bacchi, 2009; Gilbert, 2008; Lupton, 1995). These problematisation also constructs categories of people with common characteristics, such as smokers and non-smokers (Bacchi, 2009; Carro-Ripalda et al., 2013; Foucault, 1976; Jäger, 2002). This process, called subjectification, informs how people conceptualise themselves as well as their stereotype perspectives of others (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Bacchi & Goodwin, 2016; Foucault, 1976; Jäger, 2002). In this way, subjectification leads to a positioning of social categories within power relations that shift according to context (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Bacchi & Goodwin, 2016; Foucault, 1976; Howarth, 2010). For example, subjectification resulted in views of the smoker as morally inferior to the non-smoker, thus engaging them in a power relation (Bell, McCullough, et al., 2010; Brandt, 1998; Carro-Ripalda et al., 2013; Chapman & Freeman, 2008; Frohlich et al., 2012; Gilbert, 2008).

Power relations are indeed contingent on social norms; those who adhere to them are accorded the moral high ground over those who do not (Foucault, 1982; Jodelet, 2008). These power relations become embedded in everyday life, reinforcing self-monitoring and self-regulation as well as justifying the monitoring and regulation of others' behaviours (e.g., telling someone not

to smoke; Fischer & Poland, 1998). In this way, the state may use policy discourse to shape a population's behaviour from a distance, rarely interfering directly in people's lives (Bacchi, 2009; Foucault, 1975, 1976; Rabinow & Rose, 2006). It is worth noting, however, that individuals are not passive subjects acting according to the social norms imposed on them. Rather, they adapt, integrate, challenge, and/or resist these norms (Arribas-Ayllon & Walkerdine, 2011; Gilbert, 2008; Howarth, 2010).

Bacchi's take on post-structuralist policy discourse had not yet been applied to tobacco control research, making this thesis the first to do so. It has, however, been adopted in public health policy analysis, notably for examining policies concerning drug use, food insecurity, as well as physical activity and obesity (Alexander & Coveney, 2013; Bacchi, 2015; Booth & Whelan, 2014; Fraser & Moore, 2011; Lancaster & Ritter, 2014; Salas et al., 2017; Seear & Fraser, 2014; Thomas & Bull, 2018). A Bacchian approach has allowed these studies to consider not only the efficacy of policies in reducing certain health outcomes, but also to question how and why policies problematised these issues and the potential effects of these problems, often on socially disadvantaged populations. For instance, using Bacchian post-structuralism, Thomas and Bull (2018) identified that Australian drug policies problematise women's drug use within a dominant reproductive discourse, which limits their understanding of the diverse perspectives and needs of women who use drugs. Consequently, this narrow, yet dominant, policy discourse may create more harm than good for this socially disadvantaged population.

In this thesis, Bacchi's approach was applied to recent tobacco control discourse in Quebec, which, as discussed in the previous sections, refers to ways of thinking about smoking (and people who smoke by extension), which has been shaped by tobacco control efforts to denormalise smoking (Frohlich et al., 2012; Gilbert, 2008). According to literature on tobacco control, its discourse was informed by clinical and epidemiological evidence of the negative health effects of smoking and by existing moral views of smoking as abhorrent (Collishaw, 2009; Gilbert, 2008; Rudy, 2005). First, historical literature has highlighted that tobacco control discourse emerged, principally, after the Surgeon General's report in 1964 underscoring the harmful effects of smoking (Collishaw, 2009). This evidence shaped tobacco control's main objectives to improve population health by reducing smoking prevalence and protecting non-smokers from SHS

(Collishaw, 2009). Second, negative moral views of smoking and SHS, which could be observed in the 19th and 20th century namely by Christian women's organisations, became more prominent in tobacco control discourse because of their socially persuasive abilities to change behaviour (Bell, 2011; Rudy, 2005). Research has additionally demonstrated that tobacco control discourse can have inequitable effects, whereby more privileged social groups tend to adhere to this messaging more than other, more disadvantaged, social groups (Antin et al., 2017; Frohlich et al., 2012; Poland, 2000; Sanders et al., 2019; Thompson et al., 2007). Therefore, Bacchi's approach was used to deconstruct tobacco control's problematisation of smoking in a recent Quebec context, namely to identify various knowledge, assumptions, values, and beliefs collectively reproducing and reinforcing a system of thought (i.e., discourse) that renders smoking a vice. As there is a concern in the literature that tobacco control discourse might increase or maintain social inequalities in smoking, how problematisations of smoking and, in particular, of "the smoker", might affect social groups differentially was also examined.

While Bacchi's critical approach has been lauded by critical social science scholars, some have highlighted limitations to her approach (Clarke, 2019; Vitellone, 2021). More specifically, the premise of Bacchian post-structuralism, that is, the need to analyse problematisations, has come under scrutiny (Vitellone, 2021). In justifying the need to deconstruct problematisations, Bacchi (2009) argues that researchers contribute to problematisations by taking for granted that the social phenomenon under study is in fact a problem, such as smoking or drug use. Consequently, they orient their studies to generate knowledge further normalising conceptualisations of social phenomena as problems. In response, Bacchi calls for researchers to adopt a more critical stance, namely by questioning how mainstream scientific discourse contributes to problematisations. However, some have underscored that it is possible to consider a social phenomenon as a problem, while also challenging dominant problematisations. Indeed, by doing so, gaps in our understandings of a problem can be identified and new perspectives can be revealed (Clarke, 2019; Vitellone, 2021). For instance, critical perspectives in tobacco control have questioned the ways in which smoking is discussed in the scientific literature, that is, as an irrational and irresponsible individual behaviour (Bell, 2013; Dennis, 2013; Frohlich et al., 2012; Mair, 2011; Poland, 2000). In response, a body of literature, particularly comprised of qualitive research, has emerged to challenge reductive understandings of smoking and to problematise it as

a social practice that is contingent upon social, cultural, political, geographical, and historical contexts (Frohlich et al., 2012; Glenn et al., 2017; McCready et al., 2019; Poland, 2006). Bacchi's critics have further suggested that by distancing themselves from problematising, researchers cannot propose solutions, nor envision a desirable future (Clarke, 2019; Collins, 2012). For many critical social theorists, finding meaningful solutions to problems is necessary, especially providing a platform for perspectives challenging and complexifying dominant problematisations (Clarke, 2019; Collins, 2012).

2.5.3. A complementary use of intersectionality and Bacchian post-structuralism

Given that health promotion is an interdisciplinary field of research and action that addresses complex health issues (Gagné et al., 2018; McQueen, 2010), it has been argued that any one theoretical perspective is insufficient to address the complexity of such issues (Ball, 1993; Gagné et al., 2018). Moreover, analytical frameworks commonly used to examine the relationship between public health policy and social inequalities in health (e.g., the health equity assessment tool and sex and gender-based analysis) are limited in capturing its inherent complexity (Hankivsky, 2012; Hankivsky & Cormier, 2011). In particular, existing frameworks tend to focus on how policy affects a specific social group, leaving out how policies might affect those experiencing multiple levels of inequity (Hankivsky, 2012; Hankivsky & Cormier, 2011). These frameworks also take policy problematisations for granted, and thus may continue to normalise the view that a specific social phenomenon is a problem (Bacchi, 2009). Combining intersectionality and Bacchian post-structuralism attempts to fill some of these explanatory gaps by, namely, mobilising theoretical concepts, such as power relations and social identities, that bring a more critical and deeper understanding of the role of policy discourse in the reproduction of social inequalities. The remainder of this section will present the complementary and divergent elements of each theoretical perspective.

Intersectionality and Bacchian post-structuralism flow from different philosophical orientations: intersectionality originates from structuralist thought (Collins, 1990; Crenshaw, 1989), while Bacchi's approach is based in post-structuralism (Bacchi, 2009; Bacchi & Goodwin, 2016). A principal difference between structuralism and post-structuralism is the latter's rejection of the structural notion of social inequality as the product of a monolithic structure (Agger, 1991;

Archer Mann, 2013; Arribas-Ayllon & Walkerdine, 2011; Carbin & Edenheim, 2013). Post-structuralism does not refute the notion of systems or institutions exerting some form of power over a population, but rather, posits that this understanding is simplistic, reductionist, and incapable of capturing the complexity and nuance of power (Bacchi & Goodwin, 2016; Carbin & Edenheim, 2013; Foucault, 1976). Power is not perceived as necessarily manifesting in a top-down approach, nor is it something that can be possessed and used to dominate others, as is represented in a structural perspective. Instead, power is a relational force found in all dimensions of society that is constantly negotiated (Bacchi & Goodwin, 2016; Bilge, 2010; Foucault, 1976, 1980). One may think of the ping-pong dynamics of parent-child or teacher-student relationships; one asserts rules to be followed and the other may follow those rules, but may also question or challenge them (Arribas-Ayllon & Walkerdine, 2011; Foucault, 1976; Howarth, 2010). In this sense, post-structuralism acknowledges the agency of the subordinate subject to negotiate their situation and underlines how individual roles in power relations shift as they move through different social spheres (Arribas-Ayllon & Walkerdine, 2011; Foucault, 1976; Howarth, 2010). Post-structuralism thus contributes a more nuanced understanding of how power is expressed, both in society and through policy discourse, than intersectionality's structural orientation (Bilge, 2010; Carbin & Edenheim, 2013).

Some researchers have integrated a post-structural understanding of power with intersectionality (Bilge, 2010; Carbin & Edenheim, 2013; McCall, 2005). In particular, this has helped to better understand how social inequalities are not solely reproduced by structural forces in a top-down manner, but more so through the perpetuation and reinforcement of social norms in everyday relationships (Bilge, 2010; Carbin & Edenheim, 2013; McCall, 2005). For instance, in a study by Antin (2017), low-income Black American women who smoke reported experiencing more smoking stigma in their everyday interactions (e.g., with friends, family, and strangers on the street) than other social groups who smoke, such as Black men and White women, because of the stigma they already experienced from having an identity at the intersections of gender, race, and SES. Indeed, they contend that smoking stigma exacerbated the discrimination they experienced from being low-income Black women. This example demonstrates how power manifests relationally (i.e., post-structural understanding of power) to affect experiences of disadvantage for a social group of multiple social identities (i.e., intersectionality). As such, using

an intersectionality lens informed by post-structural concepts of power helps us understand a different form and experience of inequality, offering a deeper understanding of its potentiality.

Some intersectional scholarship, however, aligns with an emphasis on structural forces, particularly co-occurring structures. Structural forces inequitably organise society, creating more opportunities than barriers for some and more barriers than opportunities for others (Bilge, 2010; Collins, 1990, 2009; Crenshaw, 1989, 1991; Davis, 1981; Hankivsky et al., 2012). For example, in North America, patriarchy and white supremacy are structural forces that lead to social inequality, working together to privilege white men and disadvantage those without race or gender privilege (Crenshaw, 1989, 1991; Davis, 1981). Collins (2009) contends that underscoring the role of structural forces in (re)producing social inequalities is especially crucial in contexts where individuals, as opposed to institutions or systems, are blamed for their inability to overcome obstacles to success. In this light, social inequality cannot be remedied without addressing inequitable distributions of power at the structural level (Collins, 1990, 2009; Hankivsky, 2012).

Both intersectionality and Bacchian post-structuralism are interested in the construction of social identities (Agger, 1991; Archer Mann, 2013; Bacchi, 2009; Crenshaw, 1989, 1991; McCall, 2005). For intersectionality, social identities are the primary focus – specifically, how structural forces (re)produce social identities (Bilge, 2010; Collins & Bilge, 2016; Crenshaw, 1989, 1991; McCall, 2005). In Bacchian post-structuralism, and post-structuralism more generally, subjectification (i.e., the process of creating categories of people) is a part of policy discourse and thus, social identities are the result of subjectification through discourse (Bacchi, 2009; Bacchi & Goodwin, 2016). As such, Bacchian post-structuralism identifies the specific process that creates, reproduces, and reinforces social identities (Bacchi, 2009; Bacchi & Goodwin, 2016) that are of such interest to intersectionality. On the other hand, intersectionality's emphasis on the effects of intersecting structures in constructing intersecting social identities can aid the Bacchian post-structural analyst in identifying social identities that are excluded by the dominant discourse (Clarke, 2019). By accounting for the structural forces that reproduce and reinforce social identities of privilege and/or disadvantage, intersectionality is further helpful in framing a Bacchian post-structural lens to focus on social inequalities, specifically intersecting social identities, and the role of structural forces in perpetuating those social inequalities (Hankivsky, 2012, 2014).

While post-structuralists acknowledge the presence of social identities, they also challenge the notion of "categories" of people because it homogenises social groups and as a result, risks losing specific experiences in a broader understanding of the group experience (Bilge, 2010; McCall, 2005). Rather, they believe that social categories are fluid, complex, and overlapping, where individuals are actively negotiating and adapting the identities imposed on them (McCall, 2005). Some intersectional scholars have embraced this fluid notion of social identities (Bilge, 2010; McCall, 2005), while others like Collins (2009) have noted the importance of recognising and analysing social categories and hierarchies because they reflect the political and historical context of social inequality. Neglecting social categories may, consequently, undermine the history of oppression experienced by certain social groups based on categorisations imposed on them (Bilge, 2010; Collins, 2009). In this way, intersectionality is necessary to access comprehensive and critical knowledge of social inequalities. The interest of this thesis is therefore in understanding how policy discourse (re)produces social identities, and to do so by considering the fluidity and complexity that these identities represent, as well as the structures that (re)produced them.

Finally, intersectionality has an explicit interest not only in better understanding the underlying complexity of social inequalities, but also in redressing them (Bilge, 2010; Collins, 2009; Collins & Bilge, 2016). Indeed, it is due to the origins of intersectionality within the Black American civil rights movement that social justice is a key tenet (Agger, 1991; Bilge, 2010; Collins, 1990, 2009). However, Bacchi's approach and post-structuralism more broadly do not specifically focus on social inequalities and are not driven by the need for political change (Clarke, 2019; Frohlich et al., 2012). They may serve to identify social inequalities that are (re)produced and reinforced by policy discourse, for example by identifying power relations, yet the researcher is not obliged to consider the inequitable nature of such power relations (Bilge, 2010; Collins, 1990, 2009; Frohlich et al., 2012). Collins (2009) further argues that examining both social structures and individual experiences provides transformative knowledge that can inform policies and be used in anti-oppression advocacy. By placing social inequalities at the forefront, intersectionality requires Bacchian post-structural analysts to examine the inequitable dimensions within a policy's problematisation – an idea of particular importance to this thesis as a principal interest is the reproduction of social inequalities in smoking.

Studies that have used a combined intersectional and Bacchian post-structural approach demonstrate the important insights for research on social inequalities and policy discourse that such an approach can engender. For instance, it has been used to study how policies and programs, related to family migration and homelessness in different European contexts, problematise these social phenomena (Horsti & Pellander, 2015; Petersson, 2017; Zuffrey, 2017). With this combined approach, researchers demonstrated how policy problematisations shifted according to the ethnicity of immigrant families and social identity of people experiencing homelessness, thus revealing the limitations of population-level policies in helping everyone equitably (Horsti & Pellander, 2015; Petersson, 2017; Verloo, 2006; Zuffrey, 2017). These studies further identified that privileged social groups had problematised migration and homelessness, and in doing so, had excluded the responsibility of structural determinants, such as population-level policies. Responsibility was thus placed on the shoulders of disadvantaged social groups (Petersson, 2017; Zuffrey, 2017).

In studying the relationship between tobacco control policy discourses and social inequalities in smoking, a combined intersectional and Bacchian post-structural approach places an explicit focus on the reproduction of social inequalities in smoking through inequitable distributions of power expressed through tobacco control policy discourses (Lapalme et al., 2020). This is done not only by observing what social identities (e.g., "the smoker" and "the non-smoker") are represented in such discourses, but, more importantly, what knowledges, assumptions, values, and beliefs are contingent to those representations (i.e., subjectification; Bacchi, 2009). Further, by seeking to examine how perpetuating or disrupting representations of different social identities in discourse reinforces the ways in which social groups are differentially treated in society (Bacchi, 2009; Hankivsky, 2014; Lapalme et al., 2020), this combined approach is useful in contributing new insights to the reproduction of social inequalities in smoking.

2.6. Research question and objectives

This review of the literature underscores that social inequalities in smoking remain a pressing and persistent problem for public health, specifically in light of the important advancements in tobacco control policies. Despite growing evidence of tobacco control's potential adverse effects on increasing social inequalities in smoking, and despite reports of stark social

inequalities in smoking in Quebec, TCP in Quebec continue to advocate for increased restrictions on smoking. This led to the adoption of L44 in late 2015 and of the tobacco control strategy in 2020.

This thesis is part of a larger research project entitled *Exploring the effects of Quebec's legislation "An Act to Bolster Tobacco Control" on social inequalities in smoking* and led by Dr. Katherine Frohlich. This project has two objectives: 1) to better understand in what ways population-level tobacco control policies affect social inequalities in smoking; and 2) to better understand what effects population-level tobacco control policies have on social inequalities in smoking (see Appendix III for a published article addressing this objective). This thesis contributes to informing the first objective as it poses the following research question: how might population-level policies, such as L44, impact social inequalities in smoking?

To answer this research question, the thesis critically examines recent tobacco control discourses in Quebec, since policy studies point to policy discourse as both informing policy and as being reproduced, reinforced, and disseminated by policy (Bacchi, 2009). Thus, tobacco control discourses, notably how they problematise smoking, "the smoker", and social inequalities in smoking, are key to understanding how tobacco control policies come to affect social inequalities in smoking. More specifically, the thesis addresses the following two research objectives:

1) to critically examine the tobacco control discourses underlying L44 and in particular, to assess the role of social inequalities in smoking within these discourses;
2) to critically explore how Quebec TCP's engagement with tobacco control discourses shapes their perspectives and practices relating to the reduction of social inequalities in smoking.

While both objectives examine tobacco control discourses, they do so in different ways and within different contexts of tobacco control in Quebec. The first objective contributes to understanding how tobacco control policies affect social inequalities in smoking by deconstructing tobacco control discourses informing a specific tobacco control policy (i.e., L44). This objective also seeks to explore the role of social inequalities in smoking within these discourses in order to better understand how L44, and other policies like it, might affect such inequalities.

The second objective brings different insights than the first objective to understanding the relationship between tobacco control policies and social inequalities in smoking. It also critically explores tobacco control discourse, but for this objective, TCP's engagement with this discourse, that is how their perspectives and practices reinforce, reproduce, adapt, challenge and/or resist it, is examined. It further seeks to understand how this engagement shapes their perspectives and practices related to the reduction of social inequalities in smoking, as these interviews occurred in a context where greater governmental focus is placed on reducing social inequalities in smoking. TCP were specifically sought out because they are considered experts in tobacco control, and as such they shape and are shaped by tobacco control discourses in their everyday work (Bacchi, 2009).

CHAPTER 3. METHODS

The theoretical approaches presented in the literature review chapter laid the foundations for the methods employed in this thesis, as described in this chapter. First, an overview of the research design of the study: a qualitative critical discourse analysis study anchored in population health intervention research. Then, what and how data were collected and analysed, according to both research objectives, are detailed. This includes two Bacchian approaches to analysis: *What's the Problem Represented to Be* (WPR) was used to analyse data related to objective 1, while data for objective 2 were analysed with the discursive practices analysis. The application of intersectionality and its contribution to the analysis is also explained. Finally, procedures to ensure rigour, ethical considerations, and methodological limitations are discussed.

3.1. Research design

3.1.1. Qualitative critical discourse analysis

As this thesis aims to critically examine recent tobacco control policy discourses in Quebec to better understand how such policies might impact social inequalities in smoking, this thesis drew broadly from critical discourse analysis (CDA) scholarship. CDA represents more than a technical framework for analysis; it is also a theoretical and methodological approach to better understanding how discourse is formed, namely by the social, political, cultural, and historical contexts that shape it (Arribas-Ayllon & Walkerdine, 2011; Fairclough, 2013; Howarth, 2010; Jørgensen & Phillips, 2002; Lupton, 1992). There are multiple approaches to CDA. Some proponents analyse discourse through various forms of linguistics, such as written statements, speeches, and dialogue (Fairclough, 2013; Lupton, 1992; Wetherell, 2001). However, post-structurally-informed CDA is a more appropriate CDA approach for this thesis given the theoretical lens of the thesis. What distinguishes post-structural CDA from other forms of CDA is the emphasis on discourse as a system of thought and knowledge that cannot be accessed by linguistic analyses (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Howarth, 2010; Jørgensen & Phillips, 2002). Instead, the focus of analysis resides in the social conditions and practices that reproduce certain discourses and exclude others (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Howarth, 2010; Jørgensen & Phillips, 2002). Therefore, CDA in this text will henceforth refer to the post-structurally-informed approach.

CDA aims to analyse discourse for the ways social phenomena and categories of people are represented, thus making explicit the presuppositions of these often unchallenged perspectives (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Bacchi & Goodwin, 2016; Howarth, 2010). Further, CDA examines the conditions facilitating the production of discourse and permitting its dominance in society (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Howarth, 2010). In this way, CDA can also explore "discursive practices", that is, the concrete actions that produce discourse (Arribas-Ayllon & Walkerdine, 2011; Bacchi & Bonham, 2014; Foucault, 1969; Jørgensen & Phillips, 2002). These practices involve formal representations of discourse (i.e., laws) and its informal transmissions, such as from expert to the public or through behaviour regulation – either self-regulation or of others (Bacchi, 2009; Bacchi & Bonham, 2014; Jørgensen & Phillips, 2002). Analysing discursive practices also includes how discourse is interpreted, received, and reproduced (Bacchi & Bonham, 2014; Jørgensen & Phillips, 2002).

Since discourse is not only produced, but also *produces* it is further understood as a manifestation of power (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Howarth, 2010). It produces social norms, which form our behaviours, beliefs, and social identities (Arribas-Ayllon & Walkerdine, 2011; Bacchi, 2009; Howarth, 2010). Better understanding how discourse is formed may therefore elucidate how it comes to have certain effects (Fairclough, 2013). In this vein, CDA affords a clearer grasp of power relations between different social groups and postulates why certain social phenomena attract greater policy attention than others (Howarth, 2010). For some CDA scholars, a focus on the effects of discourse on power relations, especially how they affect disadvantaged populations, is crucial (Howarth, 2010; Woodside-Jiron, 2004). This scholarship does not seek to generate further critique, but rather, to advocate on behalf of disadvantaged populations and to encourage policy makers to reflect on their practices and values (Woodside-Jiron, 2004).

3.1.2. Population health intervention research

This thesis, a qualitative CDA study, can also be viewed as population health intervention research (PHIR), a field that examines interventions seeking to change the social conditions that either promote health and/or prevent health risks for an entire population (Frohlich, 2014; Hawe & Potvin, 2009). PHIR was developed in response to the wealth of research focused on explicating

health problems, i.e., "the science of problems", and the lack of research seeking to understand the interventions that aim to redress them, i.e., "the science of solutions" (Hawe et al., 2012; Hawe & Potvin, 2009; Potvin et al., 2013). Advancing PHIR research not only expands knowledge in the science of solutions and improves intervention practices, but also furthers understandings of health problems (Hawe et al., 2012; Hawe & Potvin, 2009). PHIR can focus on any aspect of an intervention – from its implementation process, outcomes, mechanisms, to its interactions with the contexts in which it is deployed (Hawe et al., 2012; Hawe & Potvin, 2009).

This thesis is clearly aligned with the goals of PHIR; its objectives relate to better understanding the discourse of an intervention, that is, of population-level policies aiming to change the social and physical environments in which smoking occurs. Indeed, a CDA study examining policy discourse offers an important contribution to PHIR. Focusing on policy discourse, as a mechanism by which policy functions, advances knowledge with regard to *how* interventions come to have their effects (Bacchi, 2009). Furthermore, the central position of policy problematisations in a Bacchian post-structuralist approach allows the PHIR researcher to address both the sciences of problems and of solutions. That is, deconstructing how problems are conceptualised leads to a better understanding of the ways in which interventions are developed (Bacchi, 2009). Since policy discourse can reinforce problematisations, examining that discourse also open windows on how problematisations are legitimised, reproduced, and reinforced (Shaw, 2010).

3.2. Data sources and data collection

3.2.1. Document analysis

This study used two types of data collection to address its two research objectives (see Table 1, p. 90). The first research objective was addressed by an analysis of 11 publicly accessible transcripts of legislative discussions at the Quebec National Assembly (QNA) regarding Bill 44 (i.e., the proposed bill that eventually became L44). It is important to note that L44 was an amended version of the former tobacco control laws in Quebec adopted in 2005 (i.e., Tobacco Act), in 1998 (i.e., Tobacco Act), and in 1986 (i.e., An Act to Protect Non-Smokers in Certain Spaces). Parliamentary consultation sessions to discuss potential L44 measures were held between August and November 2015, prior to L44's adoption on November 26, 2015. The 11 documents

comprised approximately 578 pages of transcription: five were transcripts of parliamentary consultations with tobacco control stakeholders from various sectors (see Table 2 for a list of stakeholders, p.110-112) and six were transcripts of debates between legislators during the clause-by-clause review of L44. These documents were downloaded from the Quebec National Assembly's website (http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-44-41-1.html).

Table 1. Research objectives and corresponding data sources

Research objectives	Data sources
1. To critically examine the tobacco control discourses underlying L44 and in particular, to assess the role of social inequalities in smoking within these discourses.	Parliamentary transcripts from L44 consultations
2. To critically explore how Quebec TCP's engagement with tobacco control discourses shapes their perspectives and practices relating to the reduction of social inequalities in smoking.	Semi-structured interviews with TCP

Transcripts of discussions with tobacco control stakeholders and legislators were selected as a data source for their material representations of discourse (Arribas-Ayllon & Walkerdine, 2011; Greckhamer & Cilesiz, 2014; Shaw, 2010). In particular, transcripts highlighted the dynamic and fluid characteristics of discourse, as parliamentary discussions represented debates between stakeholders and legislators concerning the rationale underpinning proposed measures for L44. For this reason, these transcriptions were key to analysing how the policy problematisation was constructed, including the knowledges, values, beliefs, and assumptions that constituted these problematisations as well as the context that shaped its production (Arribas-Ayllon & Walkerdine, 2011; Bowen, 2009). Further, as these discussions are done in a parliamentary context and with the goal to adopt provincial legislation, they serve to demonstrate how problematisations were legitimised and with what justifications (Shaw, 2010). These discussions also represented a range of discourses and perspectives, as participating tobacco control stakeholders came from different sectors (Arribas-Ayllon & Walkerdine, 2011).

Stakeholders represented 39 organisations, including five independent speakers, reflecting a total of six different sectors. Most organisations were from the health sector (n=18), encompassing medical associations, physicians, and public health professionals. The private sector followed with 13 represented associations speaking on behalf of different types of businesses (e.g., restaurants, bars, and convenience stores). Although the tobacco industry is part of the private sector, the two tobacco companies consulted were classified in a distinct category due to the fact of their products (i.e., tobacco products) being targeted by L44 measures. Vaping companies and associations were excluded from the tobacco industry category because they stated that they were not, at that time, speaking in the interests of the tobacco industry. Participants also represented two social service organisations and three anti-tobacco advocacy groups. Lastly, one Montreal municipal city councillor participated in the consultations. However, considering the high prevalence of smoking among socially disadvantaged populations in Quebec, two conspicuous omissions from the participant list were noted: 1) people who smoked and 2) anti-poverty advocacy groups.

The perspectives of legislators (i.e., elected members of the QNA) were also expressed during the L44 legislative proceedings. At the time of the proceedings, Quebec was led by a Quebec Liberal Party (QLP) majority government. The participating QLP representative was the Minister for Rehabilitation, Youth Protection, and Public Health, who also presented L44's bill to the QNA. There was also representation from the official opposition parties: one representative from the Parti Québécois (i.e., first official opposition) participated in all proceedings, and the representation from the Coalition Avenir Québec (i.e., second official opposition) shifted between three different members of parliament during the course of the proceedings.

3.2.2. Interviews with TCP

Data from the transcripts were complemented with qualitative semi-structured interviews with TCP to obtain a more comprehensive and nuanced understanding of how social inequalities in smoking were integrated in the tobacco control discourses. As such, findings from the document analysis provided a foundation for designing the second data source and collection, which aimed to answer the second research objective. Interviews aimed to capture how TCP's engagement with tobacco control discourses, which meant examining how their perspectives and practices

reproduced, adapted, and/or challenged tobacco control discourses, shaped their perspectives and practices relating to the reduction of social inequalities in smoking (Shaw, 2010). As these interviews took place in 2019, interviews were also meant to demonstrated how TCP perceived the tobacco control context in Quebec post-L44 implementation, including L44's perceived effects and limitations.

TCP, who worked either with tobacco control policy and programming or smoking cessation, were recruited from various local, provincial, and federal public health institutes and organisations (names of organisations are omitted to preserve participant confidentiality) to obtain different discursive perspectives and practices (Arribas-Ayllon & Walkerdine, 2011). Participants had to be located in Quebec, preferably in Montreal to facilitate face-to-face interviews. To recruit participants, I made a first list of potential participants from my own professional network and by searching the internet. The list was revised and validated by the thesis supervisors. A presentation of the study objectives and interview process was also done at a smoking cessation practitioner training day in order to recruit more participants. Finally, the snowball method, consisting of soliciting recommendations from participants, was employed to ensure that no key Quebec TCP were omitted. In total, 23 TCP were contacted.

The first contact was made by email, followed-up by telephone and/or with a second email for those whose phone number could not be found. Of the 23 potential participants, three no longer worked in tobacco control, three declined to participate, and seven did not respond. Two of the three who declined worked in smoking cessation and did so due to time constraints. The third decline, who was semi-retired from smoking prevention and tobacco control policy advocacy, did not provide a reason for declining. Regarding those who did not respond to invitations, four of the seven worked in smoking cessation and were likely too busy with their many patients. Of the other three non-respondents, one held a senior position in smoking prevention and two were smoking prevention program coordinators. A total of 10 TCP participated in interviews.

Before conducting the interviews, I drafted a semi-structured interview guide that was then discussed, revised, and validated with the thesis supervisors. The questions, inspired by preliminary findings from the document analysis, related to: 1) TCP's work in tobacco control; 2)

their understandings of smoking in Quebec and the major smoking-related problems that remain; 3) their views on the design, aims, and impacts of L44; 4) their views on the future of tobacco control in Quebec; and 5) their perspectives on social inequalities in smoking. I piloted the interview guide twice with TCP who were not included in the sample. Any unanticipated follow-up questions or re-formulated questions were noted and, at the end of the interview, pilot participants were asked for their feedback on the questions and overall structure of the interview. The first pilot participant provided some constructive feedback, which was integrated into the guide. The revised interview guide was tested with the second pilot participant who thought the interview went smoothly and offered no further feedback. The audio of these two pilot interviews was recorded in case of any need for review, however, no transcriptions were produced and no data collected during these pilot interviews were included in the final dataset. The final interview guide was approved by the thesis supervisors (see Appendix IV).

Following this pilot process, semi-structured interviews with each of the 10 participants were conducted. Eight participants, located in Montreal, were interviewed face-to-face and the remaining two participants, located outside of Montreal, were interviewed by video and telephone. The interviews, all conducted in French per the participants' preference, were recorded on my password-protected personal laptop and spanned between 60 and 90 minutes each. The entire process – from pilot interviews through recruitment and conducting interviews – took approximately five months to complete (i.e., January to May 2019). This length of time was needed to accommodate TCP's schedules.

3.3. Data analysis

3.3.1. Document analysis: What's the Problem Represented to Be analytical approach

There is no set procedure or specific technique tied to CDA (Arribas-Ayllon & Walkerdine, 2011). However, Bacchi's (2009) post-structural analytical framework *What's the Problem Represented to Be* (WPR) is a clear and concrete framework for policy discourse analysis. It namely permits an analysis of key CDA concepts, such as problematisation, normalisation, and subjectification. For this reason, WPR was employed to analyse the parliamentary document data.

To complement this framework, an intersectional lens was applied to interpret some of the data, specifically with respect to questions 4 and 5 (see below).

WPR consists of six analytical questions that deconstruct a policy's problematisation: (Bacchi, 2009, p. xii):

1. What's the "problem" represented to be in a specific policy?
2. What presuppositions or assumptions underlie this representation of the "problem"?
3. How has this representation of the "problem" come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be thought about differently?
5. What effects are produced by this representation of the "problem"?
6. How/where has this representation of the "problem" been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

WPR's first question serves to clarify the implied policy problem rather than the explicit problem at the forefront of the policy (Bacchi, 2009; Bacchi & Goodwin, 2016). Once the policy problem has been identified, the second question seeks to examine the "conceptual logics", that is, the meanings, assumptions, and knowledges that have shaped this problematisation and are taken for granted or remain unchallenged (Bacchi, 2009; Bacchi & Goodwin, 2016). The third question aims to uncover the conditions that made the problematisation possible and to better understanding the development of the problematisation prior to the policy in question. This might be done by identifying key events, legislation, practices, and knowledges that shaped the problematisation and allowed for it to become dominant. Question 4 brings forth the issues and perspectives that are excluded or silenced from the policy, i.e., what was not problematised (Bacchi, 2009; Bacchi & Goodwin, 2016). This involves reflecting on how the problem could have been conceptualised if the needs, interests, and perspectives of forgotten or overlooked social groups, such as disadvantaged groups, had been considered. For the purposes of this thesis, question 4 was also interpreted using an intersectional lens to specifically explore what social identities were excluded and/or silenced in L44's problematisations.

Question 5 unpacks an investigation of the effects of a policy's discourse in order to identify which aspects of the problematisation have detrimental and/or beneficial effects, and for

which groups, and thus prompts consideration of the policy's long-term impacts on social change (Bacchi, 2009). In this type of analysis, effects are not equivalent to the causal effects of an intervention. Rather, they relate to: 1) discourse effects, which consist of the limitations or boundaries to understanding a problem from a specific discursive perspective; 2) subjectification effects, which involve how people might perceive or experience discursive representations of themselves or other social groups (e.g., how the smoker and the non-smoker are represented). Intersectionality brings additional depth to this question by identifying oppressed social groups typically excluded from policy representation; and 3) lived effects, which represent the ways that the problematisation might impact individual lives, for instance, how it might affect access to resources or employment opportunities (Bacchi, 2009). Finally, question 6 was designed to identify how a problematisation is justified and defended, that is, how it comes to be perceived as legitimate, and further, enjoins the analyst to reflect on ways that the problematisation might be challenged or resisted, and by whom (Bacchi, 2009).

To apply WPR, each legislative document was uploaded to Atlas.ti, a software for qualitative data management and analysis. A deductive coding scheme was created based on WPR's analytical questions, with specific codes for the principal interest of the thesis: social inequalities in smoking. The coding scheme was discussed, revised, and validated with the thesis supervisors. Each document was read thoroughly and relevant data was identified with its corresponding code. Inductive codes were also added to the coding scheme. Analytical memos of thoughts, interpretations, and connections between codes were retained. This initial analysis generated highly detailed data, making the major themes difficult to discern. The thesis supervisors and I therefore agreed to redo the analysis without codes. Instead, I read each transcript document while taking careful notes of relevant data relating to WPR questions, after which a summary of these data, answering each WPR question, was produced for each transcript. I then read through the 11 summaries to identify themes, which were compared and contrasted across summaries, resulting in high-level and low-level themes. High-level themes, and the low-level themes they regrouped, were compiled into one overall summary. Themes from the 11 summaries and from the overall summary were discussed and validated with the thesis supervisors.

3.3.2. Interview analysis: A "discursive practices" analytical approach

Analysis of the interview data was only conducted after the document analysis had been completed. The objective for the interview analysis was not to analyse the policy problematisation, which had already been accomplished via the document analysis, but rather to better understand how TCP, through their perspectives and practices, reproduced, adapted, and/or challenged tobacco control policy discourses to shape their perspectives and practices in relation to social inequalities in smoking in the post-L44 context. To this end, the Bacchian "discursive practices" analysis was applied (Bacchi & Bonham, 2014). This analysis is based in the post-structural concept of discursive practices, which refers to the actions that shape and reproduce discourse (Bacchi & Bonham, 2014; Foucault, 1969). Although there is no set framework for this analysis, contrary to WPR, a discursive practices analysis seeks to identify these practices, how they shape and are shaped by discourse, and what conditions (i.e., "rules of formation") facilitate the reproduction of such practices (Bacchi & Bonham, 2014; Foucault, 1969). While this type of analysis is rarely used in public health research, it offers an innovative critical lens to the analysis of tobacco control policy by examining how TCP's interactions with tobacco control policy discourses impact their practices in tobacco control and with respect to social inequalities in smoking.

To conduct the analysis, the interview recordings were first transcribed verbatim by a professional transcriber. I subsequently reviewed those transcriptions while listening to the recordings to correct any inconsistencies in the transcripts before uploading them to Atlas.ti. I developed a deductive codebook based on the concept of discursive practices, which was discussed, revised, and validated with the thesis supervisors (see Appendix V for the interview data codebook). I then thematically analysed the data thematically using these deductive codes and kept memos of analytical thoughts during the coding process. For each interview, I wrote a brief summary of its main themes. Once all 10 interviews had been coded, I compared and contrasted themes to identify the high-level themes. Summaries were discussed and themes were agreed upon, including the high-level themes, with the thesis supervisors.

3.4. Rigour of the research process

In qualitative research, strategies have been developed to ensure methodological rigour (Lincoln & Guba, 1985; Saumure & Given, 2008). In this thesis, such strategies were not used to reach an objective "truth" regarding how tobacco control policy discourses affect social inequalities in smoking (Fusco, 2008). Rather, they serve to determine the quality and trustworthiness of the findings, as well as the integrity and legitimacy of the research process (Saumure & Given, 2008; Tobin & Begley, 2004). The following four practices were employed to ensure rigour: 1) transparency; 2) credibility; 3) reliability; and 4) reflexivity. First, transparency was achieved by explicitly documenting the step-by-step research process as well as the rationale for selecting the methods. I also kept detailed notes of every data analysis meeting held with the thesis supervisors to establish a record of decisions made and the rationale for those decisions, thereby facilitating assessment of the appropriateness of the methods (Greckhamer & Cilesiz, 2014; Saumure & Given, 2008).

Second, credibility, or providing confidence in the findings, was realised by exploring negative cases, that is, data that did not confirm the argument of the study or that countered trends in the data. In this way, negative cases complexify the phenomenon under examination (Lincoln & Guba, 1985; Saumure & Given, 2008). Triangulation is another method that was used to support the credibility of the research process (Lincoln & Guba, 1985). Two data sources (i.e., documents and interviews) were sourced to provide a richer, deeper understanding of the problem (Lincoln & Guba, 1985). To strengthen the credibility of the research, direct quotations from documents and interviews were also used in the description of findings, demonstrating that analytical interpretations are grounded in data (Greckhamer & Cilesiz, 2014). Third, reliability, meaning a consistency and stability of findings, was achieved by validating the analysis and interpretations of findings through discussion with the thesis supervisors (Lincoln & Guba, 1985; Saumure & Given, 2008). Lastly, I engaged in reflexivity regarding the data and the research process by making explicit my personal and professional background and interests. This affords greater understanding of possible influences on interpretations of findings – for both me and other researchers – while pushing me to challenge and reflect beyond the constraints of my background and interest (Lincoln & Guba, 1985; Saumure & Given, 2008).

3.5. Ethical considerations

The Health Research Ethics Committee of the Université de Montréal granted ethical approval for this study (see Appendix VI for approval letter). Since all the documents were publicly accessible, there were no ethical issues regarding the document analysis. With respect to TCP participation in the interviews, there were few ethical considerations as TCP participants were all adults who did not represent a disadvantaged population (CIHR et al., 2018). Ultimately, ensuring confidentiality of TCP and their interview data was the only ethical consideration. To respect their confidentiality, all TCP signed a consent form (see Appendix VII) confirming that their names and any other identifying information would be kept confidential. Consent forms also detailed that data would be securely stored on a personal password-protected computer accessible only by me. The thesis supervisors and the professional transcriber were the only other people allowed access to that data, which the thesis supervisors consulted only to validate analyses. While no names appeared on the transcripts or on the audio files, some participants did mention some information about their organisation in their interview. As affirmed in the consent form, all potentially identifying information was omitted from any quotations used in the thesis, publications, or presentations.

Consent forms also explained the voluntary nature of interview participation; participants could at any time refuse to answer any question or stop the interview without need for justification. No benefits could be derived from participating in the study, but participants were informed of how the study would contribute to advancing tobacco control research. I provided a verbal summary of the consent form to each participant, after which they had as much time as they needed to read it and ask questions. Hard copies of the signed consent forms are stored in a locked filing cabinet in Dr. Frohlich's research office at the Université de Montréal, to which only she and I have access.

3.6. Limitations

Regarding limitations to document analysis, the parliamentary discussions were not undertaken for research purposes (Bowen, 2009; Gross, 2018). Further, as they occurred in the past without my involvement, I could not interact with the stakeholders, for instance, to ask follow-up or clarifying questions. Document analyses thus run the risk of not providing sufficient data to

understand the social phenomena under study (Bowen, 2009; Gross, 2018). Conducting interviews with TCP was a strategy to obtain complementary data to ensure a more comprehensive understanding of the ways in which tobacco control policy discourse might come to affect social inequalities in smoking in Quebec (Bowen, 2009; Gross, 2018).

The low participation rate of TCP (i.e., 10 participants out of 23 invitations) may indicate a sampling bias. As a result, some perspectives of tobacco control policies and social inequalities in smoking may not be represented in the findings. Further, approximately half of the participating TCP were acquainted with Dr. Frohlich's work, as well as my own, and the focus we place on social inequalities. They may have placed more emphasis on social inequalities in smoking than is reflected in their regular practices due to our interest in the topic. Triangulating interviews with parliamentary documents helped to address this potential bias, as interpretations and conclusions made in this thesis are not solely based in interview data (Bowen, 2009).

Our sample reflects the diversity of TCP practice in Quebec, a relatively small population. In particular, the differences between those who work in policy and program design and implementation versus those who work in smoking cessation enabled to capture varying perspectives. Recruiting TCP outside of Montreal might have increased the sample size, but conducting in person interviews was privileged to telephone over video interviews. In person interviews capture nuances, particularly in non-verbal communication, that are harder to discern by telephone or video. Expanding participant criteria to include professionals working in community organisations with a socially disadvantaged clientele who smoke might have reduced the potential sampling bias and added other perspectives on tobacco control discourses and social inequalities in smoking. However, the rationale for limiting the sample to TCP was because of the potential for greater relevancy in interpretations regarding tobacco control discourses, as TCP work directly with these discourses and thus have more intimate and detailed knowledge of these discourses than those who do not directly work in this field.

CHAPTER 4. RESULTS

ARTICLE 2: A critical discourse analysis of a tobacco control policy in Quebec: Protecting the population against smoking or smokers?

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Contributions to this article

I conceptualised the idea and argument for this article, analysed the data, and wrote the manuscript. Drs. Frohlich and Haines-Saah guided me in the analysis, data interpretation, and presentation and discussion of findings. They also provided critical feedback on the entire manuscript.

Abstract

In this study, we used a Bacchian approach to critically analyse the discourse informing Quebec's 2015 tobacco control policy, An Act to Bolster Tobacco Control (L44), to better understand how it may affect the persistent problem of social inequalities in smoking. Our material consisted of publicly available transcripts of L44 pre-adoption parliamentary sessions with key tobacco control stakeholders. Findings suggest that L44 reinforces and advances an anti-smoking discourse by problematising "the smoker" as a distinct, morally deviant category of people from which "the non-smoker" should be protected. Our analysis demonstrates the effects of this problematisation, notably reifying power relations between non-smokers and smokers to justify non-smokers' regulation of people who smoke. We conclude that discourse fostered by L44 further subjectifies and regulates people who smoke by anchoring smoking status as a social identity intersecting with other social identities, such as socio-economic status, gender, and/or race. Consequently, by reinforcing and reproducing an anti-smoking discourse centered on the needs of the non-smoking majority, tobacco control policies have the potential to further marginalise socially disadvantaged people who smoke, thus entrenching social inequalities in smoking.

HIGHLIGHTS

- Research is lacking on how tobacco control affects social inequalities in smoking
- We critically analysed discourse underpinning a Quebec tobacco control policy
- Moral representations of smokers give non-smokers power to regulate smokers
- Power relations between non-smokers and smokers reflect differences in social class
- Tobacco control discourse may entrench social inequalities in smoking

KEYWORDS: Quebec; Social Inequalities in Smoking; Tobacco Control; Discourse; Smoking; Power Relations; Critical Discourse Analysis; Document Analysis

Introduction

Tobacco control policies, such as smoke-free legislation, taxation, and tobacco product regulation, have been championed in public health over the last 30 years for their contribution to significant decreases in smoking prevalence (Feliu et al., 2019; Hoffman and Tan, 2015). At the same time, social inequalities in smoking have increased, in that smoking prevalence remains higher among populations of lower socio-economic status (SES) than among more privileged populations (Corsi et al., 2014). Further, smoking initiation occurs at a younger age for lower SES groups, who smoke more cigarettes per day, have lower cessation rates, and are exposed to more second-hand smoke (SHS) than people of higher SES (Corsi et al., 2014; Homa et al., 2015; Kuntz & Lampert, 2016; Reid et al., 2010; Siahpush et al., 2006). Persistent social inequalities in smoking have also been noted in the Canadian province of Quebec. In 2015-16, 12.9% of people who smoked in Quebec had a university degree while 24.8% had not completed their high school education (Lasnier et al., 2019). These differences may translate to health inequalities such that low SES populations carry a disproportionately heavier burden of smoking-related illnesses (Kulik et al., 2013).

Some public health research has investigated tobacco control policies' potential unintended contribution to increasing social inequalities in smoking (Amos et al., 2011; Brown et al., 2014; Hill et al., 2014; Thomas et al., 2008). It is hypothesised that these policies may increase social inequalities in health because their focus on population-level change does not account for the specific needs of disadvantaged populations (Frohlich & Potvin, 2008). However, evidence on the nature of the effect (i.e., increase, decrease, or no effect) remains inconsistent (Amos et al., 2011; Brown et al., 2014; Hill et al., 2014; Thomas et al., 2008), with evidence elucidating *how* tobacco control policies come to have effects on social inequalities in smoking is scant.

Policy discourse has been studied extensively within social science scholarship to better understand how they are enacted and how they produce outcomes (Bacchi, 2000; Fairclough, 2013; Wetherell, 2001). Tobacco control policy discourse is relatively underexplored but may be critical in elucidating its effects on social inequalities in smoking. The existing literature suggests that tobacco control policy discourse is principally focused on denormalising smoking, i.e., transforming social representations of smoking from acceptable to unacceptable in order to reduce smoking prevalence (Kelly et al., 2018; Lavack, 1999). This denormalisation occurs in various ways: some do so by communicating the negative health impacts of smoking, often with imagery evoking negative social representations of smoking and people who smoke (Haines-Saah et al., 2015; Thompson et al., 2009), and others by rendering smoking increasingly invisible in public life (Kelly et al., 2018).

While smoking denormalisation has been found to influence smoking cessation and prevent initiation in the general population (Alamar & Glantz, 2006; Brown et al., 2009; Hammond, 2006; Kelly et al., 2018), socially disadvantaged populations who smoke have responded differently (Frohlich et al., 2010; Gilbert, 2008; McCready et al., 2019; Sanders et al., 2019; Thompson et al., 2007). Research which focused on the experiences of low SES people who smoke reported that smoking denormalising messages did not resonate with them and that they felt alienated from the tobacco control movement (Frohlich et al., 2010; McCready et al., 2019; Thompson et al., 2007). These messages have also left people who smoke feeling stigmatised and marginalised (Frohlich et al., 2012; McCready et al., 2019; Poland, 2000; Sanders et al., 2019). In some cases, tobacco use has been found to limit access to employment and health care (McKie et al., 2003; Voigt, 2012). For low SES people who smoke, smoking stigmatisation and marginalisation can

exacerbate the effects of their existing relative powerlessness and disadvantage (Antin et al., 2017; Frohlich & Potvin, 2008; Thompson et al., 2007). Qualitative research has consequently found that some low SES people who smoke continue to do so out of a sense of resignation (due to a lack of cessation resources and exposure to permissive smoking environments), while others persist in smoking as an act of resistance against dominant anti-smoking norms (Frohlich et al., 2010; Poland, 2000; Sanders et al., 2019; Thompson et al., 2007). Although this research has carved a path to better understanding the impact of tobacco control policy discourse on social inequalities in smoking, little research has examined the policies themselves to explicate their discursive effects.

In 2015, Quebec amended its 2005 tobacco control policy that prohibited smoking in all workplaces and indoor public places, such as restaurants, bars, bingo halls, bowling alleys, and casinos (QNA, 2005). In keeping with the World Health Organization's Framework Convention on Tobacco Control (2005), Quebec's 2015 policy, An Act to Bolster Tobacco Control (L44), aimed to: 1) prevent youth smoking initiation; 2) protect non-smokers from SHS exposure; and 3) encourage smoking cessation (QNA, 2015). To that end, L44 further prohibited smoking and vaping in public (e.g., playgrounds, restaurant and bar terraces) and private places (e.g., vehicles with children aged 16 and under present), and increased regulations on tobacco products (e.g., enlarged pictorial warnings on cigarette packages and banned flavoured cigarettes; QNA, 2015). As yet, there is little evidence on the equity impacts of L44, but recent findings demonstrate that while SHS exposure in vehicles and homes decreased for all SES groups after L44's implementation, significant social inequalities in these outcomes persist, especially for youth

(reference withheld for blind review). Thus, the ways in which L44 has impacted social inequalities in smoking in Quebec remains unknown.

Theoretical framework

We drew on Bacchi's critical approach to policy discourse (2009), which is situated within Foucauldian post-structuralism, to guide our study. The unique feature of this approach is its attention to "problematisations" within policy discourse. That is, rather than understanding certain social phenomena (e.g., smoking) as inherently problematic and policies as solutions to address these problems, a Bacchian approach considers how social phenomena are constructed into problems (i.e., problematisation) by policy makers and advocates and then reinforced through policy discourse. As such, policy discourses are produced by certain, often dominant, knowledges, assumptions, and values, to the exclusion of others. This specific narrative of the problem is generally considered by the public as "truth" or "fact", although many other perspectives may exist but get less traction. As a result, problematisations constrain the understandings of and solutions to policy problems.

Bacchi (2009) argues that "we are governed through problematisations" (p.25). This key aspect of her approach makes clear how these problematisations come to shape individuals' beliefs and actions. By casting social phenomena in a specific light, problematisations shape social norms by reflecting ideal behaviours and values, while simultaneously discouraging others (i.e., normalisation; Bacchi, 2009; Foucault, 1975). Professionals, including doctors, teachers, and scientists, reinforce these norms to the public through their expertise (Bacchi, 2009). In response, individuals tend to self-monitor and self-regulate their own behaviours and beliefs in accordance with dominant social norms (Bacchi, 2009; Lupton, 1995). Problematisations also produce

categories of people with common characteristics, such as “smokers” and “non-smokers”, as well as their social positions in relation to other social groups. This process, called subjectification, influences people’s behaviours, perspectives, and relationships (Bacchi, 2009; Carro-Ripalda et al., 2013).

Social norms also contribute to (re)producing power relations; those who adhere to them are perceived as having moral high ground over those who deviate from them (Foucault, 1982; Jodelet, 2008). These power relations become embedded in everyday life, reinforcing self-monitoring and self-regulation as well as justifying the monitoring and regulation of others’ behaviours (e.g., telling someone not to smoke; Fischer & Poland, 1998). It is thus through policy discourse that the state is able to monitor and regulate (i.e., govern) a population’s behaviour from a distance, rarely interfering directly in people’s lives (Bacchi, 2009; Foucault, 1975, 1976). It is important to note, however, that individuals are not passive subjects acting according to the social norms imposed on them. Rather, they adapt, challenge, and/or resist these norms (Gilbert, 2008).

Although post-structuralist approaches are increasingly used in critical tobacco control research (Fernández, 2016; Frohlich et al., 2012; Gilbert, 2008; Poland, 2000; Thompson et al., 2007), Bacchi’s approach has not previously been applied. It has, however, been adopted in public health policy analysis, notably for examining policies concerning drug use, food insecurity, as well as physical activity and obesity (Alexander & Coveney, 2013; Booth & Whelan, 2014; Fraser & Moore, 2011; Lancaster & Ritter, 2014; Salas et al., 2017; Thomas & Bull, 2018). A Bacchian approach fosters analysis beyond policies’ efficiency to modify health outcomes, seeking to question how policies problematise phenomena and the potential effects that these

problematisations may have, notably on disadvantaged populations.

This study is part of a larger project examining the implementation of L44 to understand *what* effects L44 has had on social inequalities in smoking (reference withheld for blind review) and *how* it came to have these effects. For this paper, we address the latter question by using a Bacchian approach to critically analyse L44's discourse. More specifically, we explored how this discourse problematised smoking, people who smoke, and the potential effects of this discourse on social inequalities in smoking.

Methods

To access the discourse informing L44, we collected all the publicly accessible parliamentary documents of L44 legislative discussions that took place between August to November 2015, prior to L44's adoption on November 26, 2015 (see the QNA's website for access to documents: http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-44-41-1.html). In total there were 11 documents, comprising approximately 578 pages of transcription. Of these documents, five were transcriptions of parliamentary consultations with tobacco control stakeholders from various sectors (see Table 1 for list of represented organisations) and six were transcriptions of debates between legislators during the clause-by-clause review of L44. The (ethics committee name withheld for blind review) granted ethical approval for this study.

Table 2. Detailed information of L44 parliamentary documents

Date of parliamentary session	Type of parliamentary session	Number of pages	Represented Sectors	Organisations represented by invited speakers
August 18, 2015	Consultation	87	• Tobacco Industry (1) • Private Sector (3) • Medical/Health Sector (3) • Social Services Sector (1)	• Compagnie de tabac sans fumée • Association des propriétaires de sheesha du Québec • Fédération médicale étudiante du Québec • Association pulmonaire du Québec • Institut de cardiologie de Montréal • Centre de jeunesse de Montréal – Institut universitaire • Corporation des propriétaires de bars, brasseries et tavernes du Québec • Association canadienne du vapotage
August 19, 2015	Consultation	70	• Private Sector (4) • Anti-Tobacco Groups (1) • Medical/Health Sector (3)	• Association pour les droits des non-fumeurs • Independent speakers (two doctors) • Fondation des maladies du cœur et de l'AVC, Québec • Association des restaurateurs du Québec • Association des détaillants en alimentation du Québec • Fédération canadienne de l'entreprise indépendante • Association des propriétaires du Québec
August 20, 2015	Consultation	82	• Private Sector (3) • Medical/Health Sector (4) • Social Service Sector (1)	• Association québécoise des dépanneurs en alimentation • Directeurs régionaux de santé publique • Les Breuvages Blue Spike • Institut national de santé publique du Québec • Institut Philippe-Pinel de Montréal

				• Réseau du sport étudiant du Québec • Coalition Priorité Cancer au Québec • L'union des tenanciers de bars du Québec
August 31, 2015	Consultation	53	• Tobacco Industry (1) • Private Sector (3)* • Anti-Tobacco Groups (1)	• Coalition québécoise pour le contrôle du tabac • Association des marchands, dépanneurs et épiciers du Québec • Imperial Tobacco Canada • *Coalition nationale contre le tabac et la contrebande • Fédération des chambres du commerce du Québec
September 3, 2015	Consultation	75	• Medical/Health Sector (8) • Anti-Tobacco Groups (1) • Municipal Politics Sector (1)	• Direction de la santé publique du Ministère de la santé et des services sociaux • Conseil québécois sur le tabac et la santé • Association médicale du Québec • Société canadienne du cancer – Québec • Independent speakers (two doctors; 1 epidemiologist) • Fédération des médecins spécialistes du Québec • Independent speaker (elected city councillor) • Centre intégré universitaire de santé et de service sociaux – Nord-de-l'Île-de-Montréal
November 5, 2015	Clause-by-clause review	42	N/A	• Ministère de la santé et des services sociaux
November 10, 2015	Clause-by-clause review	48	N/A	• Ministère de la santé et des services sociaux
November 11, 2015	Clause-by-clause review	17	N/A	• Direction de la santé publique du Ministère de la santé et des services sociaux
November 12, 2015	Clause-by-clause review	33	N/A	• Direction de la santé publique du Ministère de la santé et des services sociaux

November 17, 2015	Clause-by-clause review	29	N/A	• Ministère de la justice • Ministère de la santé et des services sociaux
November 18, 2015	Clause-by-clause review	42	N/A	N/A
TOTAL	N/A	578	• Tobacco Industry (2) • Private Sector (13) • Medical/Health Sector (18) • Social Service Sector (2) • Anti-Tobacco Groups (3) • Municipal Politics Sector (1) Total: **6** sectors representing **39** organisations (including independent speakers)	• 34 organisations represented • 5 independent speakers

* The *Coalition nationale contre le tabac et la contrebande* represents the interests of mostly private organisations, including those of the tobacco industry (https://www.stopcontrabandtobacco.ca/?lang=fr).

Stakeholders represented 39 organisations, including five independent speakers, reflecting six different sectors. Most organisations were from the health sector (n=18), encompassing medical associations, physicians, and public health professionals. The private sector followed with 13 represented associations speaking on behalf of different types of businesses (e.g., restaurants, bars, and convenience stores). Although the tobacco industry is part of the private sector, we classified the two consulted companies in a distinct category due to the fact of their products (i.e., tobacco products) being targeted by L44. We excluded vaping companies and associations from the tobacco industry category because they stated they were not, at that time, speaking in the interests of the tobacco industry. Participants also represented two social service organisations and three anti-tobacco advocacy groups. Lastly, one Montreal municipal councillor participated in the consultations. The perspectives of legislators (i.e., elected members of the Quebec National Assembly) were also expressed during L44's legislative proceedings. In essence, a wide range of

stakeholders were present and diverse perspectives were heard. However, considering the high prevalence of smoking among socially disadvantaged populations in Quebec, we noted two conspicuous omissions from the participant list: 1) people who smoke and 2) anti-poverty advocacy groups.

Data analysis

We applied Bacchi's (2009) critical policy analysis approach called "What's the Problem Represented to be" (WPR) to analyse our data. This approach consists of six analytical questions that aim to uncover problematisations in the policy discourse and to identify the assumptions, knowledge, and values used in their construction, including omitted perspectives and knowledge, justifications for the problematisation, as well as processes by which the problematisation becomes dominant. WPR also explores the effects that problematisations produced or may produce. WPR's six analytical questions are (Bacchi, 2009, p.xii):

Q1. What's the 'problem' represented to be in a specific policy?

Q2. What presuppositions or assumptions underlie this representation of the 'problem'?

Q3. How has this representation of the 'problem' come about?

Q4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?

Q5. What effects are produced by this representation of the 'problem'?

Q6. How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

Each legislative document was uploaded to Atlas.ti. The first author created a deductive coding scheme based on WPR's analytical questions, with additional codes for social inequalities

in smoking. To validate the codes, the first and last author coded the same legislative document and compared their coding. The coding scheme was then revised due to some discrepancies. All authors approved the final codebook. The first author then coded each document, while also adjusting the coding scheme for any inductively identified themes. Analytical thoughts and questions arising during coding were also recorded in memos. This analysis generated highly detailed data, from which it was difficult to discern major themes. The analysis was thus redone by reading each document to notate data responding to WPR questions, and then answering those questions using the WPR notes with added detail from the first analysis. Once this process was completed for all 11 documents, the first author compared and contrasted findings from the summaries and grouped them into three high-level themes. Data from WPR analyses and the overall summary of analyses were discussed and validated with the two other authors.

Findings

Our analysis allowed to identify the underlying problematisation of L44: that non-smokers continue to be exposed to discursive representations of "the smoker" as a moral deviant, at least in public life. Additionally, we discerned three overarching themes demonstrating how this problematisation is shaped, justified, and the effects it may have. Findings are structured according to those themes: 1) reinforcing the problematisation of the smoker; 2) the problematisation as bolstered through power relations; and 3) non-smokers as L44 enforcers. Quotations were translated from French to English by the first author and validated by the third, both of who are completely bilingual.

Reinforcing the problematisation of the smoker

At first glance, the problem put forward by legislators and anti-smoking stakeholders was the negative health effects of the continued population-level exposure to smoking. However, reflecting on WPR's Q1 (i.e., What's the problem represented to be?), we observed that the more preoccupying concern for legislators and anti-smoking stakeholders was non-smokers' continued exposure to the smoker in public spaces, due to the way that people who smoke are socially and morally perceived. Indeed, with Q3 (i.e., How did the problematisation come about?), we discerned that this problematisation relied upon, reproduced, and reinforced pre-existing representations of the smoker and the non-smoker. These representations (described below) have been produced and reproduced by the smoking denormalisation discourse of tobacco control policies. An anti-smoking advocate demonstrated this point by underlying the impact of smoking denormalisation efforts in Quebec: "… we think it is very important to change norms, which has been done quite a bit in Quebec during the last 25 years …" (August 20, 2015). Indeed, according to one legislator, Quebec was known for its high smoking prevalence: … Quebec, a region that used to be considered the smokers' corner of North America in the 70s and 80s …" (November 5, 2015).

As per Q2, we found that representations of the smoker and the non-smoker relied upon and reinforced assumptions about people in each respective group. People who smoke were discussed by stakeholders in two contrasting ways. Sometimes, they were deemed responsible for inflicting the consequences of smoking on themselves, others, indoor and outdoor environments, as well as on health care system costs. Highlighting this point, one legislator argued: "… we have to legislate in order for fewer people to smoke and to intoxicate others with second-hand smoke." (August 31, 2015). This representation stemmed from the perception of smoking as an individual

choice and responsibility. However, some anti-tobacco stakeholders recognised the stigmatising effect of this kind of representation on people who smoke; placing all responsibility on the individual negates the important effects of nicotine addiction. Under this lens, people who smoke were also depicted as victims suffering from smoking-related illness and addiction, and at the mercy of that addiction and the tobacco industry's marketing tactics. Indeed, an anti-smoking advocate claimed that nicotine addiction was similar to other drugs such as heroin:

> It's a hard drug that works the same neurotransmitters as heroin. So let's stop thinking that it's just a bit of smoke and that people, if they smoke, it's because they feel like it. People are sick. … it's not just a bad habit, it's an illness. (November 5, 2015).

At the same time, people who smoke were also portrayed as having some agency over their smoking practice – over where or around whom they smoked. People who smoke who do so away from non-smokers were perceived as considerate and respectful, while others were seen as deviant.

Non-smokers were, conversely, represented as victims of people who smoke, subjected to second and third-hand smoke exposure and having little agency against the harmful influence of people who smoke. Exposure to people who smoke and/or vape, was argued, could incite them to smoke and could put Quebec society at risk of smoking re-normalisation. An anti-smoking advocate highlighted this point:

> … the biggest danger is to create, in the end, new smokers, new vapers among our youth who hang out on terraces, who go to bars, who, in the end, will continue to perpetuate the gesture of smoking, perpetuate the habit, develop a nicotine addiction. (August 18, 2015)

We found that these discursive representations of the smoker and the non-smoker relied heavily on medical and public health knowledge and expertise, which corresponds to the sector that many stakeholders represent. The explicit endorsement of this expertise precluded other sources of knowledge (Q4, i.e., What is left unproblematic?), including the expertise of social inequalities researchers and the experiences of people who smoke. Medical-based knowledge also informed stakeholders' conceptualisations of health as limited to physical health, often neglecting other types of health (e.g., mental, spiritual, and well-being). Health was also discussed as a binary of healthy or not healthy, with the relationship between smoking and health clearly positioned: those who do not smoke were considered healthy and those who smoke or those who are exposed to SHS, unhealthy. A physician illustrates how just one cigarette puff creates health problems:

> So, just one cigarette, just one puff of a cigarette vasoconstricts the coronaries. So, if you do an angiogram on a patient, and then you make him smoke – we did this in our research – you see the artery start to vasoconstrict. Just one puff. (August 18, 2015).

Justifications for strengthening smoking denormalisation and for adopting proposed tobacco control measures were often rooted in the imperative of "being healthy", reflecting the value of health in Quebec society. Thus, people who smoke were not only conceptualised as partaking in a socially unacceptable practice, but more so, as transgressing an important moral and social value. We observed this moral judgment through discursive representations of people who smoke, especially in relation to non-smokers. Conversely, non-smokers were viewed as conforming to social and moral health expectations by non-smoking, and thus, were represented in good moral standing. One legislator exemplified moral representations of non-smokers when casting those who support smoke-free measures as "good" people: "… we must act as good

citizens, as good fathers, and as good mothers, we must act on terraces …" (August 19, 2015). What he is implicitly saying is that those who do not support these legislations are "bad" people.

The problematisation as bolstered through power relations

As Q5 directs, we considered the effects of these moral representations and found that they served to reinforce power relations between the non-smoker and the smoker, with those who do not smoke positioned as morally superior to those who do. We identified various ways in which these power relations were manifested in discourse. Notably, the problematisation reflected non-smokers' needs for protection against the smoker, with little consideration for the needs of people who smoke. Indeed, legislators and anti-smoking advocates expressed concern for non-smokers' exposure to the smoker, perceived that it might re-normalise smoking, incite smoking initiation (particularly for youth), and disturb non-smokers when sharing public spaces with people who smoke. These concerns were also used to justify, defend, and promote the problematisation (i.e., Q6), as argued by a legislator who underlined the importance of protecting non-smokers: "We must be prudent towards all new realities that could potentially trivialise the act of smoking or even to increase the usage of tobacco products, especially among youth, who are, with non-smokers, at the heart of my preoccupations." (August 18, 2015). Conversely, and as per Q4, we noted that people who smoke were not included in "the heart" of legislators' preoccupations. We found no evidence that people who smoke were consulted during these parliamentary proceedings; their experiences and perspectives with regard to smoking and being considered a smoker were silenced. Some legislators stated that they had spoken with people who smoke prior to consultations and relayed these perspectives during discussions, while other stakeholders drew from their perspectives as former smokers. One researcher and anti-smoking advocate interpreted

the perspectives of people who smoke with regard to smoke-free regulations: "… those sorts of regulations [smokefree parks and beaches] … I think they've been quite popular, and actually they have surprisingly little resistance from smokers themselves who, I think, recognise people's wishes and perhaps rights to experience smoke-free environments." (August 20, 2015). However, anti-smoking stakeholders' interpretations were filtered by their adherence to an anti-smoking discourse.

Addressing non-smokers' concerns through tobacco control measures, such as increased smoke-free public spaces, was another demonstration of power relations. Indeed, legislators and anti-smoking advocates argued for these measures (Q6, i.e., justifications of the problematisation) based on the notion that non-smokers have a greater "right" to public spaces than people who smoke, and thus public spaces should accommodate their smoke-free interests. This was explicitly stated by a public sector actor: "We have the right to have a drink or meal on a restaurant terrace in the summer without having to fight with smokers for space." (September 3, 2015). Although arguments for these measures were sometimes related to potential health effects of SHS, the moral imperative of smoke-free places was perceived as a legitimate argument in and of itself. By transforming public spaces into smoke-free spaces, they also become "smoker-free" spaces and since people who smoke were perceived as deviant, these places would become deviant-free. One physician underlined the salience of moral arguments for tobacco control restrictions, above and beyond evidence-based arguments:

> … I think that this legislation should be based on social reasons. … we are part of a society and I think that we should not use scientific or medical arguments to justify this legislation. But if society deems it inadequate to smoke in a restaurant or dining room, well then, even

if it's not offensive for the surroundings, well then, I think it's a societal decision … (August 19, 2015).

Non-smokers as L44 enforcers

As per Q5 (i.e., the effects of the problematisation), we found that to address non-smokers' continued exposure to the smoker, legislators and anti-smoking advocates relied on power relations between the non-smokers and the smokers. People who smoke, for instance, were expected to self-regulate their smoking in public and private places where smoking was not permitted. This was extended to places where smoking was permitted if non-smokers were present to respect non-smokers' "rights" to smoke-free air. Legislators and anti-smoking advocates anticipated this self-regulation would entice people who smoke to quit, as one legislator illustrated: "… when we make life more difficult for smokers, I agree with you, they have to make some progress." (November 5, 2015). To enforce this expected behaviour from people who smoke, legislators and anti-smoking advocates not only relied on the fear of fines, but more importantly, they counted on non-smokers to act as informal agents to enforce measures and perpetuate anti-smoking norms. Thus, the problematisation not only provided non-smokers with "rights" to more public spaces, but also "rights" and expectations to regulate those spaces, that is, to tell people not to smoke. A legislator fervently demonstrated non-smokers' ability to regulate people who smoke: "And an adult, normally, … they're able to say: Hey! Don't smoke, I have emphysema. An adult, you know, is able to do that … to affirm themselves …" (November 18, 2015). Legislators further argued that anti-smoking norms and proposed measures could be used to justify and facilitate non-smokers in their regulation of people who smoke, as was expressed by one legislator:

When there'll be a message, when there'll be a sufficiently strong law bolstering tobacco control, the non-smoker will be able to tell someone smoking beside him: Listen now,

they've [legislators] talked about this and you know, it's for your own good. That too is a signal. (November 12, 2015)

Ironically, in regulating people who smoke to reduce their public visibility, smoke-free measures may actually do the opposite. For example, rather than having people who smoke dispersed on a restaurant terrace, smoke-free policies require them to smoke at the margins, making them easier to identify as they are seen leaving to go smoke and seen smoking in nearby designated smoking places, often among other people who smoke. This may, consequently, further facilitate surveillance and regulation of people who smoke by non-smokers. A private sector actor poignantly illustrated this point:

> … well exactly, we're making that gesture [smoking] … less and less acceptable, that is that we're further ghettoising smokers and telling them: Look, you guys, you stay together, and we'll watch you, us, the non-smokers, because you're making yourselves sick. (August 20, 2015)

We also found that legislators and anti-smoking stakeholders encouraged non-smokers to regulate people who smoke by using metaphoric war language. This language, reminiscent of the criminalising language evoked by policies on illegal drugs (i.e., the "War on Drugs"), further demonstrated their intentions to enlist the help of non-smokers in reproducing power relations and justifying the new measures proposed for L44. This is observed in L44's French title (but not in the official English translation) "Loi pour renforcer la lutte contre le tabagisme", where the expression "lutte contre le tabagisme" translates to "fight" or "battle" smoking. Additionally, some anti-smoking stakeholders compared the mortality rate associated to smoking as a "hecatomb", a

term referring to a "sacrifice or slaughter of many victims" (Merriam-Webster), reinforcing the victimhood of non-smokers. One anti-smoking advocate and former smoker expressed this point ardently: "... this has to stop and there are no more justifications for not preventing the hecatomb of new generations. You have the power, you have the moral responsibility." (September 3, 2015). This quote also underlines the moral imperative of "saving" non-smokers by regulating people who smoke.

As a result of increased smoking denormalisation and regulation of people who smoke, legislators and anti-smoking advocates expected that people who smoke would experience shame for smoking, especially when smoking around children. One legislator vividly illustrated this point: "You know, seeing a dad who is driving his kids on a Saturday morning to hockey practice and smoking in his car, while making his kids play sports … that's embarrassing." (September 3, 2015). Legislators hoped that this stance would motivate people who smoke to self-regulate. However, some acknowledged the marginalising effect of shame on people who smoke, with one legislator expressing concern about ostracisation: "There are people for who smoking cessation is easier; for others, it's more complicated. … So we shouldn't ostracise everyone who continues to smoke. We want an inclusive society." (November 5, 2015). Another legislator was also preoccupied with marginalising people who smoke, believing increased smoke-free public spaces could send a message to people who smoke to stay home, thus displacing smoking to home and limiting access to public space: "… we think that the proposed bill goes relatively far enough and that it'd be difficult to go farther without, in fact, telling people who smoke to stay home." (November 5, 2015).

Discussion

Using a Bacchian policy discourse analysis (Bacchi, 2009), we sought to critically examine the discourse informing L44 to better understand how L44 might be affecting social inequalities in smoking. Bacchi's framework allowed us to critically examine the problematisation underlying this discourse and its implications. We found that, even though L44's discourse explicitly problematised smoking as impairing population health, the implicit problematisation it aimed to address was the exposure of non-smokers to moral representations of the smoker (e.g., irresponsible, ill, addicted, and deviant). Moral representations of the smoker and the non-smoker were reinforced and reproduced through an underlying anti-smoking discourse and proposed measures of L44. This problematisation relied on existing power relations between these two groups, which were also reproduced and strengthened through the discourse by privileging non-smokers' concerns and by expecting non-smokers to regulate people who smoke.

As mentioned, our analysis was particularly concerned with the persistent, pressing public health problem of social inequalities in smoking. Although these inequalities were presented by public health experts during L44 consultations, rarely were they discussed in relation to representations of people who smoke, power relations, and the regulation of people who smoke. Indeed, when referring to people who smoke, stakeholders used terms such as "smokers", "people", and "consumers", which conceal the social stratification of smoking and decontextualise moral judgements of the smokers and mask the ethical issues that ensue. Only 100 years ago, smoking was reserved for the white male elite, rendering it a marker of high SES in Western society (Rudy, 2005). Yet the rise of anti-smoking norms has transformed the social association between smoking and wealth to one of smoking and poverty (Bell, Salmon, et al., 2010; Poland, 2000). Our findings thus demonstrate that entrenched moral representations of people who smoke

as deviant disproportionately affect socially disadvantage people. Power relations between non-smokers and people who smoke tend to reflect power relations between social classes, with those of upper to middle class having greatest leverage. Moreover, regulating and excluding people who smoke from public spaces results in the regulation of socially disadvantaged people, further marginalising them from public life. In sum, the efforts of tobacco control policies to protect non-smokers from exposure to people who smoke are therefore, even if unintentionally, moralising socially disadvantaged populations and contributing to their growing exclusion from public life (Fischer & Poland, 1998; Frohlich et al., 2012; Poland, 2000).

Moral representations used to describe people who smoke in the L44 discourse correspond to their depiction in other studies with similar smoking denormalised contexts (Bell, McCullough, et al., 2010; Frohlich et al., 2012; McCready et al., 2019; Sanders et al., 2019). As with our findings, these studies suggest that these representations are rooted in discourses of health focused primarily on individual behaviour and responsibility, thus hindering an anti-smoking discourse from perceiving people who smoke as other than deviant and/or ill (Frohlich et al., 2012; Haines-Saah et al., 2015; Sanders et al., 2019). In this way, such discourses disregard the inequitable social conditions shaping smoking (Frohlich et al., 2012; Poland, 2000; Thompson et al., 2009). By speaking directly with people who smoke, especially those disadvantaged contexts, qualitative literature has captured the important complexity of their lives along with their experiences related to and/or beyond smoking (Bell, 2013; Frohlich et al., 2012; Haines-Saah et al., 2015; McCready et al., 2019; Sanders et al., 2019). Yet we observed that these voices were not heard by legislators, nor were they represented in the consultations for L44. Their exclusion from the discourse is a missed opportunity for developing more equitable anti-smoking discourse and tobacco control

policies. As no critical public health scholars, nor people who smoke, were present during the L44 consultations to question or nuance L44 discourses, it was, interestingly, the private sector that did so. They highlighted the potential unintended consequences of L44 discourses and measures on their clientele, notably those who smoke. While some legislators did consider such potential consequences, this was done mostly from a concern for local businesses, rather than concern for stigmatising people who smoke or increasing social inequalities in smoking.

We found that the discourse informing L44 privileged non-smokers' concerns, which has been discussed in reference to tobacco control policy discourse more broadly (Dennis, 2015; Fischer & Poland, 1998; Poland, 2000). As such, access to public spaces, although theoretically for everyone, is shaped by morality; those who conform to moral norms have greater "rights" to these places than those considered deviant (Brandt, 1998; Dennis, 2013, 2015; Fischer & Poland, 1998). Research has observed that people who smoke are increasingly excluded from public, and some private, spaces due to their socially perceived moral weakness to smoke (Bell, McCullough, et al., 2010; Brandt, 1998; Dennis, 2015; Diprose, 2008; Fischer & Poland, 1998; Poland, 2000). The impetus for transforming public spaces into smoke-free places has been argued as a way of "sanitising" these spaces of bothersome moral representations, i.e., dirty, ill, disrespectful, and deviant (Banerjee, 2001; Dennis, 2015; Diprose, 2008; Poland, 2000). More importantly, this translates to sanitising these spaces of disadvantaged people, who bear the weight of these moral representations (Banerjee, 2001; Dennis, 2015; Diprose, 2008). This becomes increasingly true even in spaces where smoking is allowed, as smoking stigma is strong enough to regulate there as well (Bell, McCullough, et al., 2010). Our findings indicated that legislators also justified smoke-free measures by arguing that they would motivate people who smoke to quit. However, research

demonstrates that this is not always the case, especially for low SES people who smoke whose needs are not necessarily met simply by further denormalising smoking and excluding them from public spaces (Bell, 2013; Frohlich et al., 2012; Thompson et al., 2007).

We also observed that power relations between the non-smoker and the smoker were reified by enlisting non-smokers as regulators of L44's measures, especially smoke-free spaces. The metaphoric war language employed in the discourse to achieve this has been noted by other scholars, as Brandt (1998) stated: "… non-smokers have been deputised by the state" (p.174). Indeed, these terms imply that non-smokers act as "soldiers" in tobacco control's "fight" against tobacco and consequently, people who smoke. This also reinforces power relations, where people who smoke are not helped, but "policed" or "fought off" in service of the greater good (i.e., a smoke-free society). Fischer and Poland (1998) argue that, due to the social acceptance of anti-smoking norms and smoke-free spaces, this everyday regulation is subtle, discrete, and not generally questioned or perceived as causing harm. Rather, it is seen as benevolent (Carro-Ripalda et al., 2013). It seems that further denormalising smoking and using metaphoric war language in discourses informing L44 will not only reify power relations but will likely increase the social and physical distance between non-smokers and those who smoke, making it harder for non-smokers to understand the experiences and realities of the latter (Fischer & Poland, 1998; Link & Phelan, 2001). This distance leads to policy design that benefits the non-smoking middle-class majority and marginalises socially disadvantaged people who smoke (Fischer & Poland, 1998; Link & Phelan, 2001), thereby reproducing social inequalities in smoking.

The literature demonstrates that people who smoke experience a unique situation of marginalisation due to their smoking status (Antin et al., 2017; Bell, McCullough, et al., 2010; McCready et al., 2019; Sanders et al., 2019; Thompson et al., 2007). Our findings contribute to this body of knowledge by underlining that these unique experiences arise from the smoker identity; a social category reproduced and reinforced by anti-smoking discourse. Social categories based on smoking status generate experiences of privilege and/or oppression, as per our discussion on access to public space. It is also important to consider the experiences of those whose smoker status intersects with other marginalised social identities, such as those based in SES, gender, and/or race. For instance, Antin and colleagues (2017) found that smoking stigma intensified the structural oppression and inequities experienced by Black women who smoke in the US. It would therefore be important to represent non-smokers (including stakeholders) not only as victims, but additionally as experiencing privilege. Their non-smoker privilege also intersects with other social identities that are formed by, among others, class, gender, and/or race. This intersectional lens would afford a more complex understanding of power relations between the non-smoker and the smokers, which likely vary according to intersections with other social categories. Moreover, such an understanding would not only refocus our efforts to help disadvantaged populations, but would interrogate the role of tobacco control policies' role in reproducing and reinforcing privilege and the structures that support this privilege, which ultimately widens the socio-economic gap (Lapalme et al., 2020; Nixon, 2019).

Conclusion

We conclude by briefly returning to the second part of WPR's Q6, which invites a critical reflection of alternative ways of perceiving the policy problem. In this case, it might entail reimagining tobacco control policy in relation to its differential effect on social groups. To that

end, we suggest that researchers and policy makers consider prioritising people who smoke and live in disadvantaged conditions in future policies. Tobacco control strategies in Canada and Quebec have started to do so recently by recommending greater smoking denormalisation efforts, increased smoking cessation supports for disadvantaged populations, and increasing tobacco product prices (Health Canada, 2017; MSSS, 2020). However, according to our findings, these policies remain anchored in an anti-smoking discourse that perpetuates social inequalities in smoking. We therefore recommend that policy makers in countries with comprehensive tobacco control policies suspend policy design, and rather, start by listening to the needs of disadvantaged populations who are disproportionately impacted by the negative health effects of smoking. We suggest this with the hope of shifting our efforts towards designing social policies that address the inequitable social conditions that are (re)producing social inequalities in smoking in the first place (e.g., equitable access to education, employment, housing, and income).

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ARTICLE 3: How to best reduce social inequalities in smoking? Unpacking the discursive practices of tobacco control practitioners

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I conceptualised the idea and argument for this article, conducted the interviews, analysed the data, and wrote the manuscript. Drs. Frohlich and Haines-Saah guided me in the analysis, data interpretation, as well as in the presentation and discussion of findings. They also provided critical feedback on the entire manuscript.

Abstract

In the context of recent strategies in Canada and Quebec prioritising reductions in social inequalities in smoking, we drew from the post-structural concept of discursive practices to critically explore how Quebec tobacco control practitioners' (TCP) engagement with tobacco control discourses shapes their perspectives and practices relating to the reduction of these inequalities. Semi-structured interviews were conducted with 10 TCP working in Quebec public health organisations. Data were analysed using a deductive thematic analysis focused on discursive practices. Our findings highlight how discursive practices mobilised by TCP reproduce stigmatising representations of "the smoker", leading to interventions targeting reductions in smoking inequalities (i.e., smoking prevalence for "at-risk groups") rather than social inequalities in smoking (i.e., inequitable social determinants of smoking). TCP who worked directly with socially disadvantaged people who smoke held comparatively more nuanced discursive practices regarding the social conditions placing their patients at greater risk of smoking. Our analysis suggests that reducing social inequalities in smoking will likely necessitate thinking beyond dominant discursive assumptions that shape tobacco control discourses and practices. This includes integrating lived experiences of socially disadvantaged groups to policy and program design.

Introduction

Canadian tobacco control efforts span municipal, provincial, and federal levels. Faced with persisting social inequalities in smoking, Canada and the province of Quebec's latest tobacco control action plans prioritised reducing these inequalities for the first time in 2017 and 2020 respectively (Health Canada, 2017; MSSS, 2020). Proposed actions to achieve this goal involve targeted tobacco control measures to low socio-economic status (SES) communities and increasing access to smoking cessation services. Although much research associates tobacco control policies with declines in smoking prevalence, some research finds that these same policies may inadvertently contribute to increasing social inequalities in smoking (Amos et al., 2011; Brown et al., 2014; Hill et al., 2014; Sandoval et al., 2018; Thomas et al., 2008). It is hypothesised that, by focusing on reducing the risk of smoking for the entire population, tobacco control policies have neglected the inequitable upstream social determinants placing socially disadvantaged populations at a higher risk of smoking than the rest of the population (Frohlich and Potvin, 2008). However, evidence of the equity impacts of such policies remains inconsistent (Amos et al., 2011; Brown et al., 2014; Hill et al., 2014; Sandoval et al., 2018; Thomas et al., 2008).

Tobacco control practitioners (TCP), defined as "… any health professional or programme developer who had the prevention or cessation of … smoking as a major component to their job mandate" (Frohlich et al., 2012, p. 982), are important actors in tobacco control policy and program development. Research suggests that TCP support the implementation of additional proscriptive tobacco control policies and programs, such as smoke-free policies and anti-smoking media campaigns, as a strategy to reduce social inequalities in smoking (Bisset et al., 2017; Frohlich et al., 2012; Ritchie et al., 2009; Smith et al., 2020, 2019). Yet, these are the same types of policies that have, in some cases, increased social inequalities in smoking (Amos et al., 2011; Brown et al.,

2014; Hill et al., 2014; Sandoval et al., 2018; Thomas et al., 2008). Such policies may be attractive to TCP because of the tangible, measurable, and short-term outcomes that they produce and because of their ability to denormalise smoking (Bisset et al., 2017; Frohlich et al., 2012; Ritchie et al., 2009; Smith et al., 2020, 2019). For example, tobacco control strategies prioritise policies further denormalising smoking and reducing access to tobacco products as a way to motivate socially disadvantaged populations to quit smoking (Health Canada, 2017; MSSS, 2020; Ritchie et al., 2009).

Beyond TCP, public health practitioners also tend to privilege policies and programs targeting downstream determinants to reduce social inequalities in health, despite much public health literature recommending interventions targeting the inequitable distribution of upstream social determinants (Bisset et al., 2017; Brassolotto et al., 2014; Lynch, 2017; Smith et al., 2018). To better understand the disconnect between recommendations and interventions, some research critically examines the perspectives and assumptions that shape public health practitioners' approaches to reducing social inequalities in health (Brassolotto et al., 2014; Lynch, 2017). However, scant research considers the perspectives and assumptions underpinning TCP's practices. The few existing studies found that some TCP's beliefs and practices were informed by assumptions emphasising individual responsibility for health, to the neglect of broader social factors (Frohlich et al., 2012; Ritchie et al., 2015). According to Frohlich and colleagues' (2012) study, views of smoking as an individual responsibility were more commonly attributed to those who were of low SES than their more privileged counterparts. TCP thus favoured interventions targeting individual behaviour change, rather than those addressing the social conditions placing them at a higher risk of smoking (Frohlich et al., 2012; Ritchie et al., 2015). These perspectives

and ensuing intervention approaches were demonstrated to generate stigma towards low SES people who smoked, reinforcing poverty-related stigma they already experienced (Frohlich et al., 2012). Other research suggests that smoking stigma may perpetuate social inequalities in smoking, as it tends not to reduce smoking prevalence among low SES people who smoke (Farrimond and Joffe, 2006; Frohlich et al., 2012; Thompson et al., 2007). Therefore, we broadly aimed to better understand why public health professionals, specifically TCP, are inclined to adopt downstream interventions to reduce social inequalities in health, and what is needed to incite a shift towards more upstream interventions.

Theoretical approach

To examine TCP's practices, we drew from the post-structural concept of "discursive practices", which refer to the actions, operations, or practices that produce discourse, or in other words, that produce the knowledge and assumptions that make up discourse (Bacchi and Bonham, 2014; Foucault, 1969). These practices are also recursively influenced by discourse. Practices can take the form of, for instance, processes, procedures, and social interactions (Bacchi and Goodwin, 2016). Experts, such as doctors, teachers, public health practitioners (e.g., TCP), because of their expertise, can be considered agents that produce and reproduce knowledge and assumptions and disseminate them to the public in various ways (i.e., via different discursive practices; Bacchi, 2009; Gilbert, 2008; Schrecker, 2013). For instance, TCP have contributed to designing anti-smoking media campaigns relying on stigmatising tropes of people who smoke as dirty, smelling bad, and ill, that are shaped by and contribute to reinforcing anti-smoking discourses (Diprose, 2008; Gilbert, 2008).

Discursive practices exist within a set of "rules of formation", which can be understood as conditions or premises that determine what knowledge, values, and assumptions can be included and excluded in discourse, and thus, what discourses become legitimised as "truth" (Bacchi and Bonham, 2014; Foucault, 1969). In this way, these rules also determine what discursive practices can be undertaken. Experts, such as TCP, do not necessarily abide by rules of formation passively. They may adapt, integrate, and/or question these rules according to their own perspectives, which then influence how discourse is reproduced (Schrecker, 2013).

Frequently found in psychology and health care research, the analytical concept of discursive practices is often used to study language patterns and communication (Bacchi and Bonham, 2014). A post-structural lens, however, allows for a deeper understanding of the conditions that shape discourse production and its influences, and thus, of how and why practices and interventions have specific outcomes (Bacchi and Bonham, 2014). In particular, a discursive practices-focused analytical lens guided us in critically examining the ways in which TCP reproduced, advanced, and/or challenged discursive assumptions underlying smoking, people who smoke, tobacco control, and social inequalities in smoking as well as what discursive assumptions were excluded.

This study is part of a larger research project aiming to better understand what effects a Quebec 2015 tobacco control policy, An Act to Bolster Tobacco Control (L44; QNA, 2015), had on social inequalities in smoking (reference withheld for blind review) and how it came to have these effects. This policy further prohibited smoking in some public outdoor places, such as restaurant and bar terraces, playgrounds, and nine meters from any door or window that opens, and in vehicles with children under 16 years present. It also proscribed all flavoured tobacco products (except electronic

cigarettes) and increased the size of health warning labels on cigarette packages. The present study contributes to this larger project by aiming to better understand how Quebec TCP's engagement with tobacco control discourses shapes their perspectives and practices relating to the reduction of social inequalities in smoking, in a post-L44 context where smoking is highly regulated and where governmental emphasis has recently been placed on reducing social inequalities in smoking.

Methods

With the ethical approval from (ethics committee name withheld for blind review) for the study, the first author recruited and conducted semi-structured interviews with TCP in Quebec. Participants were recruited from several local and provincial public health institutes and organisations. Inclusion criteria included working specifically in smoking prevention or cessation and being located in the province of Quebec, preferably in Montreal for face-to-face interviews. A list of potential participants was formed from the first and last authors' professional networks and by searching the websites of Quebec public health institutions and tobacco control organisations. A presentation of the study objectives and interview process was also undertaken during a smoking cessation practitioner training day to recruit participants outside of the researchers' networks. Lastly, the snowball method was employed, which consisted of asking participants for colleague recommendations. In total, 23 TCP were contacted. The first contact was made by email and follow ups were done by telephone calls and/or with a second email for those whose phone number could not be found. Of these 23 potential participants, 10 participated in the study.

Before conducting the interviews, a semi-structured interview guide was drafted by the first author, then discussed, revised, and validated by all authors. Questions broadly addressed TCP's perspectives on: their current and past practices; their perspectives of Quebec tobacco control

policies; how their work shaped these policies; future directions for Quebec tobacco control policies; their understandings of social inequalities in smoking; and how their practices may affect these inequalities. The first author piloted the interview guide twice with TCP in Montreal. Any unanticipated follow up questions or re-formulations of questions were noted and pilot participants were asked for their feedback on the interview questions and overall structure of the interview once the interview was completed. The first author revised the interview guide according to pilot participants' feedback. All authors validated the final version.

From the 10 interviews conducted, eight participants were in Montreal and were interviewed face-to-face. Two participants, from outside Montreal, were interviewed by Skype and telephone respectively. Each interview was recorded on the first author's password protected private laptop. Interviews lasted between 60 and 90 minutes and were all conducted in French. All interview recordings were transcribed verbatim and imported into Atlas.ti. We developed a deductive codebook based on the concept of discursive practices that was discussed, revised, and validated by all authors. The first author conducted a thematic analysis of the data using these deductive codes and kept memos of analytical thoughts during the coding process. After each interview, the first author wrote a summary of the interview's main themes. Once all 10 interviews had been coded, the first author compared and contrasted themes to identify high-level themes. All authors discussed and agreed upon identified themes.

Findings

The entire data collection process, including pilot interviews, recruitment, and conducting interviews, took approximately five months (i.e., January to May 2019) to complete to accommodate TCP's schedules. Our sample of 10 TCP, comprised of eight women and two men,

represents perspectives of key actors working in Quebec tobacco control, specifically smoking prevention and/or smoking cessation. Six TCP worked in smoking prevention, including advocacy for tobacco control policies, consultation on tobacco control policy and program design, tobacco control policy and program implementation support, fund distribution for smoking prevention and cessation programs, as well as writing reports on scientific literature regarding social inequalities in smoking and best practices for reducing these inequalities. The remaining four TCP worked in smoking cessation, consisting of accompanying people who smoke in the quitting process. This sample of TCP also had varying years of experience working in tobacco control. Four had worked in tobacco control for 20 or more years, three for approximately 10 years, and three for five years or less. Lastly, seven TCP had trained in a medical profession before working in tobacco control, one had a post-secondary education in the social sciences, and two had not specified their background.

All TCP were posed the same questions irrespective of differences in their backgrounds. However, participants were probed about certain aspects of their backgrounds in order to better contextualise their practices and perspectives. In particular, participants were asked to describe the specific tasks they undertake in their work and discuss how their perspectives of social inequalities in smoking relate to or shape these concrete practices. For instance, participants working in smoking prevention were asked how they considered social inequalities in smoking in the design and evaluation of their specific practices, such as developing tobacco control interventions. TCP working in smoking cessation were asked to relate their perspectives on social inequalities in smoking to their patients' experiences and their relationship to their patients, specifically comparing patients with different SES. Further, those with 10 or more years of experience were

prompted to give some background on the evolution of tobacco control policies and their discourses in Quebec and their role in shaping this evolution. Finally, participants who specified their educational background were probed to discuss how it influenced their practices and perspectives as a TCP.

Of the 13 TCP who did not participate, three no longer worked in tobacco control, three declined to participate, and seven had not responded. Two of the three participants who declined worked in smoking cessation and could not participate due to time constraints. The other TCP who declined was semi-retired in smoking prevention and tobacco control policy advocacy. This TCP had not provided any reason for declining. As for the non-respondents, four of the seven worked in smoking cessation. Of the other three non-respondents, one held a senior position in smoking prevention and two were smoking prevention program coordinators.

To facilitate the discussion of different TCP, we henceforth refer to TCP who worked in tobacco control program and policy development and implementation as "policy TCP" and those who worked in cessation as "cessation TCP". Quotes were translated from French to English by the first author and validated by the third author, both of who are completely bilingual in these two languages.

Reinforcing stigmatising representations of the smoker

The ways in which TCP described "smokers" and "non-smokers" mobilised discursive representations focused on individual attributes with little nuance for the social context of smoking. People who smoke, namely those who were socially disadvantaged, were for the most part depicted as miserable, unhappy, unhygienic, malodorous, having mental health problems, and

as not having the necessary capacities to deal with their difficult lives. As one cessation TCP told us:

> If there's a mental health problem, they smell, they smell like strongly. It's terrible. Their hygiene… they don't wash their hair, and I don't want to judge them, but there's a category of them where hygiene is really difficult. You know right away … it's 40 cigarettes per day. (Cessation TCP 3)

Some TCP used terms such as "misery" or "sad to death" to characterise people who smoke. This was particularly salient when people who smoke were seen smoking on the grounds of health care sites (e.g., hospitals or long-term care facilities), thus reinforcing a discursive representation of health as antithetical to smoking. Conversely, non-smokers were described as happy, active, healthy, and free of socio-economic difficulties. As such, many TCP argued that quitting smoking, and thus becoming a non-smoker, rapidly improves one's life – becoming happy and healthy: "… the people I was able to help, well finally within a year, maybe a bit more, well they ended up quitting smoking and now they have flourished." (Cessation TCP 2). Such representations of smoking are thus informed by discursive assumptions equating smoking with leading a lesser life. One policy TCP, however, explicitly refused to reproduce such stereotypical representations, especially of "the socially disadvantaged smoker". She advanced that there is diversity among people who smoke and thus they cannot be defined in any one specific way:

> … if we talk about the image of a smoker, well its people that you see in real life, its people you encounter in your life, and that, for me, is really something that's very diverse. I know that there's a sort of image of the disadvantaged person who bears all the miseries of the world, and I think that … it's not a myth, but it's easy to think that way … it's really not helpful for anyone to see themselves like that … sometimes, in smoking prevention, I think

about that idea, that we really should not think: smoker equals disadvantage or disadvantage equals smoker. (Policy TCP 6)

Overall, TCP expressed sympathy when evoking these representations of people who smoke. However, discursive assumptions privileging non-smokers' health over the health of people who smoke limited the sympathy they had for people who smoke. In this way, the smoker was also represented as being irresponsible for the health effects they had on others and on physical environments (e.g., cigarette butt littering and damage to indoor environments). As a result, the needs of people who smoke were perceived as less important than those of non-smokers:

> We always see it from the "poor them" perspective. But at the same time, there are 5% of smokers left in long-term residential health care centers. So then I think to myself: well, maybe it's time to protect 95% of people. (Policy TCP 1)

Some TCP acknowledged the risk that tobacco control policies might increase social inequalities in smoking and stigmatise people who smoke. Yet discursive assumptions prioritising non-smokers' health led them to continue supporting tobacco control policies. It was the ability of these policies to protect non-smokers, especially youth, from second-hand smoke and from seeing representations of smoking in public life, that deemed them necessary. Some TCP expressed views that were favourable to stigma as a motivator for smoking cessation. As such, not only was stigma perceived as acceptable, but productive. The underlying discourse shaping TCP's beliefs and practices thus seemed to be tied to the imperative to protect people's health, despite potential unintended consequences.

Reducing social inequalities in smoking or smoking inequalities?

Policy TCP explained that the last several years were marked by a growing concern with social inequalities in smoking on the part of the Quebec government. This concern and TCP's ensuing practices were informed by a discursive assumption that understanding a health problem is achieved with surveillance data on its distribution and potential causes, with little information on social context. As such, although all TCP acknowledged the social determinants influencing smoking (e.g., income, unemployment), when discussing reducing social inequalities in smoking, many TCP's perspectives were oriented towards reducing smoking inequalities rather than social inequalities in smoking. That is, they were concerned with reducing the differences in smoking prevalence between social groups (i.e., smoking inequalities) instead of addressing the social inequalities that place certain social groups at a higher risk of smoking.

Perspectives aligned with reducing smoking inequalities translated to two intervention approaches: 1) a targeted approach focusing efforts on reducing smoking prevalence specifically among socially disadvantaged groups; and 2) a population-level approach to further denormalise smoking. Regarding the former, some TCP argued that reducing smoking inequalities was a way of reducing social inequalities in smoking. According to this logic, smoking cessation improves the health of people who smoke and helps them save money that they would otherwise spend on cigarettes. These savings could then be spent on better housing, more nutritional food, and education for them and/or their children. As one TCP argued: "… smoking was one of the principal causes of inequality, not an effect, but a cause, because it gorges incomes and it makes people sicker." (Policy TCP 3).

Concerning the population-level approach, some TCP advocated for policies further denormalising smoking, such as anti-smoking media campaigns and smoke-free policies, to motivate people to quit. Some of these TCP, while acknowledging the risk that tobacco control policies might increase social inequalities in smoking, argued that the population benefits of these policies outweigh their potential harms. This was particularly true among TCP who had 25 and more years of experience in tobacco control, as they participated in the early tobacco control efforts – overcoming much resistance – and have witnessed the beneficial health effects of tobacco control policies over time. They also advanced that the tobacco industry was creating more social inequalities in smoking and more harm to the population than tobacco control policies. As such, they believed that public health scrutiny and intervention should be on industry actions rather than on tobacco control policies:

> … maybe there are some who suffer, maybe we've created some inequalities, but I'd rather say that it's the tobacco industry that has created those inequalities. And we may be maintaining them with what we do, but it's nothing compared to what the industry does. (Policy TCP 1)

However, other TCP, also aligned with discursive assumptions prioritising smoking inequalities reduction, argued that population-level tobacco control policies could not reduce smoking inequalities as it is not what these policies are designed to do. They believed that to reduce smoking inequalities, targeted prevention and cessation programs needed to accompany these policies. They thus oriented their practices toward developing media campaigns specific to socially disadvantaged communities and increasing access to smoking cessation services within these same communities.

The perspectives of cessation TCP were similarly rooted in a discursive stance prioritising the reduction of smoking prevalence, especially among high-risk groups. However, because of the nature of their work, these TCP witnessed firsthand the other problems socially disadvantaged people who smoke faced, notably with housing, nutrition, sedentariness, isolation, and mental health. This exposure led them to adapt and broaden their cessation perspective to integrate discursive underpinnings of a social determinants of health perspective. This shaped their understanding of smoking as a symptom of poverty and social inequality, not vice versa. For instance, a few TCP reported that smoking stigma led some of their patients to rarely leave their homes and seldom have visitors. They experienced increasing mental health issues due to this isolation. Consequently, cessation TCP adapted their practices to target, in addition to smoking, the other problems in their patients' lives, even if they surpassed their professional responsibilities. The practices of cessation TCP were thus broadened to include active listening regarding problems beyond smoking, referrals to other community services, and education on and tools for adopting healthy behaviours, such as stress management. One TCP further argued that smoking cessation services offer an entry point to access socially disadvantaged populations to help them improve their lives: "… I can't just treat smoking … It's like we have to consider the person in his/her globality … poverty, well the stress from not having enough money, things like that. So, we have to consider that." (Cessation TCP 4)

This broadened perspective of social inequalities in smoking also led cessation TCP to advocate for greater social policies to reduce social inequalities and thus improve their patients' overall life conditions: "... increase the number of jobs available for those populations, allow them to have more affordable housing, foodbanks, to have organisations and all that that will support them in

their lives, in their overall lifestyles." (Cessation TCP 2). It was not only cessation TCP who expressed this perspective, but a few policy TCP as well. However, one policy TCP explained that advocating for and developing policies to reduce social inequality in order to then reduce social inequalities in smoking was too difficult a task due to a lack of existing data supporting this argument.

These cessation and policy TCP also questioned assumptions regarding the ability of tobacco control policies to reduce social inequalities in smoking. Their critical views were mainly informed by firsthand observations of the unintended consequences that these policies engendered, particularly those affecting socially disadvantaged groups. For instance, one TCP had observed that increased tobacco product taxation served as a motivation to quit smoking for more privileged people but was not necessarily the case for her socially disadvantaged patients. This latter group tended to turn to contraband cigarettes that, she noticed, were less expensive and seemed more dangerous for health than commercial cigarettes. Another TCP had witnessed her patients suffering from smoking-related stigma and thus, advocated for future tobacco control policies to additionally focus on reducing smoking stigma and providing greater social support to people who smoke:

> … I think, at some point, we also need to raise awareness in the population and their entourage because I spend a lot of time educating their family and their friends on how to accompany them, to help them, and support them. … So, it's fun talking about different restrictions, but talk about them to not ostracise people. Maybe talk about this disease. People are having a hard time and it's often because they can't quit … (Cessation TCP 1)

Despite potential unintended consequences, these TCP continued to support tobacco control policies for their population-level benefits. In order to mitigate these potential negative effects, they advocated for greater access to smoking cessation services to help people quit. For example, one policy TCP noted that tobacco product taxation is a worthwhile intervention because of its benefits to the population, regardless of possible negative effects on socially disadvantaged people who smoke:

> Taxing products … there are often issues when you don't have money. It's not cool to increase the price, but it really has effects … it's a measure … that reduces gaps in prevalence, but it's a measure that can be, from an individual point of view, violent … And that's why we need a lot more things accompanying tax increases … for youth too, because it can be beneficial for them. (Policy TCP 6).

These TCP demonstrated a discursive tension between perspectives and practices centered around those prioritising smoking prevalence reductions and those concerned with improving social conditions that place socially disadvantaged people at a high risk of smoking. Indeed, they often oscillated between the two. Sometimes, they sported anti-smoking-type views, which is logical considering the nature of their work. These views reinforced their belief in the good workings of tobacco control policies and of their own practices in helping people lead smoke-free lives. This perspective, however, could elicit stigmatising comments based on assumptions that individuals are responsible for engaging in behaviours deemed unhealthy, such as smoking, gambling, drinking, or eating unhealthy foods. Other times, they understood the hardship that their patients experienced and tried to help them overcome inequitable social barriers they faced. In line with this latter discursive perspective, these TCP understood the imperative of adopting social policies

to reduce social inequalities to improve their patients' lives. As such, most of these TCP condemned the same smoking stigma that some of them, ironically, also engaged in.

Who are considered experts in policy design?

Many TCP, mostly cessation TCP, noted that people who smoke, especially those who are socially disadvantaged, are not at all represented in policy development: "… when you're a disadvantaged smoker, I don't think you really have a voice that will be heard." (Policy TCP 6). These TCP felt that these voices should be heard. In this way, they saw people who smoke as having a certain expertise pertaining to the problems they directly experience, an expertise that is complimentary to their own. As such, several cessation TCP felt that it could be beneficial for people who smoke to form a sort of advocacy group to represent their struggles and needs in the policy arena: "Maybe it could be good for that sort of committee to have a group of smokers or ex-smokers and to see what can be done and all that. I don't think people know on which door to knock." (Cessation TCP 2). Other TCP suggested having representatives, such as cessation TCP or community organisation workers, relay the experiences and concerns of people who smoke. They expressed that their broadened expertise, which now included their patients' lived experiences, was too infrequently included in policy design discussions. They felt a certain distance between policy and cessation TCP. One cessation TCP, who believed that she could represent her patients, argued that cessation TCP should always be consulted in tobacco control policy and program design. She judged that this involvement could dissipate the rejection that people who smoke feel with regard to their lack of representation in policy and program design:

> Ideally, all the tools that are developed, they should maybe pass by here and by us and we would be in charge of maybe doing some sort of evaluation of these tools … people who

> smoke already suffer and feel rejected. This feeling of rejection is difficult for them. (Cessation TCP 1).

According to some cessation TCP, the absence of expertise from socially disadvantaged people who smoke in policy and program decision-making had concrete effects on the lives of people who smoke. One TCP explained that funding for cessation services are contingent on the needs for these services in each neighbourhood, needs that are evaluated with surveillance data of neighbourhood smoking prevalence. She argued that understanding a problem, such as smoking, based solely on surveillance data failed to capture the diversity of realities and needs related to this problem. As a result of decision makers' limited understanding of smoking, cessation services lacked resources and she felt limited in helping those who needed it the most. She explained that the exclusion of lived experience from public health understandings of social inequalities in smoking contributed to entrenching these inequalities.

A few policy TCP, however, noted that policy design and consultation are complex and require knowledge of the policy design and adoption process. They were unconvinced that people who smoke had the necessary competencies to participate in legislative policy consultations:

> … the judiciary language, that's a language that lots of people have difficulty with … it's not that it's not accessible, it's that you don't necessarily speak the language of the law. Your arguments won't be constructed in a coherent way, and now I'm doing air quotes, for the State, the Institution. And well, it's also the whole idea of, well, do you know the process? Do you know where to go online to find the right parliamentary commission? (Policy TCP 6)

In this way, this participant's view seemed to be informed by discursive assumptions perceiving TCP as experts of tobacco control, excluding those without their specific expertise. Another TCP, who had a similar perspective, did, however, demonstrate interest in involving socially disadvantaged people who smoke in program design. Yet their involvement would be limited to adapting already existing models of tobacco control programs to increase their relevancy to the targeted community's smoking prevention and cessation needs. In this way, her assumptions led her to surmise that anti-smoking campaigns were what socially disadvantaged people who smoke need without consulting them on the matter.

Discussion

An analytic approach centered on discursive practices was used in this study to critically explore how Quebec TCP's engagement with tobacco control discourses shapes their perspectives and practices relating to the reduction of social inequalities in smoking. Findings first demonstrate that TCP reproduced and reinforced discursive practices that are aligned with what critical theorists in public health have termed "the new public health" (Bell et al., 2011; Petersen and Lupton, 1996). Briefly, the new public health, primarily informed by medical and epidemiological expertise, understands health as the result of both environmental and individual factors (Petersen and Lupton, 1996). Interventions are thus designed to prevent threats, also known as "risks", to these factors (Bell et al., 2011; Petersen and Lupton, 1996). One notable intervention approach is to produce and promote knowledge of health risks to the population and as a result, individuals are expected to regulate themselves and one another to avoid such risks, such as abstaining from smoking (Gilbert, 2008; Mair, 2011; Petersen and Lupton, 1996). As such, responsibility for attaining and maintaining health is placed on the shoulders of the individual, diminishing the state's role in

mitigating population risks (Ayo, 2012; Diprose, 2008; Frohlich et al., 2012; Gilbert, 2008; Mair, 2011; Petersen and Lupton, 1996).

Considering that most TCP had an education background in the health sciences and that they all worked in tobacco control, it is logical that they would mobilise new public health discourses that are prominent within these fields (Bell et al., 2011; Petersen and Lupton, 1996). We observed that they did so in three ways, through: 1) the representations of people who smoke they advanced; 2) the types of knowledge informing their practices; and 3) the interventions they supported. First, there was a tension in the way TCP described people who smoke as both without agency – due to nicotine addiction – and as responsible for their behaviour. Regarding the former, understanding nicotine addiction as a disease absolved people who smoke from individual responsibility, contrary to new public health discourses. TCP specifically emphasised that people who smoke possess limited agency over this addiction and that it is the state's responsibility to help them by providing smoking cessation services and by rendering smoking less accessible. Despite this, in their interviews, they also expressed perspectives placing responsibility for smoking on the individual. This occurred when discussing the rights of non-smokers (i.e., perceived as following tobacco control norms by self-regulating and not smoking). TCP then held the view that it is the smoking person alone who is responsible for reducing smoking risks to others and the environment.

TCP expressed little critical reflection on the potential unintended consequences of engaging in these representations of people who smoke. Literature demonstrates that because these perspectives offer little to no information on the social factors that shape smoking and because they focus on the individual – either as a sick individual or as a responsible agent – they stigmatise

people who smoke and are not helpful in motivating people who smoke to quit (Ayo, 2012; Diprose, 2008; Frohlich et al., 2012; Gilbert, 2008; Thompson et al., 2007). Considering enduring social inequalities in smoking, we need to think critically about the impacts tobacco control discourses may be having on stigmatising people who smoke, chiefly as they disproportionately stigmatise socially disadvantaged people.

Second, scholars have highlighted that new public health discourses privilege certain types of evidence and expertise over others (Mair, 2011; Petersen and Lupton, 1996). This knowledge informs how the problem of social inequalities in smoking is conceptualised and legitimises certain intervention approaches. Perspectives from the TCP in our study reflected this by explaining that most tobacco control interventions are informed by population-level surveillance data, which lacks information on social context (Mair, 2011). Tied to this is the third way in which we observed TCP mobilising new public health discourses. Although they were clearly aware of the social and structural determinants that shaped social inequalities in smoking (e.g., unemployment, low-income, low educational achievement), they also supported, advocated for, designed, and implemented interventions to reduce social inequalities in smoking focusing on risk prevention (e.g., smoking) and individual behaviour change (i.e., smoking cessation). Many TCP were also cognisant of the unintended consequences such interventions could have on reproducing social inequalities in smoking but continued to believe they were an important solution for addressing these inequalities. This disconnect is consonant to substantial research demonstrating that public health professionals understand structural influences and the need for social policies, yet in practice, interventions continue to aim risk-prevention or behavioural change, a phenomenon referred to as “lifestyle drift” (Brassolotto et al., 2014; Lynch, 2017). The focus on individual

responsibility and lack of action on the social context will likely maintain or increase social inequalities in smoking, as stated by Frohlich and colleagues (2012): "By adopting such discourses, tobacco control practitioners may, inadvertently, be reinforcing and creating the very phenomena they wish to remedy." (p.990).

To make sense of the influence of new public health discourses on the discursive practices of TCP, and of other public health professionals, the discursive practice analytical lens also examines the "rules of formation", that is, the conditions shaping and legitimising dominant discourses like new public health discourses (Bacchi and Bonham, 2014). Without explicitly using the term rule of formation, much of the critical tobacco control literature identifies neo-liberalism as a condition that led to the prominence of new public health discourses (Bell and Green, 2016). While the overuse of neoliberalism in public health literature can muddy its meaning (Bell and Green, 2016), it remains a helpful concept in elucidating the prominence of new public health discourses. Scholars often refer to the consequences of neo-liberal ideology on social norms, notably in emphasising greater individual responsibility and minimal state intervention in individual lives (Ayo, 2012; Coburn, 2000; Harvey, 2007; Petersen and Lupton, 1996). These norms are reflected in and may legitimise the adoption of new public health discourses (Ayo, 2012). Chiefly, by using strategies to denormalise health-impairing behaviours, such as smoking, and to prevent health risk, public health policies avoid intervening at the structural-level (i.e., the "cause of the cause"), such as addressing poverty, as it this may appear to interfere in individuals' lives (Ayo, 2012; Petersen and Lupton, 1996). Rather, these strategies incite individuals to regulate their behaviours according to social norms, creating a perception of individual control. This neo-liberal style of governing, or "governing at a distance", further absolves, at least partially, the state's responsibility for social

and health problems (Ayo, 2012; Mair, 2011; Petersen and Lupton, 1996). In reality, it translates to concentrating privilege and health-related resources to certain social groups, while limiting access to privilege and such resources to socially disadvantaged groups, thus perpetuating social inequalities in health (Coburn, 2000; Harvey, 2007).

To depart, even if somewhat, from the discursive position of the new public health, cessation TCP in our study demonstrated the role of direct contact with socially disadvantaged people who smoke. Their views were thus shifted from individual responsibility to the need for social policies to reduce social inequalities, which would then reduce social inequalities in smoking. This is aligned with critiques of neo-liberal discourse that advocate for greater investment in social policies (Coburn, 2000; Harvey, 2007). Although limited, evidence is increasing and demonstrates that greater investments in social policies can reduce social inequalities in health (Liu and Dutton, 2020; Rubin et al., 2016). In lieu of these policies, cessation TCP in our study did their best to intervene on the social factors influencing their patients' smoking to improve their lives and help them quit smoking.

To this end, cessation TCP underlined the importance of including the voices of socially disadvantaged people who smoke in intervention design. They further demonstrated how actively listening to their patients' lived experiences allows for a more complex and comprehensive understanding of smoking and the influences of, for instance, SES, gender, race, neighbourhood, and/or smoker status (Bowleg, 2012; Potvin, 2010). This echoes research showing that people who directly experience a health problem or intervention hold knowledge of how an intervention might translate, or fail to translate, into people's daily lives (Elliott et al., 2016). Indeed, interventions

may affect social groups differently, depending on their needs and experiences (Potvin, 2010; Warr et al., 2013). Therefore, excluding lived experience from intervention planning may jeopardise its effectiveness, as it fails to account for the real world needs of those affected (Elliott et al., 2016; Potvin, 2010; Warr et al., 2013). Studies examining practitioners working collaboratively with social groups, thus complementing practitioner and lived experience expertises, report the development of more grassroots interventions that are tailored to the specific needs of these groups (Pyett, 2002; Warr et al., 2013). In this vein, although some cessation TCP suggested organising groups for people who smoke, TCP might instead consider pairing with community organisations and community members to address social causes of smoking and other problems, such as poverty. There are, of course, challenges to working with social groups, namely negotiating between institutional and social group interests as well as competing interests within a social group (Potvin, 2010; Pyett, 2002; Warr et al., 2013). However, the potential benefits to reducing social inequalities in health justify efforts to increase collaborative efforts.

The conclusions we have drawn in this article should be considered within the limitation of our study, namely of the potential sampling bias due to the low response rate. As a result, some understandings of tobacco control and social inequalities in smoking may not be represented in our findings. Further, approximately about half of TCP who participated were acquainted with our work and the focus we place on social inequalities. They may have put more emphasis on social inequalities in smoking than is reflected in their practices due to our interest in the topic. We believe however that our sample does represent a diversity of TCP in Quebec, a relatively small population. In particular, the differences between those who worked in policy and program design

and implementation and those who work in smoking cessation enabled us to capture varying perspectives.

Conclusion

As social inequalities in smoking are not natural occurrences, TCP who design and implement tobacco control policies have an important role to play in addressing such inequalities. Understanding how TCP's engagement with tobacco control discourse shapes their perspectives and practices relating to social inequalities in smoking can generate crucial knowledge for guiding TCP with their future interventions to reducing those inequalities. Our findings suggest how TCP reproduce discursive practices that are informed by new public health discourses. These discourses mobilise narrow views of people who smoke as unhealthy and irresponsible, which disproportionately affects disadvantaged people who smoke. Cessation TCP expressed a more comprehensive perspective on reducing social inequalities in smoking, chiefly because they witnessed how their socially disadvantaged patients experienced social barriers to health that extended beyond smoking. Although most of these TCP continued to support tobacco control policies, they also advocated for more social policies to address the inequitable distribution of social factors influencing smoking and a host of other health problems. These findings underscore the necessity of thinking beyond dominant discursive assumptions shaping tobacco control. Doing so will likely necessitate the integration of multiple sources of knowledge, particularly lived experiences, to policy and program design. Without a more diverse set of perspectives and knowledge influencing policy and program design, we risk continuing to entrench social inequalities in smoking.

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CHAPTER 5. DISCUSSION

This thesis stemmed from an interest to better understand how and why social inequalities in health persist, especially considering the plethora of existing research on social inequalities in health, including on the best approaches to reduce such inequalities (WHO, 1986, 2008). Indeed, studying in health promotion, defined as a "field of action" (McQueen, 2010), directed my attention to the relationship between public health policies (i.e., a form of "action") and social inequalities in health. A pronounced example of such inequalities are social inequalities in smoking. Considering that tobacco control policies, widely celebrated public health interventions for their association to dramatic decreases in smoking prevalence, have been found, in some instances, to increase social inequalities in smoking (Amos et al., 2011; Brown et al., 2014; Hill et al., 2014; Sandoval et al., 2018; Thomas et al., 2008) is worrisome. Moreover, how policies contribute to social inequalities remains understudied. Faced with this pressing public health and health promotion problem, this thesis broadly posed the following research question: How might population-level policies, such as L44, impact social inequalities in smoking?

This thesis is comprised of three scientific articles, each of which brings a unique contribution to answering the research question. The first article discusses one dimension of the theoretical framework guiding this thesis, more specifically, the ways in which intersectionality is used in social inequalities in health research. It underlines that most research omits the study of an important tenet of intersectionality: the tenet underlying the role of social structures in reproducing social inequalities in health is often neglected to privilege the experiences of socially disadvantaged populations. This article however argues that both tenets are needed to obtain more comprehensive understanding of social inequalities in health. In this way, this article served principally to frame the research objectives of the thesis and subsequent empirical articles to focus on tobacco control policies as structural influences on social inequalities in smoking.

The two empirical articles respond to the overall research question by examining tobacco control discourses, a mechanism by which tobacco control policies operate. As such, both research objectives aim to critically explore tobacco control discourse with Bacchian post-structural analytical approaches, but they do so differently. Article 2 addresses the first objective of the research, which seeks to critically explore the discourses underpinning L44 and in particular, to assess the role of social inequalities in smoking within those discourses. This was done with

documents detailing parliamentary consultations and discussions with key Quebec tobacco control policy stakeholders. Equipped with a better understanding of tobacco control discourse underlying L44 and the possible ways it will affect social inequalities in smoking, article 3 aimed to better understand how Quebec TCP's engagement with tobacco control discourses shape their perspectives and practices relating to the reduction of social inequalities in smoking, especially in a context where a governmental priority has been dedicated to reducing those inequalities. TCP's discursive practices are particularly important as they are recognised as experts in tobacco control who, through their perspectives and practices, contribute to shaping tobacco control policy discourse, and thus to mainstream tobacco control understandings of social inequalities in smoking. Interviews with Quebec TCP were conducted for article 3 in order to access their discursive perspectives and practices.

The present chapter provides a reflection on the insights gained from the combined theoretical approach of intersectionality and Bacchian post-structuralism and from the thesis findings' cross-cutting themes in relation to the public health, health promotion, and broader social inequalities literature. It also demonstrates how these findings and their interpretation come to answer the central research question of the thesis. It is important to note that much of the conceptual literature on social inequalities employs various binary terms when referring to privileged groups versus socially disadvantaged groups (Graham, 2004b; Nixon, 2019). However, this dichotomy is not representative of social inequalities in Western society, where social groups exist along a social gradient (Graham, 2004b). Intersectionality brings some of this complexity to light by demonstrating that through intersecting structures of power, people simultaneously benefit and suffer as a result of social inequalities (Crenshaw, 1989, 1991; Davis, 1981; Nixon, 2019). For instance, a low SES non-smoker may benefit from their non-smoking status but will likely continue to suffer from lack of resources, disadvantaged living conditions, and stigma tied to being of low SES. On the other hand, a wealthy person who smokes will benefit from their privileges associated to wealth but will likely experience some smoking-related stigma (Glenn et al., 2017; McCready et al., 2019). With this awareness of the complexity that the use of binary terms excludes, the thesis is written using the terms "privileged" and "socially disadvantaged". These terms were adopted because the aim of the thesis is to better understand how policy discourse contributes to social inequalities, rather than to describe the incremental range of social inequalities and their effects.

Nonetheless, the complexity of social inequalities was considered closely while writing this thesis, notably with the use of intersectionality.

5.1. Reproducing social inequalities in smoking: the role of privilege

As discussed in Article 1, most research on social inequalities in health and in smoking focuses on health-related outcomes and/or experiences of socially disadvantaged groups (Fu et al., 2015; Labonte, 2004; Nixon, 2019). However, the effects of social inequalities in health are not limited to those without privilege. As intersectionality scholars, such as Crenshaw (1989, 1991) and Davis (1981) have argued, privileged social groups may also benefit from social inequalities. When social conditions and resources are not distributed equitably, those who are privileged can reap the benefits of structures that work in their favour or for their needs (Crenshaw, 1989, 1991; Davis, 1981; Labonte, 2004; McCartney et al., 2021; Nixon, 2019). For instance, qualitative literature suggests that outdoor smoke-free policies primarily benefit non-smokers as such policies reduce SHS exposure, yet they also inadvertently curtail access to outdoor public spaces by those who smoke, who tend to be from socially disadvantaged groups (Bell, McCullough, et al., 2010; Dennis, 2015; Diprose, 2008; Fischer & Poland, 1998; Poland, 2000). The benefits of public spaces, such as pools, playgrounds, and parks, are thus disproportionately limited for this latter group, who may not have private access to such resources (e.g., they may not have a backyard). In order to maintain the advantages they receive, it is argued that privileged social groups reproduce social inequalities, intentionally or not, by reinforcing social norms and supporting policies aligned with their interests (Crenshaw, 1989, 1991; Davis, 1981; Labonte, 2004; McCartney et al., 2021; Nixon, 2019).

Scant research examines the role of privileged social groups in reproducing social inequalities (Nixon, 2019). Thus, many public health and intersectional scholars argue that to effectively reduce such inequalities, research and practice need to understand all of the pieces of the social inequalities in health puzzle, including the contribution of privileged social groups and social structures (Crenshaw, 1989, 1991; Davis, 1981; Fu et al., 2015; Labonte, 2004; McCartney et al., 2021; Nixon, 2019, 2019). One important step towards ameliorating social inequalities is through understanding and making explicit the inherent problem with normalising social structures that inequitably distribute resources (Parent & Bourque, 2016). Indeed, this thesis aimed to

advance knowledge in this area by identifying some of the ways that tobacco control policies, as structural influences, contribute to reproducing social inequalities in smoking. In the following sections, I discuss these findings in relation to conceptual and empirical literature pertaining to the ways in which privilege reproduces social inequalities.

5.1.1. Moral regulation

Findings from both articles 2 and 3 demonstrate that tobacco control discourses often rely on and reproduce moral representations of the smoker to characterise people who smoke and of the non-smoker to describe those who do not smoke. The purpose of reproducing these types of binary representations reflects the concept of moral regulation. This concept draws notably from post-structural notions of normalisation and subjectification (Corrigan & Sayer, 1985; Ruonavaara, 1997). Moral regulation is understood as a process or mechanism that normalises certain ways of life, including how people work, live, play, and socialise, in order to regulate behaviours (Corrigan & Sayer, 1985; Dean, 1994; Ruonavaara, 1997; Valverde, 1994). It also subjectifies by contributing to the construction of social groups, according to shared characteristics. Consequently, individuals are influenced by the beliefs, values, and behaviours of the social groups to which they belong (Corrigan & Sayer, 1985; Dean, 1994; Ruonavaara, 1997; Valverde, 1994). What is determined as "moral" is context contingent as it hinges on, for instance, societal, cultural, and/or religious values (Ruonavaara, 1997).

Corrigan and Sayer (1985) argue that moral regulation is used by the state to regulate the population as a form of social control. Individuals who wish to belong, act according to the moral rules and those who defy these rules are stigmatised and marginalised. Other scholars have critiqued this structuralist view, underlining its lack of complexity and nuance (Dean, 1994; Ruonavaara, 1997; Valverde, 1994). Points of contention notably lie with top-down conceptualisations of moral regulation, where an elite group, representing the state, regulate the rest of the population (Dean, 1994; Ruonavaara, 1997; Valverde, 1994). Indeed, reflecting a post-structural perspective, other scholars advance that moral regulation can occur in multiple spheres of society, linked or not to the state, but also within everyday relationships (Dean, 1994; Ruonavaara, 1997; Valverde, 1994). Schools, hospitals, places of worship, homes, community organisations, and social media are all examples of places where different forms of moral

regulation may arise. In this way, one's engagement in moral regulation can vary according to context; in some situations, an individual might be regulating others, while in other situations, they are the one being regulated. For instance, a participant in Glenn and colleagues' (2017) study expressed that she is often met with "dirty looks, derogatory comments, and stigmatisation." (p. 20) when smoking in public spaces. Yet, when in the presence of children, she is the one commenting on (or regulating) other people's smoking.

As much literature has demonstrated that stigmatisation can be a consequence of moral regulation, it is particularly relevant to turn to Link and Phelan's (2001) conceptualisation of stigma as a tool to express power, for they state: "it takes power to stigmatize." (p. 375). Moralising and stigmatising representations of people are not just consequences of moral regulation, but also ways in which privileged groups morally regulate others (Link & Phelan, 2014). Stigmatising representations, such as those targeting the smoker, create a false sense of distance and differentiation between ourselves and others (i.e., sentiment of "us" versus "them"). This makes it more difficult to relate to the stigmatised "other" (Link & Phelan, 2001). Findings from this thesis illustrate this "othering" as tobacco control discourse not only reproduces and reinforces stigmatising representations of the smoker, but also fails to include the perspectives of socially disadvantaged people who smoke. Social distance coupled with stigma can generate feelings of resentment and antipathy between social groups (Frohlich et al., 2012; Link & Phelan, 2001; Ruonavaara, 1997; Thompson et al., 2007). An often cited example in the literature is that of the myth of the "welfare queen"; a stigmatising representation of Black poor American women, as promiscuous, lazy, and overall bad mothers who take advantage of the welfare system, which was constructed and disseminated by conservative political discourse in the 1970s (Cammett, 2014; Cassiman, 2007, 2008; Foster, 2008; Hancock, 2003; Inglis et al., 2019; Jensen & Tyler, 2015; McCormack, 2004). This highly problematic representation has been used to justify racism, sexism, and classism at the individual and structural-levels. Structurally, for example, important policy cuts were made to the US welfare system, which would have otherwise provided an important safety net for socially disadvantaged groups (Cammett, 2014; Cassiman, 2007, 2008; Foster, 2008; Hancock, 2003; Inglis et al., 2019; Shildrick, 2018). Therefore, "othering" makes possible the normalising of, and justification for, regulative, and at times structurally oppressive, treatment of socially disadvantaged groups (Fischer & Poland, 1998; Link & Phelan, 2001, 2014).

This treatment and its contribution to reproducing power relations, becomes embedded and normalized in everyday life and relations, making it difficult to question and challenge (Fischer & Poland, 1998; Link & Phelan, 2001, 2014).

Through the lens of a post-structural Bacchian analysis, findings from both empirical papers demonstrate how tobacco control discourses support the use of moral regulation via the reproduction and reinforcement of moral and stigmatising representations of the smoker and the non-smoker. In particular, Article 2 discussed the use of these representations to regulate people's behaviour, namely by embedding non-smoking values and norms in society, trickling down to normalise interactions between non-smokers and people who smoke (Fischer & Poland, 1998). The use of intersectionality in this thesis helped to provide a more fulsome conceptualisation of the moral regulation process, underscoring how moral and stigmatising representations of social groups intersect. Of particular interest are the convergences of the smoker identity with representations of other social identities, such as those relating to SES, race, and/or gender. This was observed in parliamentary discussions, but also in interviews with TCP, who relied on and reinforced moral and stigmatising representations of, namely "the poor smoker". While much smoking-related research pertain to representations and experiences of smoking according to gender, SES, *or* race, fewer studies have explored representations and experiences at the intersections of these social identities. Hilary Graham's body of work (1987, 1994, 1996), being among the first and perhaps most salient to examine experiences of smoking in relation to gender *and* social class, reveals how women who smoke are often perceived as unattractive, this being especially true for low SES women. Conversely, high-SES women have been found to use smoking as a way to perform their gender, social class, and sexual identities; privileging certain types of cigarettes over others, limiting smoking to specific social occasions (as to not be subjectified as a smoker), and using traditionally feminine or masculine mannerisms when smoking (e.g., the way the cigarette is held; Glenn et al., 2017; McCready et al., 2019; Triandafilidis et al., 2017a, 2017b).

Having the ability to navigate and shape stigmatising representations to transform them as favourable representations illustrates how privileged groups can manifest power to their benefit. It is far more challenging for those of socially disadvantaged groups to change the stigmatising and moralising representations imposed on them. Some research has found that low SES people who

smoke internalise smoking stigma, and as a result, avoid accessing vital resources such as food banks or public transit passes (Farrimond & Joffe, 2006; Inglis et al., 2019). Indeed, the use of these services targeted to socially disadvantaged groups can be stigmatising in and of themselves. Findings of this thesis therefore corroborate Link and Phelan's (2001, 2014) argument of stigma as a tool used to express power, intentionally or not. The power relations reinforced by these stigmatising representations result in othering people who smoke, especially socially disadvantaged people who smoke, which permit more privileged social groups to regulate their behaviours and use of public spaces and resources. Normalisation of these representations has repercussions on people who smoke, including employment discrimination (Roberts, 2014; Voigt, 2012), limited and/or regulated use of public spaces (see discussion in article 2), and as a cessation TCP participant shared in an interview, some socially disadvantaged people who smoke refuse to leave their homes for fear of being stigmatised, and thus may suffer from isolation and loneliness. Based on the inequitable use of moral regulation and its consequences, findings from this thesis, supported by conceptual and scientific literature, suggests that tobacco control discourses that rely on and reproduce moral and stigmatising representations entrench social inequalities.

A combined intersectionality and Bacchian post-structural approach to analyse policy discourse uncovered discourses upholding a view of smoking as an individual risk behaviour, which is aligned with critical perspectives on new public health discourses (Bell et al., 2011; Petersen & Lupton, 1996). It may thus be surmised that this is also true for other public health and health promotion policy discourses. For instance, much obesity literature suggests that overweight and obese people are problematised as responsible for their weight (Bombak, 2015; Inthorn & Boyce, 2010; Jovanovski, 2017; Puhl & Heuer, 2009; Roberts & Weeks, 2017). As a result, they experience stigmatising representations specifically related to their weight, commonly referred to as "fat shaming" (Bombak, 2015; Inthorn & Boyce, 2010; Jovanovski, 2017; Puhl & Heuer, 2009; Roberts & Weeks, 2017). Representations of overweight and obese people tend to employ qualifiers such as lazy, undisciplined, sloppy, sedentary, unhappy, and unhealthy (Jovanovski, 2017; Puhl & Heuer, 2009; Roberts & Weeks, 2017). Similar to findings from this thesis, policies targeted to reduce and prevent excess weight and obesity involve promoting individual behaviour change (e.g., increasing physical activity and promoting healthy eating) and have been found to inadvertently reinforce and reproduce moral and stigmatising representation of overweight and

obese people (Bombak, 2015; Jovanovski, 2017; Roberts & Weeks, 2017; Warbrick et al., 2019). Further, this fat shaming discourse has not necessarily reduced obesity or improved health, but has contributed to the rise of diet culture, a way of self-regulating one's or others' eating habits (Bombak, 2015; Jovanovski, 2017; Puhl & Heuer, 2009; Puhl & Suh, 2015). It is important to note that diet culture is associated to eating disorders and apprehensive relationships to food, which can have numerous physical and mental health impairing consequences (Bombak, 2015; Puhl & Heuer, 2009; Puhl & Suh, 2015). Fat stigma has also been attributed to weight-related discrimination in various settings, such as in the workplace (e.g., hiring, raises, promotions), health care, and education (Puhl & Heuer, 2009; Puhl & Suh, 2015).

Social inequalities in excess weight and obesity have also been observed in research, where rates are disproportionately higher among low SES groups and other socially disadvantaged groups (Chaufan et al., 2015; Puhl & Heuer, 2010; Warbrick et al., 2019). Therefore, as discussed in article 2, discourses that stigmatise and regulate overweight and obese people often intersect with discourses that rely on and reinforce sexist, racist, and/or elitist tropes to stigmatise and regulate socially disadvantaged groups (Jovanovski, 2017; Warbrick et al., 2019). Chaufan and colleagues (2015) further argue that the most effective way to reduce obesity is not by implementing health promoting interventions that increase physical activity, but to eradicate poverty and reduce social inequalities. An intersectional perspective would additionally call for ending racism, sexism, ableism and other forms of systematic oppression in order to reduce social inequalities in health and ultimately improve the health of the entire population (Nixon, 2019). This literature thus underlines the need to integrate and elevate social justice discourses to reduce social inequalities in health within public health and health promotion.

5.1.2. Lack of socially disadvantaged representation

Another important finding from this thesis that contributes to better understanding how tobacco control discourses factor in reproducing social inequalities in smoking relates to whose interests are heard and included and whose are excluded in discourse and policy. Both empirical articles demonstrate that the needs and interests of people who smoke, especially those of socially disadvantaged people, are not included in tobacco control-related policy and program design. Although people who smoke are directly affected by tobacco control policies, the principal goals

of tobacco control remain to protect non-smokers, particularly children and youth, from SHS and smoking initiation. With increased governmental attention on social inequalities in smoking reduction, TCP in article 3 indicated that reducing smoking prevalence among socially disadvantaged social groups had risen in their priorities. However, the involvement of people who smoke remained limited, and in some cases, absent. Those policy TCP who did involve (or planned to) socially disadvantaged people who smoke sought their input on how to best adapt tobacco control programs and policies, rather than consulting them to better understand their needs in relation to smoking and beyond. The underlying assumption of this type of involvement is that tobacco control policies and programs are able to address the needs of socially disadvantaged groups. This may be so, but it is not possible to know as long as socially disadvantaged groups are not asked what they need.

Both empirical articles of this thesis point to the role of tobacco control discourses to explain the exclusion of socially disadvantaged people who smoke from policy design. Tobacco control discourses, shaped by new public health discourses, tend to deem certain knowledge as expertise, while neglecting to recognise the contribution of other types of knowledge (Bacchi, 2009; Holmes et al., 2006; Popay et al., 1998; Potvin, 2010). Legitimised knowledge often originate from medicine and epidemiology due to their tradition of rigorous scientific methods (Holmes et al., 2006; Potvin, 2010). Knowledge and perspectives that are excluded from these discourses are referred to, by post-structural scholarship, as "subjugated knowledge" (Bacchi, 2009; Foucault, 1980; Holmes et al., 2006). According to findings in both articles 2 and 3, lived experience, especially from socially disadvantaged populations who smoke, is one such subjugated knowledge within tobacco control discourses. It is not unorthodox for discourses shaped by medical knowledge to neglect lived experience of socially disadvantaged groups (Liu & Dipietro Mager, 2016; Reverby, 2007). There are multiple examples in medical history of the exclusion of such groups from medical research and of medical experts making decisions on their behalf (Liu & Dipietro Mager, 2016; Reverby, 2007; Sherwin, 1994; Yakerson, 2019). This exclusionary expertise has led to mistreatment, oppression, and/or lack of necessary treatment for groups in need. As an example, women have historically been excluded from medical research because their physiology was thought to be confounding (Liu & Dipietro Mager, 2016; Sherwin, 1994). Indeed, in the US, women of "child-bearing potential" were excluded from most clinical trials until the

1990s, including clinical trials on lung cancer (Holdcroft, 2007; Liu & Dipietro Mager, 2016). Results from research excluding women, however, were generalised on the entire population, with no account of biological and gender differences. This skewed evidence caused women to not receive necessary treatment or to experience important side effects to medication that were not observed in clinical trials, as they were solely performed on men (Liu & Dipietro Mager, 2016; Sherwin, 1994; Yakerson, 2019).

It is not my intention to deny the merits and significant contributions of medical research in advancing the field of medicine and public health. Rather, better understanding the historical neglect of socially disadvantaged groups in medicine can help contextualise the current lack of inclusive voices in discourses and discursive practices shaped by medical knowledge, such as tobacco control-related discourses. This also contributes to explaining how social inequalities in smoking and health are perpetuated. Some literature notes that this lack of inclusion leads to the inequitable distributing of resources and opportunities (Adam & Potvin, 2017; Elliott et al., 2016; Popay et al., 1998, 2008; Potvin, 2010; Warr et al., 2013). That is, by representing the needs and interests of privileged social groups and excluding those of socially disadvantaged groups, the resources and opportunities that the latter group needs are therefore not delivered and the policies are less relevant to their lives. As such, excluding voices from research and from intervention design limits the agency of socially disadvantaged groups to make decisions for themselves, with regard to smoking, but also for what they deem as necessary in their life (Adam & Potvin, 2017; Popay et al., 2008, 2020). As cessation TCP in article 2 noted, and corroborated in some qualitative literature, socially disadvantaged people who smoke have a diversity of needs beyond smoking that are not addressed by current policies and programs. These needs typically include safe and secure housing, stable employment, better incomes, access to education or specific training programs, food security, and accessible daycare (Mackenzie et al., 2017; Parent & Bourque, 2016). One participant in a qualitative study by Mackenzie et al. (2017) succinctly argues that social disadvantage is the result of insufficient social protection: “The poor are only poor because the government have made them poor.” (p. 242).

Often unintentionally, TCP and other public health and health promotion professionals can contribute to the exclusion of socially disadvantaged voices. They may do so when they overlook

critically reflecting on their position of power as the "expert" vis-à-vis people who smoke as well as their role, and that of the programs and policies they support in reproducing anti-smoking discourses (Bourdieu & Wacquant, 1992; McCartney et al., 2021; Nixon, 2019; Popay et al., 2008; Schön, 1991; Schrecker, 2013). As a result, they continue to advocate for, and participate in, designing and implementing tobacco control programs and policies that may cause unintended consequences to socially disadvantaged groups. In this way, they maintain the status quo that disproportionately benefits those with more privilege compared to those who are socially disadvantaged (McCartney et al., 2021; Schrecker, 2013). One TCP justified this exclusion when demonstrating the difficulties that most people have in navigating the jargon-laden political consultation process. As such, only those who have the capabilities to understand this process can be heard. In response, some social inequalities scholars argue against problematising socially disadvantaged people who smoke and instead believe attention should be paid to the role of TCP, and other privileged social groups, in excluding, even if unintentionally, the voices of socially disadvantaged groups and in bolstering the voices of more privileged social groups (Labonte, 2004; McCartney et al., 2021; Nixon, 2019; Parent & Bourque, 2016).

Lastly, Frohlich and Potvin (2008) argue that it is the nature of population-level interventions, i.e., that they target the entire population, that excludes the needs of socially disadvantaged populations. This could explain, in part, why TCP tend not to consult socially disadvantaged people who smoke when designing policies and programs. In response to this shortcoming, Frohlich and Potvin propose that public health interventions adopt, what is generally referred to in the policy literature as a universal-targeted approach. This type of approach allows to target the entire population, while also adapting the intervention to the needs of socially disadvantaged groups (Benach et al., 2013; Frohlich & Potvin, 2008). Based on what cessation TCP reported, however, socially disadvantaged people may benefit more from interventions addressing structural determinants – even if these are population-level interventions (e.g., universal basic income) – than universal-targeted interventions focusing on smoking reduction. In this way, it is important to consider both who the intervention targets (e.g., a specific community or the entire population) and the issue it targets – whether structural or behavioural (McLaren et al., 2010). Yet not all structural interventions are equitable. For instance, although tobacco control policies intervene at a structural level when they denormalise smoking, they have had inequitable

effects. This emphasises the notion that, to reduce social inequalities, structural interventions must focus on transforming structures to distribute resources equitably, rather than only to certain segments of the population (Davis, 1981; Labonte, 2004; Nixon, 2019). This can be done with the involvement of socially disadvantaged populations in structural intervention design.

Some qualitative research does include the voices of people who smoke living in disadvantage to better understand the relationship between tobacco control policies and social inequalities in smoking, yet much of this research does not use an intersectional lens. These analyses are often focused on SES, gender, age, race *or* sexual orientation. Although this thesis did adopt an intersectional approach to innovate in theorising tobacco control discourse and social inequalities, it did not include empirical research with people who smoke. This exclusion represents an important limitation of this thesis. Including people who smoke in this research would have allowed an application of both of the tenets of intersectionality, as detailed in article 1 (Lapalme et al., 2020), and in this way, the thesis could have provided a more comprehensive and complex understanding of the relationship between tobacco control discourses and social inequalities in smoking. A future application of the framework developed in this thesis could collect data with people who smoke to understand how they engage with (e.g., accept, adapt, challenge, and/or resist) problematisations of "the smoker" and how they experience smoking status as a social identity intersecting with their other social identities. If people who smoke experience the social identity of "the smoker" differently according to their intersecting social identities, power relations between "non-smokers" and "smokers" reinforced by tobacco control discourses, might also be more complex.

Interviews with people who smoke focused on understanding their intersecting social identities could have also provided more depth to the analysis of TCP's discursive practices in relation to social inequalities in smoking. According to some qualitative literature, disadvantaged people who smoke are aware of the structural forces influencing their smoking (e.g., permissive smoking norms, the stress associated to living in poverty; Frohlich et al., 2010; Glenn et al., 2017). As such, their experiences and perspectives could have reinforced cessation TCP's nuanced discursive practices that brought some attention to the importance of understanding and intervening on structural factors that reproduce social inequalities in smoking, rather than those

focused on reducing smoking prevalence. Voices of people who smoke from intersecting disadvantaged social identities could further help identify some structural factors that were not considered by cessation TCP. For instance, Sanders and colleagues (2019) demonstrate how heteronormativity may contribute to increasing or maintaining social inequalities in smoking among the queer community. Indeed, by perpetuating social norms that marginalise queer people, some turn to smoking for stress relief or to resist health centric heteronormative social norms.

5.2. Looking forward: strategies to reduce social inequalities in smoking

5.2.1. Reflexivity

One concrete way of rendering privilege explicit and challenging its normalisation is through reflexivity and reflexive practice (Bisset et al., 2017; Bourdieu & Wacquant, 1992; Maton, 2003; Parent, 2016; Schön, 1991; Tremblay & Parent, 2014). Reflexivity is commonly discussed as an individual practice, where one identifies and critically reflects about their assumptions and biases (Bourdieu & Wacquant, 1992; Schön, 1991). These can be linked to one's social identity (e.g., SES, gender, and/or class), position within power relations, as well as to the extent of one's ability to influence discourse. Yet it has been argued by some scholars, namely Bourdieu (Bourdieu & Wacquant, 1992), that reflexivity transcends individual practice and involves collective reflection (Maton, 2003; Parent, 2016; Tremblay & Parent, 2014). In this way, reflexivity serves to acknowledge and question the discursive assumptions that shape dominant conceptualisations, perspectives, and practices in a specific discipline or field. Thus, reflexive practices permit researchers and practitioners to deconstruct implicit or taken for granted problematisations in order to consider social phenomenon constructed as problems through different lenses (Bourdieu & Wacquant, 1992; Schön, 1991; Tremblay & Parent, 2014). This would also influence the responses to such phenomena in discourse as well as in policy. When learnings from reflexive reflections are applied to researchers or practitioners' practices, reflexivity is then said to be transformative, as it contributes to the evolution of a discipline or field (Schön, 1991; Tremblay & Parent, 2014).

In the case of tobacco control, adopting a reflexive approach would allow tobacco control stakeholders to assess, for instance, how their social identities as well as the privileges that they experience from these tobacco control policies shape their conceptualisations of smoking, people who smoke, and tobacco control policies. Reflexive practices may also encourage stakeholders to

ponder their role in shaping tobacco control-related discourses and the moralising and stigmatising effects that they may have on people who smoke, as evidenced in both articles 2 and 3. Put simply, who benefits and who experiences the consequences of these discourses? Challenging dominant notions of expertise, and of the assumptions, beliefs, and values that inform it, may also allow for a broader integration of knowledge and perspectives, including the voices of socially disadvantaged people who smoke (Parent & Bourque, 2016). It is hoped that reflexive practices would encourage tobacco control stakeholders to consider modifying the tobacco control policies they typically support to design policies that prioritise the reduction of social inequalities in smoking, rather smoking inequalities (Bisset et al., 2017). In this way, promoting greater reflexive awareness can be extended beyond tobacco control discourses, but also to those of public health and health promotion (Bourdieu & Wacquant, 1992; Nixon, 2019; Schön, 1991; Schrecker, 2013).

Limited research exists on the reflexive practices of TCP and its effects on social inequalities in smoking. A study by Bisset and colleagues (2017) discusses the effects of a workshop organised for TCP to assist them in developing reflexivity skills and enable them to train colleagues to think reflexively. Findings from this study demonstrate that, although participants expressed interest in practicing greater reflexivity, many TCP were met with time, financial, and management constraints in implementing this practice into their work. As such, it may not be realistic to expect reflexive practices to be followed and maintained systematically without integration of reflexivity in health-related training and institutional values and practices (Bisset et al., 2017; Bourdieu & Wacquant, 1992; Schön, 1991). Bacchi's (2009) WPR analytical framework, while meant for research, could be a useful tool to facilitate practitioner engagement in reflexivity, as it poses key questions that incite a critical reflection of problematisations and discourse. Indeed, Bacchi encourages researchers to use WPR to reflect upon their own problematisations.

Although this thesis did not seek to examine TCP's reflexive practices, article 3 does contribute to the reflexivity literature. In particular, findings suggest that working directly with people who smoke, especially those who are socially disadvantaged, can trigger reflexive practices. The post-structural concept of discursive practices revealed how cessation TCP negotiated new public health discourses that shape their practices in order to adapt them to better

suit the needs of their patients. In this sense, they did not abandon such discourses, but rather the empathy that they felt for their patients allowed them to alter these discourses to include other issues than smoking. Their practices were constrained within the frame of their smoking cessation work and thus could not, for instance, design social policies that would reduce social inequalities. However, they did their best to act beyond smoking within the confines of their work, which took the form of community services referrals and active listening. Conversely, most TCP who did not work directly with people who smoke were not found to practice reflexivity, or not to the same extent as cessation TCP. As a result, policy TCP were limited in understanding the impacts of their actions on perpetuating social inequalities in smoking and did not consider broadening their interventions to address the social factors that influence social inequalities in smoking.

5.2.2. Promoting inclusive discourses

In thinking of TCP's position within power relations with socially disadvantaged people who smoke, returning to the post-structural conceptualisation of power provides valuable insights. According to this perspective, power is not understood as negative or repressive, but relational and productive, as it produces norms, identities, resources, opportunities, and as such, determines what is acceptable and possible to think and do in a given social context (Bacchi, 2009; Bacchi & Goodwin, 2016; Foucault, 1976, 1980). In this way, TCP could be guided to yield power by narrowing their social distance with socially disadvantaged people who smoke and expand the dominant notion of expertise or legitimate forms of knowledge to include lived experience (Douglas et al., 2016; Elliott et al., 2016; Parent & Bourque, 2016). The argument for excluding voices based on the complexity of policy consultation processes, as stated by some policy TCP, runs contrary to literature arguing that socially disadvantaged populations have a thorough and complex understanding of the situations that they experience (Carey et al., 2014; Douglas et al., 2016; Elliott et al., 2016; Holmes et al., 2006; Parent & Bourque, 2016; Popay et al., 2008; Whitehead & Dahlgren, 2006). Their lived experience should thus also be integrated in discourses regarding smoking, people who smoke, and tobacco control policy and program design. In particular, intersectional research has significantly contributed to elevating voices of socially disadvantaged groups that have rarely or, in some cases, never been heard within the scientific literature, enabling a broader and complex understanding of social inequalities (Bowleg, 2012; Collins & Bilge, 2016; Crenshaw, 1989, 1991; Hankivsky, 2014).

There are indeed examples of various movements led by socially disadvantaged groups, such as drug users, sex workers, and people with disabilities, illustrating that these groups do have the ability to advocate for their rights and change dominant discourses (Crofts & Herkt, 1995; Jozaghi, 2014; Kerr et al., 2006; Klein, 2020). Such movements have had a notable impact on reducing stigmatisation, voicing their concerns, community empowerment, and shifting public health policy design toward structural determinants in order to more effectively reduce social inequalities in health. For instance, since the HIV/AIDS pandemic in the 1980s in many high-income countries such as Canada, the US, and Australia, gay people and later, drug users, regrouped to advocate for the rights of people affected by and/or at high risk of contracting HIV/AIDS (i.e., AIDS Coalition to Unleash Power (ACT-UP); Crofts & Herkt, 1995; Klein, 2020). These user-led advocacy groups paved the way for future initiatives. One such initiative is the user-founded and led organisation Vancouver Area Network of Drug Users (VANDU), established in 1998, that aims to respond to the overdose crisis in Vancouver's Downtown East Side (Jozaghi, 2014; Kerr et al., 2006). Through their advocacy work in elevating the voices of drug users, VANDU and other drug user-led groups have been successful in improving the life conditions for drug users, notably by reducing overdoses and high-risk injections, as well as by changing the dominant stigmatising discourse about drug users (Jozaghi, 2014; Kerr et al., 2006; Klein, 2020). They also provide opportunities for drug users to be involved in policy design as well as in research to produce knowledge based on their lived experiences (Jozaghi, 2014; Kerr et al., 2006; Klein, 2020). Consequently, drug users have increasingly been recognised as important stakeholders with valid perspectives for policy design (Klein, 2020).

The literature on user-led movements importantly underscores the feasibility of centering socially disadvantaged people in public health discussions of issues concerning them as well as in program and policy design. The VANDU example further supports how post-structuralism conceptualises individuals as active within power relations; they may adapt, challenge, resist, and/or reverse these power relations (Arribas-Ayllon & Walkerdine, 2011; Howarth, 2010; Popay et al., 2008, 2020). An intersectional perspective compliments this post-structural perspective of resistance by encouraging researchers to use research findings to inform social justice-related interventions (Bilge, 2013, 2020; Collins & Bilge, 2016; Crenshaw, 1989, 1991), as discussed in

article 1. Although cessation TCP discussed the possibility of people who smoke organising rights-based groups, existing "smokers' rights" groups are funded by the tobacco industry to thwart tobacco control measures (Smith & Malone, 2007). Instead, considering the high prevalence of socially disadvantaged people who smoke, TCP and other public health professionals could initiate, harvest, and/or bolster movements of resistance that aim to advocate for the rights of socially disadvantaged groups (Baum, 2007; Douglas et al., 2016; Parent & Bourque, 2016; Parent & Martorell, 2019; Popay et al., 2020; Wolff et al., 2016). Nonetheless, some scholars note the importance of ensuring that community initiatives work within but also beyond their locality (Parent & Bourque, 2016; Parent & Martorell, 2019; Popay et al., 2020; Wolff et al., 2016). Due to the influence of structural determinants on social inequalities in health, preventing these inequalities from being reproduced necessitates structural-level change (Chaufan et al., 2015; Parent & Bourque, 2016; Popay et al., 2020; Wolff et al., 2016). As such, TCP, and/or other public health professionals, could help bridge the gap between action at the local and macro levels (Miller et al., 2017; Parent & Bourque, 2016; Parent & Martorell, 2019; Popay et al., 2020). This would involve working intersectoraly, as addressing structural determinants of health requires action outside of public health, with a specific priority dedicated to community member involvement as their rich knowledge of the context is critical in informing interventions (Carey et al., 2014; Elliott et al., 2016; Parent, 2016; Parent & Martorell, 2019; Potvin, 2010; Warr et al., 2013). In this way, advancing social and health equity would also benefit public health goals of reducing social inequalities in smoking (Chaufan et al., 2015; Thirlway, 2020; Young-Hoon, 2012).

5.2.3. Theoretical models on power relations

Some social inequalities in health scholars argue that one reason for the lack of structural level interventions, despite numerous calls for action at this level (WHO, 1986, 2008, 2014), lies, in part, in the limited use of theoretical models explicitly conceptualising power relations and their contribution to social inequalities in health (Graham, 2004a, 2009; McCartney et al., 2021; Nixon, 2019) For instance, Graham (2004a, 2009) advances that the well-known social determinants of health model (WHO, 2008) is often applied to target the determinants of social inequalities in health. Yet, this model is not meant for this purpose, as it does not illustrate the processes that reproduce such inequalities. Rather, it identifies various factors that promote and/or hinder health and has subsequently been applied to better understand social inequalities in health. Due to this

lack of focus on the process of reproducing social inequalities in health, action to reduce these inequalities is applied at all levels, mostly the proximal or behavioural level, while many scholars argue that the most promising interventions require structural interventions (Bambra et al., 2010; Brassolotto et al., 2014; Graham, 2004a, 2009; Lynch, 2017; McCartney et al., 2013; Nixon, 2019). Graham's work corroborates and helps to elucidate findings from article 3, where cessation TCP on the one hand, advocated for more action targeted to the structural determinants of social inequalities in smoking, but on the other hand, continued to support tobacco control policies and did not question their power relation with their patients. It may therefore be useful to integrate theoretical models within public health that explicitly explicate the reproduction of social inequalities, with a focus on structural determinants and power relations (Fu et al., 2015; McCartney et al., 2013, 2021; Nixon, 2019).

Many theoretical frameworks exist to understand the reproduction of social inequalities, with specific attention given to the role of power. The Fundamental Causes Theory, for example, where explicit focus is placed on structural determinants, namely SES, to reduce social inequalities in health (Link & Phelan, 1995; McCartney et al., 2021; Phelan et al., 2010; Phelan & Link, 2005). McCartney and colleagues (2021) suggest integrating the concept of power as a fundamental cause of social inequalities in health in order to expose and address the role of policy makers, practitioners, and privileged social groups in reproducing these inequalities. Nixon (2019) proposes the Coin Model of Privilege, where privilege and disadvantage respectively represent the two sides of a coin. Here, privilege is perceived as responsible for granting unearned privilege to some and social disadvantage to others. Finally, the concept of "structural violence" is commonly used in medical anthropology to underline the contribution of social and political structures in perpetuating social inequalities in health (De Maio & Ansell, 2018; Farmer, 1999; Fu et al., 2015; Herrick & Bell, 2020). In this instance, the inequitable distribution of resources is perceived as an act of violence perpetuated by dominant social structures, which include the state and its policies. Herrick and Bell (2020) argue that, in a context where much importance is given to population health and social epidemiology, the fact that the social determinants of health can easily be operationalised explains, in part, why this approach is favoured in public health, as opposed to others like structural violence. However, the social determinants of health model lacks the explicit

political and social justice angle that is brought forward by other theories and frameworks (De Maio & Ansell, 2018; Graham, 2004a, 2009; Herrick & Bell, 2020).

These theories and models present some limitations. In particular, they tend to isolate one structure or power relation at a time, making it more difficult to examine how these structures act in relation to one another (Crenshaw, 1989, 1991; Frohlich et al., 2001; Gkiouleka et al., 2018; Lapalme et al., 2020). Further, in focusing on structures and/or power, they omit the perspective of those experiencing social inequalities in health. As argued in article 1, better understanding the entire picture of the reproduction of social inequalities in health is important to inform equitable interventions. In this thesis, I propose the use of intersectionality in both research and practice as it addresses some of the shortcomings of other theories and models. In particular, intersectionality shifts focus away from singular power relations to intersecting structures and their effects on intersecting social groups (Bowleg, 2012; Collins & Bilge, 2016; Crenshaw, 1989, 1991; Gkiouleka et al., 2018; Hankivsky, 2014; Lapalme et al., 2020). It also calls for equal attention to be placed on the structures responsible for producing social inequalities and the experiences of these inequalities, especially from socially disadvantaged groups typically left out of research. It is therefore a theory that can guide research and practice in acknowledging their role in power relations that reproduce social inequalities in health as well as the voices that may be going unheard within public health, health promotion, and in the case of this thesis, in tobacco control discourses (Bowleg, 2012; Collins & Bilge, 2016; Crenshaw, 1989, 1991; Hankivsky et al., 2012, 2014; Lapalme et al., 2020; Ndumbe-Eyoh, 2020).

In this thesis, intersectionality was used principally for its interest in the intersecting structures that reproduce social inequalities, since much research exists on the effects that these structures have on the experiences and outcomes of intersecting disadvantaged social groups (as argued in article 1; Lapalme et al., 2020). As such, my intent was to understand what intersecting structures reproduced social inequalities in smoking and how they did so. It is in this way that intersectionality framed the problem for this thesis, that is, by focusing on examining structures, rather than those affected by these structures (Nixon, 2019). However, as many intersectional scholars convene, there is no existing intersectional method, and therefore, intersectionality is challenging to apply methodologically (Hankivsky et al., 2012). This is particularly so when

applying intersectionality to examine structures. Hankivsky et al.'s (2012, 2014) Intersectionality-Based Policy Analysis (IBPA) model provides important reflexive questions that may be useful in applying intersectionality in practice. However, it is unclear how this model can be used to examine the ways in which structural factors reproduce social inequalities. Conversely, Bacchi's frameworks facilitate an analysis of structural factors by considering policy as a structure, and explores policy mechanisms by analysing policy discourse. While the analyses for articles 2 and 3 were both guided by Bacchian post-structuralism, intersectionality played a role in critically reflecting beyond the binary of "non-smoker versus smoker" that is represented in tobacco control discourses, in order to consider the complexity of these social categories, notably the other social identities they reflect. As is discussed in article 2, examining the complexity of such social identities provides a more nuanced understanding of how discourse may perpetuate social inequalities in smoking.

While intersectionality does recognise policy as an important structural factor influencing social inequalities, it also emphasises structures positioned at a more macro level (i.e. colonialism, patriarchy, and/or capitalism; Collins, 1990, 2009). In this thesis, it was challenging to identify such macro level structures through policy discourse analysis, namely as there is scarce guidance on how to do so. Research in public health and social inequalities in health will have to reckon with this challenge, as the role of such macro level structures in reproducing social inequalities is increasingly discussed (Koum Besson, 2021; NCCDH, 2020). Yet, in keeping with an intersectional perspective, it will be important to develop analytical tools to not only analyse how those structures reproduce social inequalities in health (Koum Besson, 2021; NCCDH, 2020), but also to investigate how structures intersect with one another to have inequitable effects. From the analyses done in this thesis, it remains unclear if these structures might be analysed through policy discourse, and if so, how. Further, in article 3, it was particularly difficult to understand how TCP and macro structures relate to one another. If this is through TCP's engagement with discourse, how these structures might be identified and analysed via TCP's discursive practices needs to be parsed out. Lastly, as intersectionality places much focus on intersecting social identities, it would be pertinent to explore if analysing TCP's intersecting social identities (of privilege and/or disadvantage) might provide insights on their relationship with macro structures. Indeed, Nixon (2019) argues that privileged social identities reinforce and reproduce macro structures, as they

benefit from them. This might explain why TCP tended not to critically examine the discourses and interventions they engaged with. That is, in not recognising their own role and responsibility in reproducing structural power relations and in accepting the status quo of tobacco control discourses, they will likely continue to focus interventions on behaviour change, rather than structural change (i.e., lifestyle drift; Carey et al., 2017; Godziewski, 2021). In essence, grappling with these questions will provide important avenues for advancing social inequalities in health research as well as the applicability of intersectionality.

In conclusion, the learnings from this thesis demonstrate that population-level policies, such as L44, may impact social inequalities in health and in smoking through the discourses that shape them. In particular, discursive elements, such as the assumptions, values, knowledge, and subjectifications that inform policy problematisations, affect a policy's design as well as whose interests are included and excluded from this design. In this way, policy representation consequently influences who will benefit from the policy and who may be disadvantaged. The thesis further serves to highlight the important role that decision-makers and practitioners, in this case TCP, play in reproducing such discourses or in adapting and/or challenging them through their practices. They can thus contribute to transforming discourses and policies to become more inclusive and better represent varied lived experiences. Ultimately, questioning the discourses driving our practices and our policies and integrating the active participation of socially disadvantaged social groups in policy design are important steps to take towards designing policies that have greater relevancy for socially disadvantaged groups and therefore work towards health equity.

CHAPTER 6. CONCLUSION

This thesis was written, in large part, while in lockdown due to the COVID-19 pandemic. To reconcile the disconnect that I sometimes felt between working on this thesis and the health, social, and economic crisis happening around me, I reflected on the relevance of my thesis in these trying times. COVID-19 has exposed and worsened social inequalities, especially social inequalities in health. It has also revealed the shortcomings of our current health, economic, and social systems in reducing these inequalities and in protecting socially disadvantaged groups (Bambra et al., 2020; Khare et al., 2020; McCready et al., 2021; Tircher & Zorn, 2020). Although this pandemic has been devastating in many ways, it can also be perceived as an opportunity to learn and improve these systems. A particularly salient lesson is the importance of strengthening social protection in order to reduce social inequalities. In this way, the pandemic has been an opportunity for people to witness, at least in Canada, concrete ways that the government can protect the well-being of its population. More specifically, decision makers demonstrated their ability to anticipate and attend to unintended consequences of population-level interventions. For instance, they expected that many people would lose their employment due to population-level lockdown measures and as a response, implemented the CERB program, which has prevented many individuals and their families from losing income and falling into poverty (Bryant et al., 2020). Another example is in Quebec, where some social groups were exempt from the population-level curfew. However, it is important to note that some groups, notably people experiencing homelessness, who evidently have greater challenges finding shelter, were not exempt until a Quebec Supreme Court judge ruled in favour of an exemption (Olson, 2021). These two examples underscore the critical role decision-makers play in reducing or reproducing social inequalities.

The relevance of this thesis for health-related problems and policies beyond social inequalities in smoking, including COVID-19, lies primarily in the answers to its research question, i.e., how might population-level policies, such as L44, impact social inequalities in smoking? Namely, this thesis answers this question by identifying two mechanisms through which policies might reproduce social inequalities: 1) by excluding the voices, and thus the needs, of socially disadvantaged groups; and 2) by targeting proximal determinants (e.g., behavioural and individual risk) rather than inequitable structural determinants. This thesis further demonstrates that policy discourse informs these policy mechanisms, as policy discourse shapes the policy problematisation and subsequent policy design. In relation to pandemic-related public health

measures, for instance, insights from the first policy mechanism would suggest that we ensure all voices are heard (Khare et al., 2020; McCready et al., 2021; Mykhalovskiy et al., 2020; Mykhalovskiy & French, 2020). We might indeed investigate how "the homeless" were problematised to better understand why the curfew measure was not crafted to anticipate the inequitable consequences on this population. Further, those who advocated on behalf of people experiencing homelessness illustrated that providing a platform to voice their needs resulted in exempting them from the curfew (Olson, 2021). Findings related to the second policy mechanism might serve to support the social protection responses that were adopted during the pandemic, such as CERB, which target more upstream determinants (e.g., income and employment). Had discourses focused on individual responsibility for employment and financial planning dominated policy discussions, the repercussions of unemployment would likely have significantly worsened social inequalities. Thus, applying the overall insights from this thesis to the pandemic demonstrates that policy solutions to protect the population, especially socially disadvantaged groups, are feasible. Their implementation depends largely on political will, conveyed through the discourses of decision makers.

In being able to apply the insights from this thesis to other health and social phenomena, this thesis contributes to critical conceptual and empirical literature on discourse pertaining to tobacco control, public health, and health promotion policies. By adopting a critical lens, I sought to deconstruct what is problematised, how it is problematised in policy discourse, how it might shape practices, and how it might affect social inequalities in health. This perspective not only challenges the dominant way in which policy makers, practitioners, and researchers understand a problem and corresponding interventions, it also equips us with new ways of conceptualising social phenomena and new solutions towards promoting health equity. This thesis did not, therefore, intend only provide a critical analysis of tobacco control policies, in line with other sociology of health research, but rather, to work *with* public health. Indeed, Mykhalovskiy and colleagues (2019) demonstrate that much public health research is either in service to (i.e., *in* public health) or critical of public health (i.e., *of* public health). They argue that public health research could benefit from critical research that engages with public health actors, thus increasing the practical implications and potential alleviation of the unintended consequences of discourse and interventions. As such, I plan to discuss the key findings of this thesis with the TCP that

participated in this study as well as their organisations in the hopes of contributing to new reflections on how to conceptualise smoking, people who smoke, social disadvantage, and best practices to reduce social inequalities in smoking.

6.1.1. Directions for future research and practice

Critical perspectives in public health and health promotion research are particularly important in the growing context of tobacco control. Electronic cigarettes, for instance, have been incorporated in tobacco control discourses, and under L44, vaping is subjected to the same restrictions as smoking (QNA, 2015). One exception was made to allow for the sale of flavoured electronic cigarettes, notably to help maintain cigarette smoking cessation for those using electronic cigarettes. Flavoured cigarettes and other tobacco-related products, on the other hand, have been proscribed. A large body of research has developed over the last decade pertaining namely to the health consequences of electronic cigarettes and their potential for initiating people to smoking cigarettes, especially youth, and for aiding in smoking cessation (El Dib et al., 2017; Hartmann-Boyce et al., 2016; Khouja et al., 2021; Pisinger & Døssing, 2014; Soneij et al., 2017). While it was beyond the scope of this thesis to examine the discourses relating to electronic cigarettes, its policy implications, and potential effects on social inequalities in smoking and in vaping remains an important and relatively unexplored area of research. This is particularly so since electronic cigarettes have been integrated into mainstream tobacco control policies, not only with L44 in Quebec, but also at the Canadian federal level as well as in other high-income regions as well (Government of Canada, 2018b; Kennedy et al., 2017; QNA, 2015). In order to prevent social inequalities in health from increasing, it would therefore be important to explore how tobacco control discourses have adapted to the addition of electronic cigarettes (Bell & Keane, 2014; Thirlway, 2018; Tokle & Pedersen, 2019).

Cannabis policies designed to protect public health may also benefit from an emphasis on collaboration between research and practice, notably to reduce social inequalities in health. Since cannabis legalisation in Canada in October 2018 (Government of Canada, 2018a), cannabis smoking in Quebec has also been subjected to the same restrictions as tobacco products under The Cannabis Regulation Act (QNA, 2019) and in this way, is also shaped by discourses informing tobacco control policies. It would therefore be pertinent for public health research to examine how

cannabis-related discourses have changed since legalisation, as well as how they differ from and have been shaped by tobacco control-related discourses. Lessons from this thesis and other tobacco control discourse and policy research could help inform cannabis-related policies and programs in order to prevent them from having unintended consequences on social inequalities in cannabis smoking. Conversely, understanding how cannabis-related discourses have influenced tobacco control discourses is salient. For instance, in the province of Alberta, cannabis smoking is prohibited in all public places, leaving the only possible place to smoke cannabis in private homes (LAA, 2017). Research may explore how discourses influencing such cannabis restrictions extend to discourses focused on cigarette smoking as well as the implications for social inequalities in smoking and SHS exposure, especially if people are led to smoke indoors.

On a theoretical note, applications of intersectionality in public health research have been gaining much ground in the last decade. However, as argued in article 1 and by certain intersectionality scholars, the importance of including both tenets of intersectionality in research is due to an observed tendency towards depoliticised intersectional research and a reduced focus on Black women's experiences (Bilge, 2013; 2020; Ndumbe-Eyoh, 2020). In particular, Bilge (2020) asks: "What makes intersectionality an empty shell onto which scholars of all stripes can conveniently project their own concerns and feel completely legitimate to do so? What authorizes the easy removal of Black feminists from their theoretical innovation, intersectionality?" (p. 2298). These questions are not intended to deny the notable and important advancements that intersectional research and dialogue have made in elevating the voices of socially disadvantaged groups and uncovering the complexities of social inequalities. Yet, the decrease of Black female voices in intersectional research serves as a crucial reminder of the need for researchers to understand the roots of intersectionality and to be reflexive in its use and of their potential role in perpetuating structural racism and sexism embedded in academia and public health systems (Bilge, 2013, 2020; Ndumbe-Eyoh, 2020; Williams et al., 2019).

I, myself a white woman, have integrated intersectionality into my thesis without the involvement of Black women scholars or participants. I take the discussion on Black women's place within intersectional research seriously and made sure to credit Black women activists and scholars in the development of intersectional research, such as Angela Davis (1981), Patricia Hills

Collins (1990), and Kimberlé Crenshaw (1989, 1991). I further urge scholars, decision makers, and practitioners to engage with intersectionality and to examine the role of intersecting forms of structural racism and sexism in policy discourse and experiences of this discourse in Black women's experiences. For instance, some research, although limited, has explored how Black low-SES women who smoke experience smoking stigma (Antin et al., 2017). This research demonstrates that Black women's experiences of anti-smoking discourses differ from those of other socially disadvantaged groups. There is therefore a need to explore how intersecting structural racism and sexism might shape tobacco control discourses and policies. I also suggest involving Black women in this research and that findings be conveyed to their communities.

The roots of intersectionality within social movements for Black women's rights should also remind us of the need for public health researchers and practitioners to be engaged with social movements. This is especially the case for those working in health promotion, an area of research and practice in public health that promotes the value of social justice and health equity (Baum, 2007; WHO, 1986). Indeed, in order to place greater emphasis on structural-level interventions for health equity, researchers and practitioners will likely have to include advocacy in some form within their workload (Cohen & Marshall, 2016; Parent & Bourque, 2016; Parent & Martorell, 2019; Raphael, 2017; Smith et al., 2016; Smith & Garthwaite, 2016). According to Carlisle (2000), there are two ways of engaging in public health advocacy. The "representational" way involves working closely with policy makers to ensure that public health and social inequalities in health issues become and remain political priorities. The "facilitational" way includes bringing public attention to the issues facing socially disadvantaged communities that are typically unknown to the general public. This may also encompass support for community-driven initiatives and projects. In the context of this research and as a person who does not smoke, nor who is a community advocate, I do wish to critically contribute to discourse and policy in order to work towards health and social equity. As an example, I engaged, in a small way, in this more facilitational form of advocacy by contributing to public discussions on the impact of stigmatising representations of the smokers (see Annexe VIII for my Globe and Mail letter to the editor).

Some researchers view political engagement as a compromise to objectivity (Rychetnik & Wise, 2004; Smith et al., 2016). It is indeed this objectivity that policy makers often value in their

collaborations with researchers (Sommer, 2001). This may explain why some researchers can find themselves being discouraged from becoming involved in public health advocacy (Cohen & Marshall, 2016). However, as Smith and colleagues (2016) argue, the structural nature of social inequalities in health warrants some form of advocacy, whether it is representational or facilitational, in order to reduce social inequalities in health. To encourage greater political engagement, public health discourses may need to provide more space to the importance and benefits such an engagement can bring to structural change (Cohen & Marshall, 2016). This involves training public health students in advocacy for them to develop the necessary skills as well as providing greater support and opportunities from public health institutions (Cohen & Marshall, 2016; Rychetnik & Wise, 2004; Smith et al., 2016).

To conclude, while it is tempting to be swayed by the public mantra, "we're in this together", displayed on rainbow signs in the context of COVID-19, the differentiated effects of the pandemic and of corresponding restrictions have clearly exemplified that this is not so. However, we know that social inequalities can be ameliorated; they require that we as a society choose to reduce them. This is of course a daunting task, but with this thesis, my intention was to demonstrate that a first step towards designing and implementing equitable policies is to critically examine the discourses that shape our thinking, regardless of how well-meaning we may be, and to reflect on the ways in which we might incorporate different perspectives, especially those of socially disadvantaged groups, to expand our understanding of social phenomena.

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APPENDIX I. Glenn, N.M., Lapalme, J., McCready, G., & Frohlich, K.L. (2017). Young adults' experiences of neighbourhood smoking-related norms and practices: A qualitative study exploring place-based social inequalities in smoking. *Social Science & Medicine*, 189: 17-24

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Young adults' experiences of neighbourhood smoking-related norms and practices: A qualitative study exploring place-based social inequalities in smoking

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ABSTRACT

In this qualitative exploratory study we asked how smoking among young adults relates to the local neighbourhood context to better understand place-based social inequalities in smoking. We used data collected through focus groups with young adults from four economically diverse neighbourhoods in Montreal, Canada. Using the collective lifestyles framework to guide data analysis, we examined within and between neighbourhood social norms, practices, and agency. We found that some smoking-related social norms, practices and agency were particular to neighbourhoods of the same socio-economic status (SES). For example, permissive smoking-related social norms in low-SES neighbourhoods made it difficult to avoid smoking but also reduced local experiences of smoking-related stigma and isolation. In high-SES neighbourhoods, strong anti-smoking norms led to smoking in secret and/or amidst 'acceptable' social settings. Findings may inform future investigations and local-level interventions focused on this age group.

1. Introduction

Smoking prevalence in many industrialised countries has declined significantly in recent decades (Corsi et al., 2014). Nevertheless, it is still responsible for 21% of all cause mortality in Canada (Généreux et al., 2012). Furthermore, the burden of smoking is not equally distributed across all members of society but instead follows a steep social gradient (Généreux et al., 2012). In Canada, smoking prevalence and initiation is highest among young adults (aged 20–34 years) in comparison to other age groups (Statistics Canada, 2017). Smoking prevalence and initiation among young adults is also unequally distributed according to socio-economic factors such as education and neighbourhood-level deprivation (Hammond, 2005). This is worrisome because it is during this developmental stage that life-long health-related practices and behaviours, such as smoking, are often established (Biener and Albers, 2004; Hammond, 2005). What is more, prolonged cigarette use from young adulthood significantly reduces life expectancy (Doll et al., 2004). Therefore, it presents the ideal opportunity for smoking prevention strategies.

Existing research has revealed that smoking is spatially patterned and tends to be concentrated in neighbourhoods categorised as low-socio-economic-status ([SES] Généreux et al., 2012; Pearce et al., 2012). Pearce et al. (2012) have identified neighbourhood social practices and area-level policies as key pathways linking neighbourhood-level disadvantage and smoking. Nevertheless, because neighbourhood influences on health behaviours such as smoking are inherently complex, we require more nuanced and theoretically driven understandings of how and why the relationship between smoking and place exists to address social-spatial inequalities in smoking among young adults (Frohlich et al., 2001; Pearce et al., 2012). The collective lifestyles framework offers a theoretical grounding from which to undertake such an exploration (Frohlich et al., 2001). It situates smoking as a social practice intertwined with local smoking-related norms, social structures, and agency rather than an individual behaviour

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(Frohlich et al., 2001). We drew on the collective lifestyles framework to examine young adults' experiences of smoking-related norms, practices, and agency in their neighbourhoods and compare across neighbourhood-level SES to better understand social-spatial inequalities in smoking among this age cohort.

2. Background

For the last 15–20 years, population-level tobacco control strategies (e.g., media campaigns, smoke free legislations, and restrictions on the sale of tobacco products) have aimed to protect the population from the harms of tobacco by reducing smoking prevalence and exposure to second-hand smoke (World Health Organization [WHO], 2003). For instance, in Quebec, Canada, a notable comprehensive tobacco control policy was implemented in 2006 that restricted smoking in public spaces such as in restaurants, bars, and workplaces (Quebec National Assembly [QNA], 2006). It was amended in 2015 to include restrictions in cars with children present, on bar and restaurant terraces, in playgrounds, and within a nine-meter radius of all public and private entrances/exits (QNA, 2015). Beyond the intention of protecting the public, tobacco control policies have also functioned to de-normalize smoking (i.e., change public perceptions of smoking from acceptable to deviant; Bayer and Stuber, 2006; Graham, 2012). Although these policies have received praise from the public health community, their broad reach has primarily benefited the middle class 'majority' and thereby excluded other, often vulnerable, social groups that comprise the remainder of the population (Frohlich and Potvin, 2008; Hill et al., 2014). As an unintended consequence, social inequalities in smoking have increased in the decades since the 1960s (Corsi et al., 2014).

Some researchers have suggested that tobacco control policy and de-normalization of smoking has fuelled smoking-related stigmatisation and isolation. For example, smoke-free zones created through public policies have 'put smokers in their place,' that is either on display (e.g., stoops of buildings) or hidden away in undesirable locales (Poland, 1998). Thompson et al. (2007) used the metaphor of "smoking islands" to highlight the geographic and symbolic segregation of people who smoked. The authors argued that this kind of "reverse ghettoization" functioned to protect the middle classes from the infiltration of practices and "dirt" from the lower/working classes (Thompson et al., 2007, p. 511). This isolation-stigmatisation spiral can be particularly pronounced among already vulnerable people, contributing to a double burden of poverty and smoking (Bayer and Stuber, 2006; Frohlich and Potvin, 2008; Thompson et al., 2007). Not all research has supported these findings, however (Tan, 2013). Tan (2013) reported that young adults who smoked transformed smoking zones into enabling spaces of socialization and belonging.

Neighbourhood-level pro-smoking norms, often found in low-SES neighbourhoods, have also created social pressures that made it difficult for residents to avoid smoking. This has strengthened the smoking-poverty connection and worsened the burden of smoking in these sub-populations (Thompson et al., 2007; Lewis and Russell, 2013). Neighbourhood pro-smoking social norms have also resulted in residents feeling "trapped" by or fatalistic toward smoking (Lewis and Russell, 2013; Pateman et al., 2016). Conversely, "healthy living" discourses can permeate citywide smoking-related norms and create an environment hostile to smoking, as Haines-Saah et al. (2013) reported in Vancouver, Canada. Young adults felt these norms could have been a source of motivation to quit but also of shame and exclusion if one was unable to successfully do so (Haines-Saah et al., 2013). Poland (2000) examined smoking-related social norms and practices in public spaces, and the interactions between smokers and non-smokers in Toronto, Canada. He found discourses of consideration based on neo-liberal values (Lupton, 1995) were "a powerful organizing logic for the internalization of codes of conduct and self-control with respect to smoking in public" (Poland, 2000, p. 2). Being a "considerate smoker" enabled people to participate in the "purification of public space" and avoid stigmatisation, feel good about their smoking, and demonstrate self-control, alignment with social expectations, and responsible citizenship (Poland, 2000, p. 12). Gough et al. (2013) reported similar findings in their study of smokers from a disadvantaged community in the United Kingdom.

Research focused specifically on smoking related social practices and norms among young adults is relatively sparse. What is known, is that young adults commonly engage in social smoking, that is smoking predominantly in social settings, among friends, and when alcohol is involved (Biener and Albers, 2004; Nichter, Nichter, Carkoglu, Lloyd-Richardson, & the Tobacco Etiology Research Network, 2010). Social smoking is frequently reported as part of early smoking trajectories (seen among adolescents and young adults; e.g., Biener and Albers, 2004; MacFadyen et al., 2003; Nichter et al., 2010). Smoking socially can provide an avenue for young adults to experience abandon and temporary relief from the restrictive norms of everyday life with little stigma attached (Nichter et al., 2010). What is more, social smoking does not necessarily entail that young adults adopt a smoker identity and, in fact, many maintained that they were non-smokers even if they smoked in social situations (e.g., 'Phantom Smokers; ' Choi et al., 2010). This provides a way for young adults who smoked to embody two opposing discourses at once: that is, personal risk management and youthful rebellion (Brown et al., 2013; Haines-Saah et al., 2013; Lupton, 1995). While this research has revealed some of the particularities of smoking among young adults, it has not addressed how these might relate to social inequalities in smoking among this age group (Hammond, 2005). The majority of the scholarship on young adults has been conducted on college campuses or among highly educated or high-SES participants (e.g., Biener and Albers, 2004; Nichter et al., 2010; MacFadyen et al., 2003) and therefore may not be representative of the experiences of young adults from across the social spectrum. Given the importance of this life stage for tobacco control intervention, we need to better understand the smoking-related smoking practices, norms, and agency and consider the impact of differing social circumstances to create policies that can address social inequalities in health among this age group.

2.1. The collective lifestyles framework

We used the collective lifestyles framework to investigate smoking as a social practice, reflective of group norms and perceptions, which shape and are shaped by the social structure of context (differently, based on people's level of agency; Frohlich et al., 2001). The collective lifestyles framework provided a heuristic for understanding the social meaning of smoking while highlighting the recursive relationship between behaviour and context (e.g., neighbourhood). It includes: (1) social practices; (2) social structure; and (3) agency (Frohlich et al., 2001). Social practices are what we do (i.e., health behaviours) and also how and why we do these things (Giddens, 1984). They are the actions that arise from and transform our world. Social structures are "the rules and resources in society" (Frohlich et al., 2001, p.781; Giddens, 1984). Examples of rules and resources regarding smoking include local smoking norms and codes of conduct such as smoking bans, presence or absence of tobacco retailers, and public ashtrays. Agency represents people's capability to transform social structures through social practices (Giddens, 1984), for example restaurant and bar owners may construct shelters for smokers outside of their

establishments in response to groups of smokers gathering in those locations.

We explored local smoking-related social practices, social norms, and agency among young adults from neighbourhoods of varying levels of SES in Montreal. We compared the findings across neighbourhoods (high and low-SES), which allowed us to make tentative claims about how social inequalities in smoking can relate to place of residence among young adults. We use these to point out areas where more thorough investigations are warranted. Our aim is ultimately to contribute to the creation of a foundation on which to support the building of ethical tobacco control interventions that address existent social inequalities in smoking.

3. Methods

This exploratory qualitative descriptive study (Sandelowski, 2000) involved the analysis of data collected in the development of a survey tool for a larger research program, the Interdisciplinary Study of Inequalities in Smoking (http://www.isis-montreal.ca/index.php/en/). The purpose was to better understand the relationship between smoking and neighbourhood-level SES among young adults. Data collection occurred in 2009 using focus groups conducted with young adults (18–25 years) who self identified as smokers (i.e., having smoked at least 100 cigarettes in their lifetime and smoked at least one cigarette in the last week). Participants were told that the research team wanted to identify characteristics of individuals and neighbourhoods that influenced smoking in their neighbourhood. The focus groups followed a semi-structured guide, which included questions such as,"what about your neighbourhood do you think might be encouraging or discouraging people to smoke?"

Participants lived in four different neighbourhoods in Montreal, which were selected based on neighbourhood-level SES and language (primarily either French or English speaking). Neighbourhood-level SES was derived using four indicators: income, centrality (comparing high income and single-detached dwellings from low income living in apartments and using public transport), education level, and language/ethnicity (Daniel and Kestens, 2007). Neighbourhood sampling included extreme cases (i.e., maximum variation sampling) to facilitate comparison across neighbourhoods (Sandelowski, 2000). In the low-SES neighbourhoods participants were recruited through community organizations and in the high-SES neighbourhoods through a sport centre and a private college. In total, nine focus groups were conducted including 39 young adults. There were two focus groups led in each of the four neighbourhoods, one with men and another with women. An additional focus group was conducted among women living in Century Park (due to interest and scheduling). The nine focus groups (four in high-SES, five in low-SES neighbourhoods) provided sufficient data to respond to our research question with adequate depth (O'Reilly and Parker, 2012). The neighbourhoods have been given pseudonyms: Waterdale – high-SES primarily English-speaking (n = 7); Pleasantview – high-SES primarily French speaking (n = 7); Corktown – low-SES primarily English speaking (n = 8); and Century Park – low-SES primarily French speaking (n = 17). The focus groups were conducted in the primary language of the neighbourhood by an experienced facilitator and lasted between 49 and 75 min. They were audio-recorded and transcribed verbatim. Participants received CAD $20 compensation for their time. The Health Research Ethics Committee of the University of Montreal granted ethical approval for the study.

Transcripts were imported into Atlas.ti and coded in their original language using a deductive-inductive approach informed by qualitative content analysis (Sandelowski, 2000). We began the analysis by developing a coding scheme, which involved defining codes, deductively based on the collective lifestyles theoretical framework and the research questions and inductively based on a primary reading of the transcripts. We coded two transcripts (one high and one low-SES) according to the coding scheme and met to assess reliability comparing across coders. All discrepancies were discussed and we adjusted the codes and code definitions as necessary to facilitate clarity and alignment. We then coded all of the transcripts in Atlas.ti according to the revised coding scheme. Through the process of coding the authors developed higher-level interpretations related to the theoretical framework. These were recorded using analytic notes (Maykut and Morehouse, 1994). The final level of analysis involved comparing codes and interpretations across neighbourhood-level SES. This process took place over a series of in-person meetings where interpretations were discussed, original data were reviewed, and thematic findings were established and agreed upon.

4. Findings

To preserve the unique context of each neighbourhood we present our findings as vignettes. These include a brief description of each neighbourhood and the people living there (supported by statistics obtained from the 2011 Canadian Census and the Ville de Montréal; Statistics Canada, 2011; Ville de Montréal, 2011, 2014a, 2014b; 2014c) followed by the smoking related social practices, norms, and agency as conveyed by our participants.

4.1. Waterdale

A historically affluent, predominantly English-speaking neighbourhood, Waterdale remained high-SES at the time of our investigation (Canadian Census, 2011). Although the neighbourhood was located close to the city centre it was primarily residential with single-family homes on large lots and mature trees lining the streets. Waterdale was well serviced by local boutiques, cafés, restaurants, various professional and public services, and parks, although these services were concentrated on commercial streets creating a distinct residential-commercial divide.

Participants from Waterdale described their neighbourhood as one with strong social norms intimately tied to the image of being a "good and safe" place. Smoking in the neighbourhood was not well accepted and often led to "looks" or comments intended to make smokers feel uncomfortable and ultimately to discourage them from smoking. Regardless of the local norms, young adults explained smoking was common among their peers. Local smoking practices most often included friends and social settings such as at parties. Smoking in social situations provided a way of breaking the ice and often facilitated the meeting of new people. Being a "social smoker" rather than a regular or "real" smoker, as they were sometimes described, was considered the only right way to smoke. Social smokers adhered to local smoking norms and practices and only smoked in appropriate social situations. They also did not show signs of addiction (at least not publically), which allowed them to circumvent the negative connotations attached to smoking and instead display neoliberal values of self-responsibility and control (Lupton, 1995). Rarely would a social smoker smoke alone (again, not publically where one could be seen).

With regards to agency, smoking was described as an individual choice within individual control. Smoking-specific social norms influenced when, where, and with whom the young adults felt they should smoke – yet the young adults expressed agency in shaping these norms and practices. These included smoking out of view in alleyways, parks, and forested areas and not smoking on main streets or in front of adults. A woman explains,

> It feels weird smoking a cigarette in front of them [adults], so you try and avoid that and it's I guess a form of respect just walking around, we don't just smoke out in the open. Now we do because we're just a bunch of kids but if you're alone, I won't smoke down the street of [Waterdale] alone. (Women, Waterdale)

The social practice of smoking in groups also protected young adults from judgement and the disapproving gaze of others. It was not only the young adults in Waterdale that hid their smoking. A woman explained, "I know my dad smokes but in secret. He tries to hide it. I know he does" (Women, Waterdale). Quitting was also a choice one had if and when one desired. Local social norms dictated that smoking was 'bad' in general but acceptable only among young adults because it represented youthful rebellion. It was not a habit the participants planned to continue through adulthood. The women explained,

> I haven't really tried to quit yet but, a lot of people have tried to quit, but it's not that it doesn't work it's just kind of like, "I don't want to yet." We're still young, we just hit the legal age, just let us have a little bit of fun. I don't want to smoke my whole life. I want to quit by the time I'm 22 or something. (Women, Waterdale)

The participants explained that smoking was a way of relieving stress, which they argued arose primarily from high familial and social expectations (e.g., school grades). They said these pressures influenced smoking initiation, which was seen as a youthful rebellion taken up in response to a restrictive, "uptight" environment. A woman explains, "Rebel, yeah. It's because we're brought up so uptight in this neighbourhood" (Women, Waterdale). As such, smoking provided a way to demonstrate agency in the face of restrictive childhood rules (which they felt no longer applied to them) while avoiding the emerging responsibilities and expectations of adulthood (to which they aspired but felt they did not yet need to comply).

4.2. Pleasantview

Pleasantview was a high-SES, primarily Francophone neighbourhood (Ville de Montréal, 2014b). This description, however, does not capture the vibrancy of this place. It was home to festivals, parks, cafés, boutiques, restaurants, and various professional and public services. It was centrally located and well serviced by public transit. Streets often had mature trees and apartments had small patches of front and back gardens. Housing was mixed including apartment blocks, new build mid-rise condominiums, and some single family homes, although it was predominantly made up of stacked, multi-family and student dwellings (Ville de Montréal, 2014a).

Unlike in Waterdale, young adults in Pleasantview said smoking was relatively common in their neighbourhood. Nevertheless, local social norms, which were connected to smoking legislations (e.g., public smoking bans) and broader anti-smoking sentiments (e.g., smoking is unhealthy), shaped local smoking practices, such as not smoking in the vicinity of non-smokers or children. Participants tended to agree with popular anti-smoking discourses and accepted the resultant restrictions as common sense. They explained that deviating from local smoking practices and non-compliance with local norms could lead to negative consequences including dirty looks, derogatory comments, and stigmatisation. However, the reason to comply was not these negative consequences but rather respect for others; similar to what was heard in Waterdale. One woman explains,

> You can often tell when people will like turn away or move out of the way because there's smoke, without making a comment, so I'll pay more attention out of respect. At the park, I'll even be the person to say those comments [to people who smoke in the presence of non-smokers] because I think it's unbelievable. (Women, Pleasantview)

Agency arose amidst such circumstances because the young adults felt they could choose to smoke in other locations, away from non-smokers. One woman explained, "it's fun; you stand on the terrace [outside a bar] with a drink and smoke." They claimed public spaces such as bar terraces, private balconies, and parks away from children as smoking spaces. The practice of smoking around children was considered a particularly egregious offence in Pleasantview and was in opposition to local smoking norms. The young adults explained that they were responsible for setting a good example and not endangering the health of children by smoking nearby.

As in Waterdale, smoking practices, including those around initiation and cessation, were seen primarily as a reflection of individual choice (i.e., agency). At the same time smoking was something to be undertaken primarily in social settings, indicating the existence of a similar typology of smokers — the social versus the real smoker — that we saw in Waterdale. Because local smoking-related social norms included a tolerance of individual choice (to smoke), while at the same time accepting the rhetoric that 'smoking is bad,' the young adults were careful about disclosing their smoking status in specific contexts, particularly among non-smokers. One man explained,

> P1: So for example at my work, there aren't any other smokers. I can't tell them that I'm going out for a smoke, except during my lunch I'll go
>
> I: You don't hide, but you
>
> P1: I don't talk about it, I don't brag about it, it's not like "oh I'm cool, I smoke a cigarette"
>
> P1: Unless there's another smoker with you, then you'll tell them
>
> P2: Are you going for a smoke?
>
> P1: Yeah, exactly, come smoke one with me. (Men, Pleasantview)

Some participants expressed resistance to what they called "trendy" local social norms that prioritized health over choice and encouraged people not to smoke and instead smoked openly as an act of calculated resistance.

Young adults in Pleasantview also described smoking as a way to structure their day. It provided a much-needed break or "pause," as a woman explained, "sometimes I have the impression that I wouldn't take any breaks if I didn't smoke" (Women, Pleasantview). In this way smoking was an avenue through which the young adults could claim agency over the structure of their lives. As it was in the other neighbourhoods, smoking was seen as a stress reliever, where stresses were often linked to daily responsibilities (principally school and work). One of the men explained, "it's mostly stress, you're in a big rush and at the end, your cigarette is really good" (Men, Pleasantview). Because of negative health consequences, most participants in Pleasantview expressed the desire to quit smoking, again showing their adherence to broader anti-smoking norms within their local practices.

4.3. Corktown

Corktown was classified as low-SES (Ville de Montréal, 2014c). Much of the population, 60.9%, were immigrants to Canada, making Corktown rich in cultural diversity (Ville de Montréal, 2014c). Nearly half of the residents (47%) indicated neither French nor English as their first language (Ville de Montréal, 2014c). Corktown was farther from the city centre in comparison to the other three neighbourhoods although it was easily accessible by public transport. Streets were lined with mature trees and there were many restaurants representing a vast array of cultural influences.

The young adults from Corktown reported permissive local smoking-related social norms and practices and argued: "everyone smokes all the time." Local smoking practices, unlike in the higher-SES neighbourhoods, dictated that people could smoke anywhere and there were only a few circumstances under which it was less acceptable, namely around children. Social norms encompassed few informal rules and the formal regulations (e.g., public smoking bans) were often ignored. One exception was smoking indoors in public spaces, although participants did describe seeing people smoke inside the local metro station revealing flexibility with regards to adherence. Due to the greater permissiveness of local smoking-related norms, participants expressed concern for their neighbourhood's reputation stating smoking bans had forced smokers into the streets, making them more visible and therefore contributing to Corktown's poor image.

The young adults from Corktown expressed fatalistic attitudes toward smoking and argued it was inescapable because friends, family, and others in the neighbourhood all smoked. Accompanying these feelings was a distinct lack of agency with regards to transforming local smoking practices and shifting norms. Rather, they expressed the desire for more government control and intervention:

> Every time I try to stop, I walk down the street and there's somebody smoking and I'm like "I want a cigarette now!" I'm like resisting, I walk down again and they're smoking and then I'm like "I definitely need to get a cigarette!" I've been trying to quit for the longest time and I can't. Because every time there's always cigarette blowing in my face, or I see somebody I'm like "damn!" Yeah, that's how I feel. They [the government] should ban it. (Women, Corktown)

Not all young adults in Corktown agreed however, that local smoking practices and norms were shaped by the government but instead invoked a sense of individual agency and alignment with neoliberal ideals (Lupton, 1995), "it's your choice; you smoke, you smoke, you don't, you don't, you started because of a personal decision, you can stop because of a personal decision" (Women, Corktown). Nevertheless, most participants wanted to quit smoking but were unable to do so which they felt was because of pervasive local pro-smoking norms, again highlighting their lack of perceived agency.

Participants cited reasons for smoking initiation that included appearing "cool" and high exposure to smoking (i.e., family members, friends, and others in the neighbourhood), indicative of the local pro-smoking norms. Local smoking practices included smoking in social settings among friends, particularly when drinking alcohol, as well as smoking alone as a way to relax and take time for one's self.

We did not find evidence of any distinctions between social and 'real' smokers as we did in the high-SES neighbourhoods. Permissive local smoking norms meant there was little stigma attached to smoking in the neighbourhood. That being said, smoking contraband cigarettes (i.e., "natives") was looked down upon. People who smoked these were regarded as having gone too far with their habit and prioritizing smoking above all else. The young adults distanced themselves from such people, as one woman explained, "those [people who smoke natives] I find are the ones that are like heavy smokers! Like heavy smokers to the point if they have no money, like they'll find just to buy cigarettes. I'm not like that. Like I smoke, except if I don't have the money, I can't smoke."

Similarly in the other neighbourhoods, smoking was described as a way of having control over one's daily life, enabling the young adults to better cope with stresses (i.e., family obligations, problematic interpersonal relationships, financial instability, and a general lack of opportunity for work and study), as well as the stress of living in the neighbourhood. Smoking provided an escape or a calming break from routines and an outlet for a gamut of emotions ranging from depression to happiness to boredom.

4.4. Century Park

Century Park was classified as a low-SES predominantly francophone neighbourhood (Ville de Montréal, 2011). Historically, it was an industrial neighbourhood that had more recently attracted new immigrants, although predominantly francophone (Ville de Montréal, 2011). Century Park was very centrally located and urban with little green space surrounding the mix of new-build condominiums and older, stacked row housing. It was relatively close to downtown and the tourist attractions of old Montreal. Although this centrality brought vibrancy and plentiful resources to Century Park residents, it also contributed to the transient nature of the local population, with 80% of residents renting.

Like in Corktown, young adults from Century Park described local smoking related norms as permissive of smoking. It was common to see people smoking anywhere and everywhere. Local smoking practices, however, encompassed formal rules, such as not smoking inside establishments, and informal rules, like not smoking in the presence of children. The women explained why this was important,

> Oh no, it's because I don't want to, it's like if you smoke all the time with your children or whatever, kids will see that you smoke, they'll want to do what the adults do, so they'll start smoking. Not me. When there's a kid, if you smoke, hide. (Women, Century Park)

However, people frequently smoked outside of local daycares or in parks with children nearby, revealing greater flexibility in local smoking practices in comparison to the other neighbourhoods. Local pro-smoking norms meant that there was little stigma attached to smoking, including smoking of 'natives,' contraband cigarettes, which many Century Park residents admitted to smoking because of their affordability. Unlike participants from the other three neighbourhoods, some young adults from Century Park expressed concerns for their right to smoke and displayed resistance to local and also broader anti-smoking norms. The overwhelming sentiment expressed by participants in Century Park, however, was that people had little agency over re/shaping local smoking practices and norms. Rather, people felt entrapped by pro-smoking norms and other difficult life circumstances perceived to be beyond their control such as problematic interpersonal relationships, family, peers, accessibility, poverty and above all stress and boredom caused by the conflation of these factors. Smoking was described as inevitable; it was not a question of *if* one would become a smoker, but *when*. These sentiments led to a palpable sense of resignation, defeat, and hopelessness around smoking as expressed by the men as being "enslaved" and the women as follows,

P2: And everyone smoked around me, my entire family smokes so

P1: You start to smoke.

P2: Everyone smokes, so I don't see why I wouldn't smoke. (Women, Century Park)

When discussing the relationship between their neighbourhood's image and anti-smoking legislations, the young adults in Century Park expressed the same concerns as those from low-SES Corktown. That is, anti-smoking regulations shifted local practices in a way to move smokers onto the streets making them more visible and therefore contributing to the neighbourhood's poor image and reputation. Participants also noted that city officials often neglected the cleaning and maintenance of their neighbourhood. According to their experiences there were scarcely any public smoking accommodations such as ashtrays and garbage cans, which did not respond to local practices and led to pollution in the neighbourhood (e.g., cigarette butts on the ground).

Like the young adults in the other neighbourhoods, participants from Century Park described smoking as marking the routines of their day. It offered a pause or break, relief from boredom or stress, and a moment to oneself. As it did for the young adults in low-SES Corktown, smoking provided a way of coping in the face of few life opportunities and meaningful endeavours, "It's just that I think it replaces something that's missing, it fills a hole and in my case, it's boredom. That's boredom." (Women, Century Park). Others described smoking as a necessary comfort when faced with stress, anger, or depression full of familial and financial strife. Some participants expressed the desire to quit smoking, however they commonly cited structural barriers to achieving this, including lack of publicly funded services stating the majority of services that they were aware of consisted of anti-smoking education campaigns rather than actual cessation support.

5. Discussion

In this exploratory study we drew on the collective lifestyles framework to examine the connection between neighbourhood-level SES and local smoking-related social practices, norms, and agency among young adults. Our aim was to better understand social-spatial inequalities in smoking. Although each neighbourhood was unique, there were also similarities in smoking-related social practices, norms, and agency according to neighbourhood level-SES. Data were collected three years after the implementation of anti-tobacco legislation in Quebec that restricted smoking inside restaurants and bars (QNA, 2006). This legislation undoubtedly shaped local smoking-related norms and practices among the young adults as we discuss.

Participants from low-SES neighbourhoods reported permissive local smoking norms, despite the 2006 laws (Lewis and Russell, 2013; Pateman et al., 2016), whereas in high-SES neighbourhoods, smoking was highly socially regulated and contained (e.g., in social settings such as outside of bars or at parties). The young adults living in the high-SES neighbourhoods expressed agency with regards to re/shaping local smoking practices and norms even though these were restrictive and often anti-smoking in nature. They argued that local smoking practices were aligned with, and emerged from, their own personal philosophies (e.g., one should not smoke around non-smokers), however the connection to broader anti-smoking rhetoric, neoliberal values (e.g., self-control, individual responsibility; Lupton, 1995), and provincial legislation (QNA, 2006) were undeniable. Researchers have found that mainstream tobacco-control measures disproportionately benefit people of high-SES (Hill et al., 2014), which could explain the alignment between the local smoking practices and norms in the high-SES neighbourhoods and the recent provincial anti-smoking legislation (QNA, 2006). Conversely, in the low-SES neighbourhoods young adults described smoking as an inevitable consequence of living in a place with strong pro-smoking norms over which they expressed little to no agency in re/shaping.

Other researchers have reported similar feelings of resignation toward smoking among low-SES adults (Pateman et al., 2016) and youth living in disadvantaged communities (Lewis and Russell, 2013). Unlike the young adults living in low-SES neighbourhoods, Frohlich et al. (2010) discovered that in comparison to middle class smokers, working class smokers were less welcoming toward tobacco control efforts to reduce consumption because they felt these would leave them with stigmatised smoking identities. Expressing desperation to escape the "inevitable" clutches of smoking (and related stigmatisation), the young adults we spoke to voiced the opposite desire – that is for greater government intervention and restriction on smoking (including a complete cessation of tobacco sales). In doing so they demonstrated resistance to the neoliberal imperative of individual responsibility and instead insisted that the government should shoulder this weight (Brown et al., 2013; Lupton, 1995). Nevertheless, without the agency to change either tobacco control policies or public perceptions of smoking, young adults living in low-SES neighbourhoods found themselves in a double bind: that is, local pro-smoking norms meant they could not escape becoming a smoker while global anti-smoking discourses dictated they suffer the repercussions of the spoiled smoking identity. This could create a cycle whereby broader anti-tobacco interventions and discourses meant to reduce population-level smoking prevalence function instead to further marginalize young adults living in already disadvantaged circumstances due to their inability to adapt to the demands of tobacco control (Frohlich and Potvin, 2008).

Similar across all neighbourhoods was the sentiment that smoking around children was unacceptable (Rooke et al., 2013). This was unsurprising given the broad support for outdoor smoking restrictions in children's spaces (e.g., parks/playgrounds) expressed as far back as 1988 (i.e., prior to most public smoking restrictions; Thomson et al., 2009). Nevertheless, in one of the low-SES neighbourhoods (Century Park) there was clearly some flexibility in terms of how this was interpreted since people frequently smoked outside of daycares and near play equipment in the parks. This is not unlike the way mothers living in disadvantaged neighbourhoods negotiated keeping a smoke-free home while watching the children, which often involved a flexible interpretation of non-smoking spaces such as in an open doorway or a room where the children did not play (Robinson and Kirkcaldy, 2007). Parents living in Century Park may have had to contend with similar life circumstances. Therefore the flexibility of local smoking-related norms and practices could be illustrative of how residents were able to shape these according to local needs and life circumstances. However, the failure to comply with broader anti-smoking smoking norms (Thomson et al., 2009; WHO, 2003), could contribute to the neighbourhood's bad reputation, increase stigmatisation and isolation of the local community (Poland, 1998), and exacerbate existing social-spatial inequalities in health. This demonstrates how anti-tobacco strategies can be inadequate for addressing the needs of people living in low-SES communities who would benefit from interventions on the 'causes of causes,'; that is, on the social-political forces that (re)create the life circumstances (e.g., poverty, lack of education/training) that leave them with little choice, agency, or opportunity to achieve their life goals (Frohlich and Potvin, 2008). In fact, we found that stressors described by participants living in low-SES neighbourhoods as contributing to their

need to smoke, such as poverty and lack of educational/employment opportunities would be amenable to political action whereas the stressors discussed by the young adults living in high-SES neighbourhoods related to familial expectations and plentiful opportunities (i.e., not in need of social intervention).

In high-SES neighbourhoods, smoking practices among young adults and local norms included displaying consideration for non-smokers (Poland, 2000; Rooke et al., 2013; Tan, 2013). Rather than being places of isolation and stigmatisation (i.e., smoking islands; Thompson et al., 2007) smoking spaces for young adults in high-SES neighbourhoods were akin to the 'enabling' spaces described by Tan (2013). That is, they were spaces where young adults could "(re)fashion their own sense of wellbeing," restore "a more enabling narrative of smoking spatialities and subjectivities" and form social bonds with other smokers (Tan, 2013, p. 173). The young adults living in high-SES neighbourhoods demonstrated their youthful spirit, unique identity, and abandon through smoking (Rooke et al., 2013; Tombor et al., 2015) while circumventing "the sharp edges of criticisms and disdain" (Poland, 2000, p. 5) by doing so according to local practices and norms (which complied with broader anti-smoking norms and neoliberal values; Lupton, 1995; WHO, 2003). In this way they displayed agency in re/shaping smoking-related norms and practices to suit their unique needs and life stage (Tan, 2013).

In low-SES neighbourhoods, the freedom afforded by local smoking norms that encouraged smoking 'anywhere' and 'everywhere' was not perceived as freedom at all (or enabling; Tan, 2013), but rather as a trap from which it was difficult to escape (Lewis and Russell, 2013; Pateman et al., 2016). Pro-smoking norms effectively created smoking islands out of the low-SES neighbourhoods and contributed to the already poor reputations of these places. Poland (1998) writes about smoking places as 'undesirable locales,' which we see from our findings can extend beyond the particular, as he articulated, to the entire low-SES neighbourhood. This led to stigmatisation from people living outside neighbourhood boundaries, intensified the isolation of residents (Thompson et al., 2007), and reinforced existing class distinctions (Graham, 2012), separating the 'unclean' lower classes from the 'tidy' middle classes (Thompson et al., 2007). Neighbourhood-SES-related local smoking norms and practices can create smoking spaces that are 'enabling' for some young adults (i.e., in high-SES neighbourhoods; Tan, 2013) while 'isolating' for others (i.e., in low-SES neighbourhoods; Thompson et al., 2007). This enabling versus isolating divide appears dependant on the agency that residents express with regards to shaping local practices and norms to align with broader anti-smoking rhetoric (which is itself closely connected to social class) and therefore presents an avenue through which social class divides are upheld and existing social inequalities in smoking exacerbated among young adults (Graham, 2012; Thompson et al., 2007).

We found that young adults living in high-SES neighbourhoods frequently made reference to social smoking whereas this was not the case in low-SES neighbourhoods. Participants from high-SES neighbourhoods described the social smoker in contrast to the 'real' smoker: Someone who was addicted and *had* to smoke, and therefore would do so anywhere and anytime (even if 'inappropriate'). This was a virtual portrait of the local smoking-related social norms and practices among young adults in low-SES neighbourhoods. Social smoking practices may represent part of the fluid or shifting smoking identities common of early smoking trajectories and young adulthood (Haines-Saah et al., 2013; Rooke et al., 2013; Tombor et al., 2015) or a stable consumption pattern (Schane et al., 2009), however the possible connection to social class may be far from benign. Young adults living in low-SES neighbourhoods could be denied access to privileges (e.g., social mobility, rights, and justice; Brown et al., 2013) because of their failure to demonstrate the self-control and restraint inherent to smoking socially. This could create 'legitimate' grounds for class-based segregation and stigmatisation (tied to the public health imperative for smoke-free spaces; Brown et al., 2013). We make only tentative claims regarding the connection between the social smoker distinction and neighbourhood-level deprivation among young adults because of the exploratory nature of this study. However, we argue that based on our findings this is certainly an area where further research is required. If indeed there is a connection this could present another avenue through which social-spatial inequalities in health are upheld/exacerbated among this age group with repercussions through the life course.

6. Conclusion

Existing research has focused on describing the relationship between neighbourhood and smoking behaviours. There has been little enquiry into *why* and *how* this relationship exists differentially according to neighbourhood-level SES, particularly among young adults. Furthermore, we argue that the broad reach of population-level tobacco control neglects these neighbourhood-level differences and are not particularly salient to segments of the population already vulnerable to the long-term consequence of tobacco use (such as young adults living in low-SES neighbourhoods). If we continue to ignore these specific realities, tobacco control policies may exacerbate rather than address existing social inequalities (Frohlich and Potvin, 2008; Thompson et al., 2007). We found that young adults have a particular relationship to smoking that could serve to perpetuate social inequalities in smoking based on neighbourhood-level SES. This is particularly worrying during this early life stage because of the way social disadvantage is accrued over the life course (Brown et al., 2013, p. 340). This provides support for our argument that more targeted, theoretically driven research (and subsequently, interventions) are necessary if these inequalities are to be addressed. The findings from our study could inform the creation of more comprehensive qualitative studies that explore placed-based social inequalities in smoking among young adults and ultimately provide the foundation for tobacco control strategies and policy that addresses existent social inequalities at the local level.

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APPENDIX II. Lapalme, J., Glenn, N.M., & Frohlich, K.L. (2021) Do you mind if I smoke here? Exploring the insights that public benches bring to public health research. *Canadian Journal of Public Health*, 117(1): 71-73

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COMMENTARY

Do you mind if I smoke here? Exploring the insights that public benches bring to public health research

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Abstract
In this commentary, we illustrate how exploring the meanings and uses of everyday, seemingly mundane, public objects can advance our understanding of health-related practices and the social norms that shape them. We use the example of the public bench and smoking for this purpose. By observing the design of public benches, the places where they are found, the meanings people attribute to them, and the way people use them, we can learn what health-related practices (e.g., smoking) and who (e.g., people who smoke or who do not smoke) are included and excluded as part of local community life. We thus consider the idea that public benches can be instructive in helping us understand how our health-related practices may be shaped by what can be seen enacted on or from public benches. We ultimately demonstrate how this type of object-based experiential exploration, largely absent from public health research, can provide a novel and insightful perspective to public health research.

Résumé
Dans ce commentaire, nous illustrons comment l'exploration des utilisations et des significations attribuées aux objets publics quotidiens apparemment anodins peut avancer notre compréhension des pratiques liées à la santé et des normes sociales qui les façonnent. Nous utilisons, à cette fin, l'exemple du banc public en lien avec le tabagisme. Le design des bancs publics, les endroits où ils se trouvent, la façon dont ils sont utilisés et le sens qui leur est attribué peuvent nous renseigner sur les pratiques liées à la santé (p.ex. fumer) et sur les personnes (p.ex. les gens qui fument et ceux qui ne fument pas) qui font partie intégrante ou, à l'inverse, sont exclues de la vie communautaire. Ainsi, nous considérons les apprentissages que les bancs publics nous permettent de faire pour mieux comprendre comment les pratiques liées à la santé sont influencées par ce qui peut être vu en y étant assis ou en observant ceux qui y sont assis. Enfin, nous démontrons comment cette exploration expérientielle basée sur l'objet, largement absente en santé publique, peut offrir une perspective de recherche novatrice dans ce domaine.

Keywords Urban health · Social norms · Smoking · Residence characteristics

Mots-clés Santé en zone urbaine · normes sociales · fumer · caractéristiques de l'habitat

A woman is sitting on a bench near a bus stop. She scrolls through her phone as a man approaches and sits in the empty space next to her. He glances at her while her eyes stay fixed on the screen. As he reaches into his coat pocket to take out a cigarette, he looks to the woman next to him as if to check that it is okay with her that he lights up. Although she does not look up from her phone, he gets up and walks several feet away. There he smokes his cigarette and waits for the bus to arrive.
On the other side of town, a young woman is standing in the busy plaza next to the subway station waiting for a friend. She is tired. Her legs ache and her back throbs. Most of the benches are occupied; there are two women

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smoking and chatting on one bench, while another hosts a small family. There is a third bench with a free spot next to an older woman. She appears to be watching the comings and goings of the busy station. The young woman lets out a sigh as she lowers herself onto this bench. She rummages through her purse and pulls out a cigarette, lights it, and leans back as she inhales.

These scenarios may seem familiar to us, but they are most likely so mundane that we have not taken particular notice or reflected on their meaning. However, if we explore these everyday experiences more carefully, we may see the very fabric of local social life, that is, who and what health-related practices belong in these places. For example, in both vignettes, there are no signs prohibiting smoking near the public benches. Yet, something compels the man to move away to smoke, whereas across town, the young woman sits next to someone and unabashedly smokes.

Disciplines such as anthropology, archeology, design, and urban planning have examined the meanings and uses of everyday objects to better understand the social world in which these objects are found. They demonstrate how these everyday objects, rarely considered in daily life, are not merely passive, but rather, interactive, formative, and transformative (Adams and Yin 2017). Often these objects are used in ways beyond how they were intended. We do not always sit on public benches; some people use them to practice skateboarding tricks or to put down heavy bags while waiting for the bus. These objects therefore reflect our everyday social practices, and in doing so, they reflect the local social norms that shape these practices. As such, objects may be considered cultural or social artifacts (Glenn and Clark 2015). The lack of attention paid to non-human entities within public health research represents a missed opportunity to better understand the complexity of our social world (Rock et al. 2014). Heeding this call and inspired by the traditions of studying objects, more specifically by Heidegger's (1971) phenomenological writings on the "thing-ness" of things, in this commentary, we reflect on the public bench in relation to smoking. Experiential examples of public benches have been drawn from our own experiences along with some qualitative literature on place-based smoking (Bell 2013; Bell et al. 2010; Poland 2000; Thompson et al. 2007).

The public bench

In urban environments, we find public benches aplenty: at bus stops, in plazas, in parks, near hospitals and other public institutions, and along sidewalks. We sit on them to wait for the bus or a friend to arrive, to take a break from a long walk, to watch our children play in the park, or to have a smoke. Sitting on a public bench may also provide us with the opportunity to observe the world around us: trees, birds, architecture, people walking by, and cars driving past. Simultaneously, we are also observed by this same world. People walking by may glance at the bench to look at who is sitting on it and what they are doing. In this way, the public bench is instructive; by observing the world from the public bench or by observing what and who is displayed on it, we learn about socially acceptable practices and who is included and excluded from local social life in the place where the public bench is found. Consequently, our health-related practices may be influenced by what we see from or on the public bench.

A public bench's design may also reveal local social norms. Some public benches are not just intended for sitting, but for preventing certain activities and excluding specific subgroups of the population (Bergamaschi et al. 2014). For instance, the armrests on a public bench, although functioning as places to rest one's arms, can also send the message: "No lying or sleeping here" or, in other words, no homeless people allowed (Bergamaschi et al. 2014). Public benches then become "hostile architecture", at least toward some (Bergamaschi et al. 2014), and thus, they may not be so public after all. Conversely, bright and colourful public benches invite passersby to lounge on them and enjoy their surroundings.

The public bench and smoking

Research has demonstrated that smoking prevalence varies by geographical contexts (Barnett et al. 2017). Local smoking-related norms may contribute to these differences; in places where anti-smoking sentiments reign, smoking prevalence tends to be lower than in places where smoking is permissive (Barnett et al. 2017). Reflecting on how people experience public benches and what meanings they attribute to them may reveal local smoking norms and practices as well as the ways these norms and practices are negotiated and circumvented. In a place where smoking is socially unacceptable, health-related practices may shift depending on time of day. We may not see anyone smoking on public benches in the daytime because it can lead to judgemental looks or comments (Bell et al. 2010; Poland 2000). Rather, people may sit quietly while getting some fresh air, stretch their legs after a jog, or catch up with their friends. After nightfall, however, these same public benches may transform from family-friendly places to a site for young people to gather, socialize, drink beer, and smoke away from the judgemental gaze of others (Bell et al. 2010; Poland 2000; Thompson et al. 2007). In this sense, these public benches may represent both places of belonging and places of exclusion, only to be used freely as "smoking places" in secret, after dark, and when no one else is around. The implicit message is that smoking is not socially acceptable, and by extension, neither is the smoker.

Public benches may be experienced differently in areas where smoking is socially acceptable. In these places, people are permitted to smoke openly on public benches either alone or while socializing with friends (Thompson et al. 2007). This public smoking can indicate some level of social acceptability of smoking and public benches may represent unofficial smoking places in these communities. People do not need to avoid stigmatizing looks or comments by hiding their smoking. They can smoke freely, day or night, on public benches and they may even find belonging and community with others by initiating conversation over shared cigarettes. Yet, being exposed to visual and olfactory smoking cues from people smoking on public benches may make smoking prevention and cessation challenging (Thompson et al. 2007). In these same communities, there may also be benches where people do not smoke. These may be located near playgrounds, daycares, or other child-related places (Bell et al. 2010; Poland 2000). In places where there are many non-smokers, those who smoke may choose a bench farther away from non-smokers to spare them from their smoke (Bell 2013; Bell et al. 2010; Poland 2000). This demonstrates that local permissive smoking norms can also be negotiated, especially in children's and non-smokers' presence.

Conclusion

Everyday objects found in our public environments can further inform us on the complexity underlying health-related practices. Exploring how we interact with public benches can teach us about the local social acceptability of smoking, and consequently, who is included and excluded from local community life. Further, we learn about how health-related practices, such as smoking, are negotiated, adapted, and circumvented according to local social norms. These micro-examinations can also be used to reflect on more distant factors influencing our local norms and to explicate these place-based differences. With regard to our exploration of smoking on public benches, we might consider how population-level tobacco control policies interact with local communities to differentially affect smoking norms and practices, and consequently unequally affect people's everyday lives. This type of object-based experiential exploration also allows for naturalistic observation, where one can observe how health-related practices unfold in everyday life without any interference from research, and thus poses minimal ethical risk (Canadian Institutes of Health Research et al. 2018). Public health should thus further engage with this type of research in order to deepen our understanding of health-related practices and the environments that shape them.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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APPENDIX III. Gagné, T., Lapalme., J., Ghenadenik, A., O'Loughlin, J., & Frohlich., K.L. (2020) Social inequalities in second-hand smoke exposure before, during, and after Quebec's 2015 "An Act to Bolster Tobacco Control" (2013-18). ***Tobacco Control***

Socioeconomic inequalities in secondhand smoke exposure before, during and after implementation of Quebec's 2015 'An Act to Bolster Tobacco Control'

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ABSTRACT

Background To better understand whether tobacco control policies are associated with changes in secondhand smoke (SHS) exposure across socioeconomic groups, we monitored differences in socioeconomic inequalities in SHS exposure in households and private vehicles among youth and adults before, during and after adoption of Quebec's 2015 *An Act to Bolster Tobacco Control*.

Methods Using data from the Canadian Community Health Survey, we examined the prevalence of daily exposure to SHS in households and private vehicles among youth (ages 12 to 17) and adults (ages 18+) across levels of household education and income (separately) in 2013/2014, 2015/2016 and 2017/2018. We tested differences in the magnitude of differences in outcomes over time across education and income categories using logistic models with interaction terms, controlling for age and sex.

Results We detected inequalities in SHS exposure outcomes at each time point, most markedly at home among youth (OR of SHS exposure among youth living in the 20% poorest households vs the 20% richest=4.9, 95% CI 2.7 to 6.2). There were decreases in SHS exposure in homes and cars in each education/income group over time. The magnitude of inequalities in SHS exposure in homes and cars, however, did not change during this period.

Conclusions The persistence of socioeconomic inequalities in SHS exposure despite implementation of new tobacco control laws represents an increasingly worrisome public health challenge, particularly among youth. Policymakers should prioritise the reduction of socioeconomic inequalities in SHS exposure and consider the specific needs of socioeconomically disadvantaged populations in the design of future legislation.

INTRODUCTION

Tobacco control policies are championed as one of the most important public health successes considering marked declines in cigarette smoking prevalence over time. These declines, however, have been experienced inequitably across socioeconomic groups in most high-income countries. Smoking prevalence in Canada, for example, decreased by 79% over the last 60 years among those with a university education, but by only 25% among those who did not complete high school.[1] Today, Canadian adults are 1.6 times more likely to smoke if they are in the bottom quintile of household income (vs the top quintile), and 3.9 times more likely to smoke if they have not completed high school (vs university completed).[2] In this context, the discovery that some tobacco control interventions designed to reduce smoking prevalence may have contributed to these socioeconomic inequalities is sobering.[3–5]

Socioeconomically disadvantaged groups are also more likely to be exposed to secondhand smoke (SHS).[6–9] Differences in exposure to SHS across socioeconomic groups may relate to gaps in knowledge and awareness of the dangers of SHS, composition of social networks, levels of nicotine dependence, stress from living in deprivation and lack of consideration of these inequalities in the design of tobacco control policies.[10–16] Smokers in socioeconomically disadvantaged groups are also more likely to be exposed to permissive smoking environments in homes, neighbourhoods, workplaces and leisure environments.[11 12 16–18] These socioeconomic inequalities particularly affect youth as they are more often exposed and vulnerable to the health effects of SHS exposure than other age groups. These effects include elevated risks of lower respiratory tract infections, asthma, wheezing, middle ear infections, sudden unexpected death in infancy and invasive meningococcal disease.[19–22]

This paper examines the association between socioeconomic inequalities in SHS exposure and a recent smoke-free public health intervention that, due to its population-level nature, did not consider the needs of specific population subgroups. Smoke-free policies are designed to target the population-at-large and are championed as a highly effective intervention with synergetic benefits. These effects include reducing the prevalence of smoking and SHS exposure by: (1) protecting non-smokers, especially children, from SHS exposure, (2) preventing children from modelling the behaviour of other household members, (3) de-normalising smoking and (4) reducing the number of places where people can smoke, thereby encouraging smokers to quit.[23–25] Most smoke-free policies regulate smoking in public spaces, with few directly targeting smoking in private spaces such as households. Policies in public spaces, however, are known to have had spillover effects on smoking practices in private spaces. Studies across multiple countries report decreases in SHS exposure in households after implementation of smoke-free legislation in public places.[26–31]

Smoking in private vehicles has also been targeted by tobacco control policymakers over the past decade. Given the higher levels of exposure to SHS in small enclosed spaces, numerous studies suggest that SHS exposure in vehicles could be directly related to a higher risk of nicotine

dependence, early smoking initiation and negative respiratory outcomes.[32–36] Socioeconomically disadvantaged youth and adults are more likely to be exposed to SHS in private vehicles than more privileged groups.[6 37 38] Smoke-free policies that target vehicles directly have been implemented in high-income countries including Canada, some US states (eg, Maine, California), the UK and Ireland to protect children from SHS-related harms.[39–42] Results regarding their effects on SHS exposure in vehicles among children and adults are mixed.[41–45] In particular, SHS exposure in vehicles has remained relatively high among children despite smoke-free policy implementation.[21]

Research on the association between smoke-free policies and socioeconomic inequalities in SHS exposure remains underdeveloped. Only three studies have investigated the role of smoke-free policies on socioeconomic inequalities in SHS exposure in private vehicles, showing conflicting results. In Wales, Moore *et al* examined differences between 2007/2008 and 2014 following a media campaign promoting voluntary smoke-free rules in cars with children and found that children in poorer families reported a larger decrease in SHS exposure in cars compared with their more privileged counterparts.[40] In the USA, Murphy-Hoefer *et al* examined differences in Maine between 2007 and 2008 to 2010 following the passage of a law prohibiting smoking in cars with children and found significant decreases only among higher education and income groups.[39] Also in the USA, Kruger *et al* compared SHS exposure in vehicles between 2010/2011 and 2013/2014 when voluntary smoke-free rules in cars increased, and found relatively equal decreases in SHS exposure among adults across education and income groups over time.[46] For SHS exposure in households, Nanninga *et al* reviewed nine studies and argued that, whereas there was little evidence to support whether smoke-free policies reduced socioeconomic inequalities in SHS exposure in the household, their capacity to increase inequalities was unlikely.[47]

This paper extends this literature in the context of a recent tobacco control legislation in the Canadian province of Quebec. This province (8.5 million inhabitants) has had among the highest levels of SHS exposure at home across the 10 Canadian provinces (5.7% vs the national average of 3.9% in 2014).[48] It also has marked differences in SHS exposure across socioeconomic groups (ie, in 2015/2016, adults in the province were 5.6 times more likely to be exposed to SHS at home if they had not completed high school (vs university completed)).[7 37 38] In November 2015, the Quebec government passed a comprehensive tobacco control legislation, *An Act To Bolster Tobacco Control*, with three objectives: (1) to prevent youth smoking initiation; (2) to protect non-smokers and children from SHS exposure; and (3) to encourage smoking cessation.[49] There was no obvious prioritisation given to socioeconomic inequalities in smoking or smoking-related outcomes. This legislation was an amendment to the Quebec's 2005 *Tobacco Control Act,* which initially prohibited smoking in all non-home workplaces, restaurants and bars, public transportation and on all primary and secondary school grounds.[49] To achieve its 'SHS exposure' objective, the 2015 law amended the *Tobacco Control Act* smoke-free policy in three ways. First, it extended smoking prohibitions to bar and restaurant patios, playgrounds, within 9 metres from building entrances and in vehicles with youth under the age of 16. Second, it required health and social service establishments and post-secondary education institutions to develop a smoke-free policy plan by the end of 2017. Finally, it permitted landlords to enforce a smoke-free policy in multi-unit apartment buildings.

Despite the number of smoke-free policies implemented worldwide in the last decade, their relationship to socioeconomic inequalities in SHS exposure remains unclear. To inform this knowledge gap, we considered the implementation of the *An Act To Bolster Tobacco Control* law in 2015/2016 as a critical opportunity to examine this issue. Specifically, we examined trends in socioeconomic inequalities in the prevalence of SHS exposure in the household and private vehicles among youth (ages 12 to 17) and adults (ages 18+) across 2-year periods corresponding to the periods before (2013/2014), during (2015/2016) and after (2017/2018) the implementation of the law.

METHODS

Data

We used data from six annual cycles (2013 to 2018) of the Canadian Community Health Survey (CCHS).[50] The CCHS is the largest repeat cross-sectional health survey in Canada. It collects data on health status, healthcare utilisation and health determinants in the Canadian population annually. It incorporates a large sample and is designed to provide reliable estimates at the health region level (ie, geographical units within provinces) every 2 years. Between 10 000 and 12 000 people living in Quebec age ≥12 were recruited annually between 2013 and 2018. The response proportion in Quebec was 68% in 2013/2014, 64% in 2015/2016 and 65% in 2017/2018. A detailed description of the sampling methodology is available elsewhere.[50]

Measures

Our dependent variables were: (1) *exposure to SHS in the household*, measured with: 'Including both household members and regular visitors, does anyone smoke inside your home, every day or almost every day?' (Yes/No) and (2) *exposure to SHS in private vehicles*, measured by: 'In the past month, were you exposed to secondhand smoke, every day or almost every day, in a car or other private vehicle?' (Yes/No). We note that CCHS only administered these questions to non-smokers in 2013/2014, precluding us from exploring how smokers' practices changed during this period.

We defined socioeconomic groups using household education and income. *Household education* was coded by Statistics Canada using information on the highest level of education in the household, into three categories: (1) High school not completed; (2) High school completed; and (3) Post-secondary education completed. *Household income* was coded by Statistics Canada using data on income, household size and community size into a decile rank to represent a relative measure of household income compared with other households at the provincial level. We recoded this variable from deciles into quintiles: 1 - living in one of the 20% poorest households in the province to 5 - living in one of the 20% richest households in the province. When testing differences in outcomes across socioeconomic groups, we controlled for age (among youth: 12–13, 14–15 and 16–17; among adults: 18–24, 25–34, 35–44, 45–54, 55–64 and 65+) and sex (male/female).

Statistical analyses

We first estimated the prevalence of exposure to SHS in the household and private vehicles among non-smokers ages 12 to 17 and 18+ across socioeconomic groups in 2013/2014, 2015/2016 and 2017/2018. We then tested, in three steps, the statistical significance of: (1) associations of SHS exposure outcomes with education and income in each 2-year time point, (2) average trends in outcomes over the course of the three time points and (3) differences in trends across socioeconomic groups over time, using different logistic models adjusted for age and sex. To

accomplish the second and third steps, we pooled observations between 2013 and 2018 and modelled: Model 1 - the socioeconomic indicator and time (using dummy terms for 2015/2016 and 2017/2018 with 2013/2014 as the reference category) and; Model 2 - the socioeconomic indicator, time and its interaction term. A statistically significant interaction term would indicate that the magnitude of inequalities in SHS exposure outcomes differed according to year. The pooled sample sizes for 2013 to 2018 varied among adults from 50 850 to 53 263 and among youth from 4795 to 5019 depending on the dependent (SHS exposure at home or in cars) and independent (household education or income) variables. To test the robustness of estimates we reproduced models: (1) controlling for living in a rural area (Yes/No), and (2) using individual-level education instead of household education in the adult sample.[37] Results were consistent in these sensitivity analyses with those of the primary analyses. Analyses were produced with a listwise deletion approach using Stata 15.[51]

RESULTS

Exposure to SHS across socioeconomic groups

Table 1 presents the prevalence of exposure to SHS in the household and private vehicles among non-smoking youth ages 12 to 17 and adults ages 18+ between 2013/2014 and 2017/2018. Table 2 presents the OR of exposure to SHS in the household and private vehicles among education and income groups adjusted for sex and age.

Household education

In 2013/2014, non-smoking youth in households where no one completed high school reported a 453% (95% CI 2.38 to 12.80) higher odds of being exposed daily to SHS in their household and a 259% (95% CI 1.30 to 9.96) higher odds of being exposed daily to SHS in private vehicles compared with those in households where a household member completed post-secondary education. These differences remained strong in 2017/2018 (OR for SHS in the household=3.19, 95% CI 1.44 to 7.05; OR for SHS in private vehicles=3.89, 95% CI 1.50 to 10.11). Similarly, in 2013/2014, non-smoking adults in households where no one completed high school reported a 56% (95% CI 1.08 to 2.25) higher odds of being exposed daily to SHS in their household and a 191% (95% CI 2.05 to 4.13) higher odds of being exposed daily to SHS in private vehicles compared with households in which a member had completed post-secondary education. These differences also remained strong in this age group in 2017/2018 (OR for SHS in the household=1.45, 95% CI 1.00 to 2.11; OR for SHS in private vehicles=1.74, 95% CI 1.12 to 2.70).

Household income

In 2013/2014, non-smoking youth in households in the lowest income quintile reported a 406% (95% CI 2.25 to 10.45) higher odds of being exposed daily to SHS in their household and a 166% (95% CI 1.41 to 5.04) higher odds of being exposed daily to SHS in private vehicles compared with those in households in the highest income quintile. Differences remained strong in 2017/2018 (OR for SHS in the household=4.45, 95% CI 2.07 to 9.54; OR for SHS in private vehicles=2.68, 95% CI 0.94 to 7.61). Similarly, in 2013/2014, non-smoking adults in households in the lowest income quintile reported a 36% (95% CI 0.96 to 1.93) higher odds of being exposed daily to SHS in their household and a 163% (95% CI 2.05 to 4.13) higher odds of being exposed daily to SHS in private vehicles compared with those in households in the highest income quintile. Differences in adults increased to reach statistical significance for SHS exposure in the household and remained strong for SHS exposure in private vehicles in 2017/2018 (OR for SHS in the household=1.76, 95% CI 1.14 to 2.73; OR for SHS in private vehicles=2.05, 95% CI 1.39 to 3.03).

Trends in SHS exposure across socioeconomic groups

After examining inequalities in SHS exposure outcomes across 2-year time points, we tested trends in outcomes between 2013/2014 and 2017/2018, and differences in trends across socioeconomic groups. Tables 3 and 4 present the pooled ORs of exposure to SHS in the household and private vehicles for time, household education (table 3) and household income (table 4) over the course of the 2013 to 2018 period, and the results from the 'education x time' interaction tests. Overall, we found substantial average decreases in exposure to SHS for each outcome/age pair between 2013/2014 and 2017/2018 (Model 1). Non-smoking youth had a 45% lower odds (95% CI 0.41 to 0.73) of being exposed to SHS in the household and a 62% lower odds (95% CI 0.27 to 0.53) of being exposed to SHS in private vehicles in 2017/2018 compared with 2013/2014. Similarly, non-smoking adults had a 25% lower odds (95% CI 0.63 to 0.89) of being exposed to SHS in the household and a 46% lower odds (95% CI 0.45 to 0.65) of being exposed to SHS in private vehicles in 2017/2018 compared with 2013/2014.

Regarding differences in trends in SHS exposure across levels of education and income (Models 2 in tables 3 and 4), we found no significant differences for each outcome/age pair between 2013/2014 and 2017/2018. The statistical significance of interaction tests for household education ranged from p=0.369 for SHS in private vehicles among adults to p=0.883 for SHS in private vehicles among youth. Similarly, the statistical significance of interaction tests for household income ranged from p=0.273 for SHS in the household among adults to p=0.971 for SHS in private vehicles among youth.

DISCUSSION

The current state of knowledge suggests that there are socioeconomic inequalities in SHS exposure yet the effects of smoke-free policies on SHS exposure across socioeconomic groups remain unclear. To address this gap, we reported trends in SHS exposure in homes and cars across education and income groups between 2013/2014 and 2017/2018 following the implementation in 2015 of a new tobacco control law in Quebec. Three main results emerged from our analyses: (1) SHS exposure decreased across education and income groups over the 2013 to 2018 period, (2) relative inequalities in SHS exposure remained substantial and unchanged across this period and (3) relative inequalities in SHS exposure in the household were markedly larger among youth compared with adults.

The considerable decline in population levels of SHS exposure over this relatively short time period is worthy of celebration given the facts that: (1) SHS exposure in Quebec homes had already decreased by 32% over the 5 years preceding 2013 and; (2) smoke-free policies targeting cars with children have not always succeeded in reducing the prevalence of SHS exposure in other Canadian provinces.[44 52 53] Beyond their influence on smoking prevalence, it is likely that tobacco control policies implemented over the past decade have had a direct impact on population levels of SHS exposure.[54]

Table 1 Prevalence of secondhand smoke exposure among Quebec non-smokers, by household education and income. Canadian Community Health Survey, 2013 to 2018

	2013/2014		2015/2016		2017/2018	
	%	95% CI	%	95% CI	%	95% CI
SHS exposure in the household among youth ages 12 to 17						
Household education						
High school not completed	46.1	27.5 to 64.8	37.2	23.1 to 51.3	22.8	10.2 to 35.4
High school completed	31.7	18.1 to 45.2	21.4	14.1 to 35.2	24.7	14.1 to 35.2
PS education completed	14.5	11.9 to 17.1	9.9	7.8 to 12.0	8.4	6.5 to 10.3
Household income						
First quintile	22.7	16.2 to 29.2	15.1	10.1 to 20.0	17.6	11.9 to 23.3
Second quintile	18.5	12.3 to 24.7	10.8	7.1 to 14.4	12.1	8.0 to 16.2
Third quintile	17.6	12.5 to 22.7	14.3	9.9 to 18.6	9.6	6.0 to 13.1
Fourth quintile	16.5	10.3 to 22.7	11.3	6.7 to 15.6	5.1	2.0 to 8.1
Fifth quintile	5.5	2.3 to 8.6	5.9	2.6 to 9.3	4.6	1.8 to 7.4
SHS exposure in the household among adults ages 18+						
Household education						
High school not completed	6.4	4.9 to 7.8	6.1	4.1 to 8.2	4.6	3.3 to 5.9
High school completed	7.1	4.8 to 9.4	7.2	5.5 to 8.9	5.6	4.2 to 7.0
PS education completed	4.8	4.2 to 5.4	3.4	2.9 to 4.0	3.6	3.1 to 4.1
Household income						
First quintile	5.8	4.5 to 7.1	4.8	3.5 to 6.0	5.2	3.8 to 6.5
Second quintile	5.9	4.6 to 7.1	5.3	3.9 to 6.7	4.9	3.9 to 6.0
Third quintile	4.9	3.8 to 6.1	4.3	3.2 to 5.5	4.1	3.2 to 5.0
Fourth quintile	5.5	4.2 to 6.7	3.7	2.7 to 4.7	3.3	2.5 to 4.2
Fifth quintile	4.3	3.2 to 5.4	3.3	2.3 to 4.3	3.0	2.1 to 3.9
SHS exposure in private vehicles among youth ages 12 to 17						
Household education						
High school not completed	34.7	14.6 to 54.8	15.8	4.0 to 27.6	17.0	3.8 to 30.1
High school completed	29.9	17.1 to 42.6	15.7	6.8 to 24.6	9.6	3.8 to 15.4
PS education completed	13.5	10.9 to 16.0	7.0	5.4 to 8.6	6.0	4.3 to 7.6
Household income						
First quintile	21.6	14.8 to 28.4	9.6	5.5 to 13.7	8.4	4.6 to 12.2
Second quintile	13.8	8.6 to 19.0	10.1	6.2 to 14.1	6.8	3.6 to 10.1
Third quintile	16.3	10.1 to 22.4	9.2	5.9 to 12.5	8.5	4.7 to 12.2
Fourth quintile	14.3	8.6 to 20.1	5.5	2.8 to 8.2	5.7	1.9 to 9.5
Fifth quintile	9.4	5.4 to 13.3	5.0	2.3 to 7.6	3.5	1.0 to 6.0
SHS exposure in private vehicles among adults ages 18+						
Household education						
High school not completed	6.5	4.9 to 8.1	4.9	3.6 to 6.2	3.0	2.0 to 3.9
High school completed	8.0	5.1 to 10.8	5.0	3.7 to 6.3	4.6	3.1 to 6.1
PS education completed	5.0	4.3 to 5.7	2.8	2.4 to 3.3	2.8	2.4 to 3.2
Household income						
First quintile	8.0	6.1 to 9.8	4.6	3.3 to 5.9	4.7	3.7 to 5.7
Second quintile	6.0	4.3 to 7.7	2.8	2.0 to 3.6	3.1	2.1 to 4.1
Third quintile	5.8	3.9 to 7.6	3.3	2.5 to 4.1	3.6	2.6 to 4.5
Fourth quintile	5.4	4.2 to 6.5	3.3	2.4 to 4.2	2.3	1.5 to 3.1
Fifth quintile	3.5	2.5 to 4.5	2.5	1.8 to 3.2	2.3	1.7 to 3.0

Estimates are weighted using the survey and bootstrap replicate weights designed by Statistics Canada.
PS, post-secondary; ;SHS, secondhand smoke.

That socioeconomic inequalities in SHS exposure were maintained before and after adoption of the law is worrisome and challenges the 'one-size-fits-all' nature of most smoke-free policies today. Population-level interventions seek to change the underlying conditions of risk for an entire population, neglecting *ipso facto* the specific needs of vulnerable populations in the context of socioeconomic inequalities.[3 10] As a result, those who could most benefit from these policies are, at times, the ones who least benefit from them.[2] Population-level interventions are also liable to increase socioeconomic inequalities when directly targeting downstream behaviours such as smoking instead of their structural determinants (eg, inequalities in access to financial security).[55 56] The limitations of population-level interventions are reflected in cases where overall smoking prevalence has declined following the implementation of population-level policies, but remained high or

Table 2 Education and income-based inequalities in secondhand smoke exposure among Quebec non-smokers. Canadian Community Health Survey, 2013 to 2018

	2013/2014		2015/2016		2017/2018	
	OR	95% CI	OR	95% CI	OR	95% CI
SHS exposure in the household among youth ages 12 to 17						
Household education						
High school not completed	**5.53**	**2.38 to 12.80**	**5.34**	**2.71 to 10.55**	**3.19**	**1.44 to 7.05**
High school completed	**2.66**	**1.36 to 5.20**	**2.50**	**1.36 to 4.57**	**3.60**	**1.90 to 6.82**
PS education completed (ref.)	–	–	–	–	–	–
Household income						
First quintile	**5.06**	**2.25 to 10.45**	**2.82**	**1.28 to 6.22**	**4.45**	**2.07 to 9.54**
Second quintile	**3.88**	**1.84 to 8.17**	1.93	0.90 to 4.13	**2.84**	**1.33 to 6.09**
Third quintile	**3.58**	**1.66 to 7.71**	**2.68**	**1.31 to 5.48**	2.19	0.99 to 4.82
Fourth quintile	**3.33**	**1.53 to 7.23**	2.03	0.93 to 4.44	1.12	0.43 to 2.91
Fifth quintile (ref.)	–	–	–	–	–	–
SHS exposure in the household among adults ages 18+						
Household education						
High school not completed	**1.56**	**1.08 to 2.25**	**2.78**	**1.71 to 4.52**	**1.45**	**1.00 to 2.11**
High school completed	**1.54**	**1.02 to 2.32**	**2.41**	**1.76 to 3.29**	**1.55**	**1.14 to 2.10**
PS education completed (ref.)	–	–	–	–	–	–
Household income						
First quintile	1.36	0.96 to 1.93	**1.60**	**1.04 to 2.45**	**1.76**	**1.13 to 2.73**
Second quintile	1.41	0.98 to 2.02	**1.75**	**1.15 to 2.66**	**1.77**	**1.16 to 2.69**
Third quintile	1.17	0.81 to 1.70	1.43	0.93 to 2.21	1.48	0.99 to 2.19
Fourth quintile	1.32	0.91 to 1.92	1.15	0.75 to 1.76	1.14	0.77 to 1.69
Fifth quintile (ref.)	–	–	–	–	–	–
SHS exposure in private vehicles among youth ages 12 to 17						
Household education						
High school not completed	**3.59**	**1.30 to 9.96**	2.52	0.96 to 6.61	**3.89**	**1.50 to 10.11**
High school completed	**2.66**	**1.36 to 5.21**	**2.44**	**1.18 to 5.04**	1.71	0.79 to 3.67
PS education completed (ref.)	–	–	–	–	–	–
Household income						
First quintile	**2.66**	**1.41 to 5.04**	1.97	0.96 to 4.05	2.68	0.94 to 7.61
Second quintile	1.54	0.79 to 3.00	2.18	0.99 to 4.74	2.18	0.73 to 6.54
Third quintile	1.83	0.90 to 3.74	1.87	0.91 to 3.82	2.64	0.87 to 7.96
Fourth quintile	1.58	0.78 to 3.21	1.11	0.48 to 2.53	1.70	0.51 to 5.59
Fifth quintile (ref.)	–	–	–	–	–	–
SHS exposure in private vehicles among adults ages 18+						
Household education						
High school not completed	**2.91**	**2.05 to 4.13**	**3.02**	**2.01 to 4.54**	**1.74**	**1.12 to 2.70**
High school completed	**2.27**	**1.49 to 3.44**	**2.10**	**1.48 to 2.98**	**1.94**	**1.30 to 2.89**
PS education completed (ref.)	–	–	–	–	–	–
Household income						
First quintile	**2.63**	**1.74 to 3.99**	**1.91**	**1.20 to 3.05**	**2.05**	**1.39 to 3.03**
Second quintile	**2.10**	**1.33 to 3.31**	1.12	0.72 to 1.75	1.40	0.88 to 2.24
Third quintile	**1.77**	**1.12 to 2.80**	1.36	0.90 to 2.05	**1.62**	**1.07 to 2.46**
Fourth quintile	**1.56**	**1.07 to 2.26**	1.31	0.88 to 1.95	0.96	0.63 to 1.48
Fifth quintile (ref.)	–	–	–	–	–	–

Estimates are OR adjusted for age and sex. Education and income were modelled separately. Estimates are bolded when the 95% CI excludes the null value. Estimates are weighted using the survey and bootstrap replicate weights designed by Statistics Canada.
PS, post-secondary; SHS, secondhand smoke.

stable in disadvantaged populations.[57–59] This is not the case for all programmes and policies—stop smoking services in the UK and taxation on tobacco products in multiple countries are cases in point.[4 60 61] To reduce both population prevalence and socioeconomic inequalities in smoking, policymakers should ultimately champion approaches that address the limitations of both targeted and population-based interventions, for example, universal policies with an added focus on vulnerable groups and/or weighting the intensity of the intervention by different groups' disadvantage.[62 63]

In the context of SHS exposure, interventions will have to better address the needs of people in socioeconomically disadvantaged groups, particularly those with children given the magnitude of inequalities in this age group. Multiple obstacles faced by people to smoke outside their homes and quit smoking have been highlighted in the literature. These include: (1) the

Table 3 Trends in secondhand smoke exposure, on average and by education group, among Quebec non-smokers between 2013/2014 and 2017/2018. Canadian Community Health Survey, 2013 to 2018

	SHS in the household Ages 12 to 17				SHS in the household Ages 18+				SHS in private vehicles Ages 12 to 17				SHS in private vehicles Ages 18+			
	Model 1		Model 2		Model 1		Model 2		Model 1		Model 2		Model 1		Model 2	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Household education																
High school not completed	**4.49**	**2.96 to 6.80**	**5.19**	**2.32 to 11.62**	**1.84**	**1.45 to 2.32**	**1.70**	**1.21 to 2.30**	**3.23**	**1.91 to 5.48**	**3.68**	**1.34 to 10.06**	**2.56**	**2.05 to 3.19**	**2.45**	**1.76 to 3.40**
High school completed	**2.91**	**2.01 to 4.23**	**2.71**	**1.38 to 5.34**	**1.81**	**1.47 to 2.22**	**1.60**	**1.06 to 2.41**	**2.31**	**1.54 to 3.48**	**2.68**	**1.36 to 5.28**	**2.10**	**1.66 to 2.65**	**2.14**	**1.42 to 3.23**
PS education completed (ref.)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Year																
2013/2014 (ref.)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
2015/2016	**0.64**	**0.49 to 0.85**	**0.65**	**0.47 to 0.88**	**0.77**	**0.65 to 0.93**	**0.71**	**0.56 to 0.89**	**0.46**	**0.34 to 0.63**	**0.48**	**0.35 to 0.66**	**0.57**	**0.47 to 0.69**	**0.55**	**0.43 to 0.69**
2017/2018	**0.55**	**0.41 to 0.73**	**0.54**	**0.40 to 0.74**	**0.75**	**0.63 to 0.89**	**0.76**	**0.62 to 0.93**	**0.38**	**0.27 to 0.53**	**0.41**	**0.28 to 0.58**	**0.54**	**0.45 to 0.65**	**0.56**	**0.45 to 0.69**
Interaction terms			–	–			–	–			–	–			–	–
HS not completed x 2015/2016			1.05	0.38 to 2.88			1.39	0.82 to 2.33			0.71	0.18 to 2.79			1.39	0.87 to 2.20
HS not completed x 2017/2018			0.63	0.21 to 1.89			0.95	0.60 to 1.50			0.90	0.22 to 3.61			0.80	0.48 to 1.31
HS completed x 2015/2016			0.91	0.37 to 2.28			1.41	0.85 to 2.34			0.91	0.33 to 2.53			1.02	0.61 to 1.70
HS completed x 2017/2018			1.32	0.51 to 3.41			1.00	0.61 to 1.65			0.62	0.23 to 1.69			0.93	0.53 to 1.61

Estimates are OR adjusted for age and sex. Model 1 included household education and time and Model 2 included the two variables and their interaction. Estimates are bolded when the 95% CI excludes the null value. Estimates are weighted using the survey weight and bootstrap replicate weights designed by Statistics Canada.
HS, high school; PS, post-secondary; SHS, secondhand smoke.

Table 4 Trends in secondhand smoke exposure, on average and by income group, among Quebec non-smokers between 2013/2014 and 2017/2018. Canadian Community Health Survey, 2013 to 2018

	SHS in the household Ages 12 to 17				SHS in the household Ages 18+				SHS in private vehicles Ages 12 to 17				SHS in private vehicles Ages 18+			
	Model 1		Model 2		Model 1		Model 2		Model 1		Model 2		Model 1		Model 2	
	OR	95 CI	OR	95 CI	OR	95 CI	OR	95 CI	OR	95 CI	OR	95 CI	OR	95 CI	OR	95 CI
Household income																
First quintile	**4.94**	**2.66 to 6.16**	**5.06**	**2.47 to 10.40**	**1.55**	**1.22 to 1.97**	1.33	0.93 to 1.90	**2.43**	**1.63 to 3.65**	**2.64**	**1.39 to 5.01**	**2.48**	**1.64 to 3.74**	**2.66**	**1.75 to 4.05**
Second quintile	**2.83**	**1.87 to 4.29**	**3.91**	**1.85 to 8.23**	**1.62**	**1.29 to 2.05**	1.40	0.98 to 2.00	**1.87**	**1.21 to 2.88**	1.55	0.80 to 3.03	**1.97**	**1.26 to 3.07**	**2.07**	**1.32 to 3.26**
Third quintile	**2.84**	**1.86 to 4.36**	**3.65**	**1.71 to 7.81**	**1.34**	**1.06 to 1.71**	1.16	0.80 to 1.69	**2.01**	**1.31 to 3.08**	1.82	0.89 to 3.70	**1.73**	**1.09 to 2.74**	**1.79**	**1.13 to 2.84**
Fourth quintile	**2.19**	**1.39 to 3.43**	**3.39**	**1.57 to 7.33**	1.21	0.96 to 1.52	1.29	0.89 to 1.88	1.49	0.93 to 2.39	1.59	0.78 to 3.21	**1.53**	**1.05 to 2.22**	**1.56**	**1.07 to 2.26**
Fifth quintile (ref.)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Year																
2013/2014 (ref.)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
2015/2016	**0.66**	**0.50 to 0.86**	1.07	0.43 to 2.67	**0.80**	**0.68 to 0.95**	0.73	0.48 to 1.09	**0.47**	**0.35 to 0.64**	0.49	0.22 to 1.09	0.69	0.45 to 1.05	0.70	0.46 to 1.07
2017/2018	**0.57**	**0.43 to 0.75**	0.83	0.34 to 2.04	**0.78**	**0.66 to 0.92**	0.67	0.45 to 1.00	**0.39**	**0.29 to 0.54**	**0.34**	**0.12 to 0.98**	**0.65**	**0.43 to 0.99**	**0.66**	**0.43 to 0.99**
Interaction terms			–	–			–	–			–	–			–	–
First quintile x 2015/2016			0.56	0.19 to 1.63			1.19	0.69 to 2.06			0.77	0.28 to 2.16			0.81	0.45 to 1.48
Second quintile x 2015/2016			0.88	0.31 to 2.46			1.36	0.78 to 2.38			0.98	0.30 to 3.22			0.85	0.48 to 1.47
Third quintile x 2015/2016			0.49	0.17 to 1.43			1.24	0.71 to 2.16			1.43	0.53 to 3.90			0.60	0.33 to 1.10
Fourth quintile x 2015/2016			0.73	0.25 to 2.13			1.30	0.77 to 2.18			1.35	0.37 to 4.88			0.74	0.40 to 1.36
First quintile x 2017/2018			0.73	0.26 to 2.05			1.22	0.71 to 2.10			1.10	0.37 to 3.23			0.81	0.44 to 1.50
Second quintile x 2017/2018			0.60	0.20 to 1.78			1.30	0.77 to 2.21			1.44	0.39 to 5.39			0.97	0.52 to 1.80
Third quintile x 2017/2018			0.60	0.20 to 1.82			0.89	0.51 to 1.56			0.72	0.24 to 2.15			0.86	0.49 to 1.50
Fourth quintile x 2017/2018			0.32	0.10 to 1.11			0.89	0.53 to 1.51			1.06	0.26 to 4.27			0.65	0.38 to 1.13

Estimates are OR adjusted for age and sex. Model 1 included household income and time and Model 2 included the two variables and their interaction. Estimates are bolded when the 95% CI excludes the null value. Estimates are weighted using the survey weight and bootstrap replicate weights designed by Statistics Canada.
SHS, secondhand smoke.

presence of permissive smoking norms and smoking-related stigma, (2) the lack of safe outdoor spaces to smoke and (3) the lack of relevant SHS-related mass media campaigns for disadvantaged smokers.[13 64–66] Future efforts to support disadvantaged smokers in modifying their smoking practices should also include addressing misconceptions about SHS in the household (eg, smoking in another room, under an oven fan or near an open window) as well as the lack of smoking cessation resources and support for parents to smoke outside while parenting children. Creating programmes to tackle these issues, however, require continued investments in public health that are not guaranteed in jurisdictions such as Quebec, in which the share of governmental spending on public health was second lowest across Canadian provinces in 2019.[67]

Strengths and limitations

We drew on the methodological strengths of the CCHS to produce representative estimates of socioeconomic inequalities in SHS exposure in the Canadian province of Quebec. We highlight three limitations. First, the CCHS did not collect data on variables such as car ownership, housing type or the smoking status of other household members, which would have helped us draw a more nuanced portrait of SHS exposure. Second, despite the large sample size in the CCHS, the samples for youth were relatively small (n=approximately 1500 every 2 years), limiting the potential for examining differences in the subset of youth ages 12 to 15 targeted by the law as well as detecting differences in the associations of interest across time points. Finally, we highlight that our study design precludes inferring a causal relationship between the Act to Bolster Tobacco Control law and trends in SHS exposure across socioeconomic groups between 2013 and 2018. Other studies should examine trends in SHS exposure across provinces using study designs that can provide evidence of a causal effect of tobacco control policies, longer follow-ups and other regions as counterfactuals.

Conclusion

Tobacco control is a critical public health institution which has done much to improve population health. This includes the prevention of SHS exposure at all ages and across all socioeconomic groups. Whereas smoke-free policies may be associated with strong declines in overall prevalence, they do not appear to yield similar results regarding the reduction of socioeconomic inequalities in SHS exposure. We found that the implementation of Quebec's 2015 *An Act to Bolster Tobacco Control* was unlikely to be associated with changes in the magnitude of socioeconomic inequalities in SHS exposure in the household and private vehicles among youth and adults up to 2018. Alongside reducing socioeconomic inequalities in smoking, tackling the unequal presence of smoking-related outcomes such as SHS exposure among vulnerable groups must also be emphasised as a priority of tobacco control programmes. The latest strategic policy document on tobacco control published by the Quebec government in May 2020, that is, *Stratégie pour un Québec sans tabac 2020–2025*, is encouraging because of its focus on inequalities and high-risk populations as cross-cutting themes, and taxation and stop smoking services as key interventions. In order to support future tobacco control policy efforts, future studies need to unpack: (1) the reasons why socioeconomically disadvantaged smokers, including those with children, are more likely to smoke inside their home, and (2) which interventions are most likely to promote smoke-free rules in homes and cars across socioeconomic groups.

What this paper adds

- Secondhand smoke (SHS) exposure decreased in homes and private vehicles during the period in which Quebec's 2015 law was implemented.
- Socioeconomic inequalities in SHS exposure in homes were larger among youth (<18) than adults (18+).
- SHS exposure remained more prevalent in households with lower education/income in 2017 to 2018.
- There was no change in relative inequalities in SHS exposure between 2013/2014 and 2017/2018.

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Contributors TG, JL and KLF designed the study. TG and AG performed the analyses. TG, JL, AG, KLF and JOL interpreted the findings. TG and JL wrote the first draft. TG, JL, AG, KLF and JOL contributed to the final draft.

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APPENDIX IV. Interview guide

GUIDE D'ENTREVUE

Entrevues avec professionnels de santé publique

Avant l'entrevue

1). Remercie le participant d'avoir accepté de participer à l'étude.

2). Donne une copie du formulaire de consentement au participant.

3). Revoit le formulaire de consentement avec le participant. Assure toi qu'il est signé par le participant et la chercheuse.

4). Rappelle le participant que tout ce qu'il/elle partagera lors de l'entretien sera complètement confidentiel et que leur nom, ni leur organisme sera associé à ses propos.

5). Rappelle le participant que sa participation est complètement volontaire et qu'il/elle peut cesser l'entretien à n'importe quel moment ou il/elle peut refuser de répondre à n'importe quelle question.

6). Vérifie que les questions du participant sont comblées.

7). Vérifie que les enregistreuses sont prêtes.

8). Commence l'entrevue.

L'entretien

Cet entretien vise à mieux comprendre le contexte de prévention de tabagisme au Québec. Les questions porteront largement sur le contexte actuel de tabagisme, la dernière loi concernant la lutte contre le tabac et les prochaines étapes pour la prévention de tabagisme au Québec.

- Pour commencer, j'aimerais que vous me parlez de **qu'est-ce qui vous a mené à travailler en prévention de tabagisme.**
  Probe : Pourquoi avez-vous commencé à travailler en prévention de tabagisme? Qu'est-ce qui

vous a interpellé à travailler dans ce domaine?

Probe : Que faites-vous, plus concrètement, comme travail en prévention de tabagisme?

- J'aimerais que **vous me parlez du contexte actuel de tabagisme au Québec**.
  Probe : Quelle est la prévalence de tabagisme?

  Probe : Qui fument? Qui ne fument pas?

  Probe : Qui est « le fumeur »? Quand vous imaginez un fumeur, vous voyez qui?

  Probe : Pourquoi certaines personnes fument et d'autres ne fument pas? (ou d'autres ont arrêté de fumer?)

  Probe : Comment est-ce que les gens perçoivent le tabagisme? Est-ce que c'est acceptable? Est-ce qu'il y a des places ou des milieux où c'est acceptable et d'autres non?

- J'aimerais qu'on parle de la *Loi concernant la lutte contre le tabagisme*, la dernière loi de lutte contre le tabagisme qui a été adopté à la fin de 2015. **Qu'est-ce qu'on cherchait à faire avec cette loi?**
  Probe (pour ceux qui ne connaissent pas cette loi) : celle qui interdit de fumer, notamment, sur des terrasses de bars et restaurants, dans des terrains de jeux, dans des voitures avec des enfants présents et à 9 mètres d'une entrée.

  Probe : Quel(s) problème(s) cherchait-on à remédier?

  Probe : Qui cherchait-on à protéger? À aider? À réguler? Comment?

- **Pourquoi avions-nous besoin de cette loi (ou de ces interdictions) à ce temps (2015)?**
  Probe : Qu'est-ce qui a déclenché la planification pour cette loi (ou ces interdictions)? Une personne ou groupe en particulier? Un évènement ou produit? Des données probantes?

  Probe : Quelles perspectives menaient le plaidoyer pour la loi (ou les interdictions)?

  Probe : Est-ce qu'il y avait des perspectives qui n'ont pas été incluses?

- Selon vous, **qu'est-ce qui a changé depuis l'implantation de la Loi concernant la lutte contre le tabagisme?**
  Probe : Qu'est-ce qui a changé, dans le contexte du tabagisme, depuis les dernières années, notamment depuis les dernières interdictions de fumer (par exemple, sur les terrasses de restaurant et bars, de 9 mètres d'une entrée, dans une voiture avec un enfant présent, dans les terrains de jeu).

Probe : Quels sont les changements en lien avec le tabagisme? (prévalence)

Probe : Quels sont les changements sociaux? (dénormalisation du tabagisme)

Probe : Est-ce qu'il y a eu des effets inattendus? Si oui, lesquels?

- **Que pensez-vous de cette loi (ou des dernières interdictions de fumer)?**
  Probe : Est-ce que la loi a réussi à atteindre son objectif?

  Probe : Qu'est-ce qui manquait loi?

  Probe : Que feriez-vous de différent?

- Selon vous, **quelles sont les prochaines étapes en matière de prévention de tabagisme au Québec?**
  Probe : Pourquoi ces étapes?

  Probe : Quelles sont les populations ciblées? Pourquoi? Comment aider ces populations?

  Probe : Quelles opportunités existent (ou sont anticipées) pour réaliser ces prochaines étapes?

  Probe : Quels défis existent (ou sont anticipés) pour réaliser ces prochaines étapes?

  Probe : Qui (ou quels groupes) sont impliqués dans la planification ou la consultation de ces prochaines étapes? Est-ce qu'il y a des groupes exclus?

- **Quelle priorité accordez-vous aux inégalités sociales de tabagisme dans la prévention du tabagisme au Québec?**
  Probe : Quelle priorité est-ce que les interventions de prévention de tabac (dont L44) accordent-elles aux inégalités sociales de tabagisme?

  Probe : Quels groupes sont les plus affectés par les inégalités sociales de tabagisme?

- **Avez-vous d'autres choses à dire par rapport au tabagisme au Québec ou la prévention du tabagisme au Québec** ?

APPENDIX V. Interview data codebook

CODEBOOK

TCP Interviews

Theoretical Concepts: Discursive Practices

If we understand discourse as a set of socially produced knowledge and assumptions about the world and/or a specific social phenomenon that is disseminated and understood as 'fact' or 'truth', then discursive practices are the actions or 'practices' that produce these knowledge and assumptions, or in other words, that produce discourse. We are interested in the practice itself, but also of what those who do this practice understand it to be or how they justify it as a valid practice within the greater discursive context. Recursively, these practices are also influenced by discourse. Experts, such as doctors, teachers, public health professionals (e.g. TCP), because of their expertise can be considered the agents that produce and reproduce knowledge and disseminate them to the public in different ways (i.e. via different discursive practices). Discursive practices, and thus discourse, exist within a set of rules (referred to as rules of formation by Foucault). These rules can be better understood as conditions that determine what can be said, what can be done and what can be excluded/silenced. These rules therefore determine what discursive practices can be undertaken, i.e., what knowledge can be produced and how it can be produced. It thus also determines what discourse can become dominant in society (i.e. legitimized as 'truth'), why, and how. In this way, rules also determine what knowledge cannot be produced or can be omitted from the dominant discourse and why. Considering certain professionals as experts (and others not) is also determined by these rules. Rules however do not just determine what discursive practices can be undertaken and what discourse can become dominant, but also discursive practices and discourse influence these rules (or influence what conditions are considered as 'rules' and which ones are not).

In paper 2, we deconstructed the discourse driving L44, made explicit the assumptions and knowledge that characterized and informed this discourse, and we explored how this discourse could come to have effects on social inequalities in smoking. We examined this discourse before L44 was adopted. L44 was then adopted in November 2015 and as a piece of legislation, it is considered, in Foucauldian terms, as a 'statement' or in other words, a materialized form of discourse. That is, the discourse discussed pre-L44 was literally written in paper and passed into law, which then has influence over everyday life (i.e. the conduct of conduct), e.g. what people think (e.g. 'smokers are bad') and how people act (e.g. telling people not to smoke, hide smoking). Paper 3 (and therefore this analysis), is interested in to exploring the tobacco control discourse post L44 by examining TCP's discursive practices, how they adapt, question, and/or challenge them and they relate to reducing social inequalities in smoking is (or not).

Codes

Code category	Description	Codes
Discursive Practices, i.e. produce or reproduce knowledge	With these codes I will be not only be looking for what practices TCP undertake, but also *how* they undertake them and how they understand/perceive their practices. I'm also interested in looking for what practices are not undertaken or what practices are	• Practices integrating social inequalities in smoking • Practices omitting social inequalities in smoking • Meanings of discursive practices

	dismissed in regards to addressing social inequalities in smoking.	
Rules of formation (conditions that determine what can be said/done and what cannot be said/done)	With these codes, I'm looking for what influences (in the larger context) TCP's practices and perspectives on their practices, the discourse, and the rules that determine their practices (not sure I have any data on their perceptions of the rules, but maybe). I'm also interested in understanding what perspectives are not included or what perspectives are dismissed.	• Conditions that determine practices (said and done) • Conditions that determine what is excluded/silenced

APPENDIX VI. Ethics approval

Université de Montréal

Comité d'éthique de la recherche en santé

N° de certificat
16-182-CERES-D(1)

CERTIFICAT D'APPROBATION ÉTHIQUE

- 1er renouvellement -

Le Comité d'éthique de la recherche en santé (CERES), selon les procédures en vigueur et en vertu des documents relatifs au suivi qui lui a été fournis conclu qu'il respecte les règles d'éthique énoncées dans la Politique sur la recherche avec des êtres humains *de l'Université de Montréal*

Projet	
Titre du projet	**No smoking allowed! Exploring Quebec's legislation An Act to Bolster Tobacco Control's discourse and its impact on social inequalities in smoking**
Étudiante requérante	**Josée Lapalme** (ND), Candidate au Ph. D. en santé publique (promotion de la santé), École de santé publique - Département de médecine sociale et préventive
Sous la direction de	Katherine Leigh Frohlich, professeure titulaire, École de santé publique - Département de médecine sociale et préventive, Université de Montréal
Autres membres de l'équipe:	Jennifer O'Loughlin (CRCHUM), Rebecca Haines-Saah (U Calgary), Kristin Voigt (McGill) & Thierry Gagné (IRSPUM)
Note :	Ajout du financement de l'IRSCC et ajout des collaborateurs à la subvention (18 janvier 2018)
Financement	
Organisme	Institut de recherche de la Société canadienne du cancer
Programme	
Titre de l'octroi si différent	Exploring the effects of Quebec's legislation "An act to Bolster Tobacco Control" on social inequalities in smoking
Numéro d'octroi	
Chercheur principal	Katherine L. Frohlich
No de compte	

MODALITÉS D'APPLICATION

Tout changement anticipé au protocole de recherche doit être communiqué au CERES qui en évaluera l'impact au chapitre de l'éthique. Toute interruption prématurée du projet ou tout incident grave doit être immédiatement signalé au CERES.

Selon les règles universitaires en vigueur, un suivi annuel est minimalement exigé pour maintenir la validité de la présente approbation éthique, et ce, jusqu'à la fin du projet. Le questionnaire de suivi est disponible sur la page web du CERES.

[redacted]

Guillaume Paré
Conseiller en éthique de la recherche.
Comité d'éthique de la recherche en santé
Université de Montréal

29 août 2018
Date de délivrance du renouvellement ou de la réémission*

1er septembre 2019
Date du prochain suivi

10 février 2017
Date du certificat initial

1er septembre 2019
Date de fin de validité

*Le présent renouvellement est en continuité avec le précédent certificat

adresse postale
C.P. 6128, succ. Centre-ville
Montréal QC H3C 3J7

3333 Queen-Mary
2e étage, bur. 220-3
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Téléphone : 514-343-6111 poste 2604
ceres@umontreal.ca
www.ceres.umontreal.ca

APPENDIX VII. TCP consent form

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT

Exploring the effects of Quebec's legislation "An Act to Bolster Tobacco Control" on social inequalities in smoking

Candidate au doctorat
Coordonnatrice du projet
Josée Lapalme
Département de médecine sociale et préventive
École de santé publique
Université de Montréal
[redacted]
j.lapalme@umontreal.ca

Chercheuse principale
Katherine L. Frohlich
Département de médecine sociale et préventive
École de santé publique
Université de Montréal
[redacted]
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Objectif du projet

Cette étude vise largement à mieux comprendre de quelles façons la *Loi visant à renforcer la lutte contre le tabagisme* au Québec pourrait avoir un impact sur les inégalités sociales en matière de tabagisme. Afin d'atteindre cet objectif, nous cherchons à explorer dans un premier temps, les perspectives des professionnels de santé publique qui travaillent en prévention et/ou en cessation tabagique concernant cette loi et ses effets potentiels sur les inégalités sociales en matière de tabagisme et de la santé. Dans un deuxième temps, nous examinerons les points de vues des personnes qui sont en situation de défavorisation et qui fument concernant l'impact de cette loi sur leur expérience de tabagisme.

Déroulement

Si vous acceptez de participer à cette étude, nous vous demanderons de discuter, lors d'une entrevue, du contexte de tabagisme au Québec ainsi que du contexte de prévention du tabagisme au Québec. L'entrevue individuelle sera dirigée par la candidate au doctorat et coordonnatrice du projet, Josée Lapalme, et sera d'une durée approximative de 60 à 90 minutes. L'entrevue sera enregistrée avec l'aide d'un support audio et se déroulera à l'endroit public de votre choix (par exemple, votre lieu de travail, un café, ou une bibliothèque) et au moment qui vous conviendra.

Participation volontaire et droit de retrait

Votre participation à cette étude est tout à fait volontaire. Vous avez le choix d'accepter ou de refuser de participer. Si certaines questions vous rendent mal à l'aise, vous pouvez refuser d'y répondre. Si vous refusez de participer, ou si vous décidez de vous retirer de l'étude, vous n'aurez à donner aucune raison, ni à subir aucun préjudice. Vous pouvez vous retirer de l'étude à tout moment en contactant la chercheuse principale. Dans cette éventualité, toutes vos informations seront détruites.

Confidentialité
Nous vous assurons que toutes les informations que vous nous fournirez seront traitées de façon strictement confidentielle. Le formulaire de consentement, les enregistrements, et les transcriptions verbatim des enregistrements seront conservés sous clé au bureau de la chercheuse principale à l'Université de Montréal. Les fichiers électroniques seront protégés à l'aide de mot de passe sur l'ordinateur de Josée Lapalme, qui est également protégé par mot de passe. Le tout sera conservé pour une période maximale de sept ans après la fin du projet. L'accès aux données brutes sera limité à la chercheuse principale et sa directrice de thèse.

Les résultats de cette étude seront publiés dans des revues scientifiques et présentés lors de conférences. Toutes informations pouvant conduire à l'identification de votre identité et celle de votre organisme seront enlevées lors de la diffusion des résultats. À des fins de contrôle du projet de recherche, votre dossier pourrait être consulté par une personne mandatée par le Comité d'éthique de la recherche en santé de l'Université de Montréal (CERES) qui adhèrent à une politique de confidentialité stricte.

Bénéfices et inconvénients
Vous n'aurez pas de bénéfices directs suite à votre participation à cette étude. Cependant, grâce à votre participation, nous pourrons mieux comprendre les effets des politiques publiques de tabagisme sur les inégalités sociales de tabagisme et de la santé. Cette information nous permettra d'informer les futures politiques publiques afin qu'elles aient pour effet de réduire les inégalités sociales de tabagisme et de la santé.

Il n'y a aucun inconvénient associé à la participation de cette étude, à part le temps que vous consacrez pour l'entrevue.

Compensation
Il n'y a pas de compensation pour votre participation à cette étude.

Personnes ressources
Si vous avez des questions par rapport à l'étude vous pouvez contacter la coordonnatrice du projet, Josée Lapalme, ou la chercheuse principale, Katherine Frohlich.

Pour toute préoccupation sur vos droits ou sur les responsabilités des chercheurs concernant votre participation à ce projet, vous pouvez contacter le conseiller en éthique du Comité d'éthique de la recherche en santé de l'Université de Montréal (CERES) :
Adresse courriel: ceres@umontreal.ca
Numéro de téléphone : (514) 343-6111 poste 2604
Site Web: http://recherche.umontreal.ca/participants.

Toute plainte concernant cette recherche peut être adressée à l'ombudsman de l'Université de Montréal, au numéro de téléphone (514) 343-2100 ou à l'adresse courriel : ombudsman@umontreal.ca L'ombudsman accepte les appels à frais virés. Elle s'exprime en français et en anglais et prend les appels entre 9h et 17h.

Consentement
En signant ce formulaire de consentement, vous confirmez que vous avez lu et compris le contenu de ce formulaire. Vous comprenez que votre participation est volontaire, et que vous êtes libre de vous retirer de l'étude en tout temps. Finalement, vous acceptez que la chercheuse principale vous contacte, au besoin, pour faire un suivi ou pour recevoir vos commentaires.

Nous vous remercions d'avance pour votre collaboration dans cette étude!

Cordialement,

Josée Lapalme, MA
Candidate au doctorat en santé publique
Coordonnatrice du projet

Katherine Frohlich, PhD
Professeure agrégée

Consentement

Déclaration du participant

Je comprends que je peux prendre mon temps pour réfléchir avant de donner mon accord ou non à participer à la recherche.

Je peux poser des questions à l'équipe de recherche et exiger des réponses satisfaisantes.

Je comprends qu'en participant à ce projet de recherche, je ne renonce à aucun de mes droits ni ne dégage les chercheuses de leurs responsabilités.

J'ai pris connaissance du présent formulaire d'information et de consentement et j'accepte de participer au projet de recherche.

_____	_____	_____
Prénom et nom du participant (caractères d'imprimés)	Signature du participant	Date

Engagement du chercheur

J'ai expliqué les conditions de participation au projet de recherche au participant. J'ai répondu au meilleur de ma connaissance aux questions posées et je me suis assurée de la compréhension du participant. Je m'engage à respecter ce qui a été convenu au présent formulaire d'information et de consentement.

_____	_____	_____
Prénom et nom de la chercheuse (caractères d'imprimés)	Signature de la chercheuse	Date

APPENDIX VIII. Globe and Mail Letter to the editor

The Globe and Mail, 11 décembre 2019, page A12

LETTERS TO THE EDITOR

STUDYING SMOKERS

Re We Increasingly Empathize With Addicts, But We Still Tar Smokers (Opinion, Nov. 30): We should consider who we are referring to when we talk about smokers.

In Canada, smoking is increasingly divided by social class, where smoking and exposure to second-hand smoke are highest among the socio-economically disadvantaged compared with more affluent groups. According to the Public Health Agency of Canada's report on health inequalities, people without a high-school degree are about four times more likely to smoke than those with a postsecondary education.

There is no doubt that smoking is harmful to health. But with every stigmatizing comment or reproachful glare to someone smoking, we are shaming people more likely to be socially disadvantaged. Instead of policing smoking, our efforts should be focused on improving the social conditions that put populations at a disproportionately higher risk of smoking.

Josée Lapalme PhD candidate,
École de santé publique de
l'Université de Montréal