THE NATIONAL STRATEGY: MOVING FORWARD

THE **2005** PROGRESS REPORT ON TOBACCO CONTROL

Our mission is to help the people of Canada
maintain and improve their health.

Health Canada

Prepared by the Canadian tobacco control community:

The Tobacco Control Liaison Committee of the
Federal Provincial Territorial Advisory Committee on Population Health and Health Security,
in collaboration with non-governmental organizations.

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EXECUTIVE SUMMARY

Canada has always been a world leader in tobacco control. Over the past forty years, using a combination of legislation, public education campaigns, and public health actions, we have reduced the percentage of Canadian smokers to its lowest point in 50 years.

As the annual progress report for Canada's national tobacco control strategy, *Moving Forward* has for the past five years presented a yearly snapshot of provincial, territorial, and federal efforts to reduce tobacco use.

Each year, the report alternates between a concise report in even-numbered years and an expanded report in odd-numbered years. This, an expanded version, contains three sections. As it does every year, the Tracking Key Indicators section presents statistics on smoking prevalence and cigarette consumption in Canada as collected by the Canadian Tobacco Use Monitoring Survey. This year the report also includes data on domestic cigarette sales and on the health effects of tobacco use.

In its first year, the progress report noted some gaps in our knowledge of tobacco use in Canada. This year the report is able to present data that will help fill an existing gap, notably the lack of survey data from the North. Because of the fewer number of households with telephones in the North, data collection in Yukon, Northwest Territories, and Nunavut is more difficult. For this reason, the territories typically are not included in large surveys. However, through an agreement between the Government of the Northwest Territories Department of Health and Social Services and Health Canada a tobacco use survey was completed in the Northwest Territories in 2004, and some of those results are presented in Tracking Key Indicators.

In the 2004 edition, *Moving Forward* discussed the relationship between tobacco use, health determinants, and health disparities. This year the report expands on that discussion with a closer look at gender and tobacco use, which suggests that cessation strategies need to be tailored not just to age, but to gender as well. Moving Toward a Smoke-Free Society takes a closer look at the National Strategy's four goals: prevention, cessation, protection, and denormalization. And finally, Progress in Strategic Directions showcases a sampling of tobacco control initiatives from across the country.

In terms of tobacco control, five years is a relatively short time. And yet, over the past five years we have seen progress. We have continued to add to our knowledge, and continued to develop resources and create tools. We have steadily and systematically gathered data—comparable data suitable for research. We know that the National Strategy that was revised in 1999 has taken us further down the road to a healthier society.

However, as noted in Tracking Key Indicators, as the prevalence rate declines at a slower pace, Canada appears to be approaching a more difficult to reach population of Canadian smokers. With data from the North and with an analysis of health disparities, we know that there can be systematic variations in the distribution of tobacco use. Perhaps it is time to once again revisit our national strategy and target those harder to reach populations using tactics specifically designed to meet their needs.

INTRODUCTION

Canada has always been a world leader in tobacco control. Over the past forty years, using a combination of legislation, public education campaigns, and public health actions, we have reduced the percentage of Canadian smokers to its lowest point in 50 years.

For the past five years, this progress report, *Moving Forward*, has presented examples of activities undertaken by provinces, territories, NGOs, and the federal government. In many instances, these tobacco control efforts are collaborative. In fact, in 1999 when the current tobacco control strategy was approved, the federal/provincial/territorial Ministers of Health agreed that "sustained, comprehensive, integrated, and collaborative approaches were required for successful tobacco control." Like its four predecessors, this report again presents examples of just such approaches.

In its original mandate, the tobacco control progress report was intended to "track trends over time and pinpoint gaps in the knowledge required to combat tobacco use." Thanks to the Canadian Tobacco Use Monitoring Survey (CTUMS), *Moving Forward* has been able to present each year up-to-date, reliable, and comparable data on tobacco use in Canada. In addition, this year we are pleased to present data that will help fill an existing gap. Because of the fewer number of households with telephones in the North, data collection in Yukon, Northwest Territories, and Nunavut is more difficult. For this reason, the territories typically are not included in large surveys.

In 2003, an agreement was reached between the Government of the Northwest Territories Department of Health and Social Services and Health Canada to carry out a tobacco use survey in the Northwest Territories. The 2005 *Moving Forward* includes data from the Northern Tobacco Use Monitoring Survey of 2003–2004.

Although tobacco uptake, use, and addiction is an extremely complex problem, we have succeeded in reducing tobacco use in Canada. We have learned through experience, and are still learning, what works best. We have learned how to implement tobacco control legislation while successfully withstanding the tobacco industry's persistent legal challenges. We have learned to support that legislation with research and monitoring. We have learned how to create and target media campaigns. We have learned how to tailor cessation programs to the needs of specific groups. We have learned to extend our education efforts to the very young. Most of all, we have learned to work more effectively together because tobacco use, with its enormously negative consequences for our society, is everyone's problem. By reporting on tobacco control activities, the National Strategy's progress report continues to be a vehicle for sharing best practices, disseminating information, and providing input into a continuous learning process.

Moving Forward alternates between a concise report in even-numbered years and an expanded report in odd-numbered years. This, an expanded version, contains three sections. Tracking Key Indicators presents statistics on smoking prevalence and cigarette consumption in Canada, on domestic cigarette sales, and on the health effects of tobacco use. It also discusses the relationship between tobacco use, health determinants, and health disparities with a closer look at gender and tobacco use. Moving Toward a Smoke-Free Society takes a closer look at the National Strategy's four goals: prevention, cessation, protection, and denormalization.

Progress in Strategic Directions presents a small selection from the vast number of tobacco control activities being conducted by territories, provinces, and the federal government, often working in partnership with NGOs, community groups, and voluntary health agencies.

Progress in Strategic Directions is organized according to the National Strategy's five strategic directions

- Policy and legislation
- Public education (information, mass media, programs, and services)
- Industry accountability and product control
- Research, evaluation, and monitoring
- Building and supporting capacity for action

The reporting period for this edition of *Moving Forward* is spring 2004 to spring 2005. This edition presents data collected by the 2004 Canadian Tobacco Use Monitoring Survey.

TRACKING KEY INDICATORS

Tobacco control in Canada benefits from a continuous learning process. We have been persistent in developing measures to assess, monitor, and improve tobacco control programs and activities, while continually searching for ways to fill the gaps in our knowledge.

One critical gap has been a lack of survey data from the North. Because data collection is more difficult in Yukon, Northwest Territories (NWT), and Nunavut, the territories have typically not been included in large surveys. In the winter of 2003, a Northern Tobacco Use Monitoring Survey (NTUMS) was conducted by the NWT Bureau of Statistics, with data analysis and a report completed in the fall of 2004. The data from this NTUMS will augment the data from the 2004 Canadian Tobacco Use Monitoring Survey (CTUMS) presented here.

Since 1999, CTUMS has been providing up-to-date, reliable, comparable, and continuous data on tobacco use in Canada. The survey was instituted by Health Canada with input from the provinces and is conducted by Statistics Canada. It provides half-year (Wave 1) and full-year data provincially with a national roll-up, using a full-year sample size of over 20,000 respondents. About 50% of those surveyed are between 15 and 24 years of age because this is the population most at risk for taking up smoking.

Some gaps still remain. Tobacco control advocates recognize that there are groups, which probably have a large percentage of regular and heavy smokers, that are not captured in surveys. These include individuals who are incarcerated or institutionalized, and homeless people, of whom many are marginalized youth.

Traditionally, tobacco use is measured in three ways:

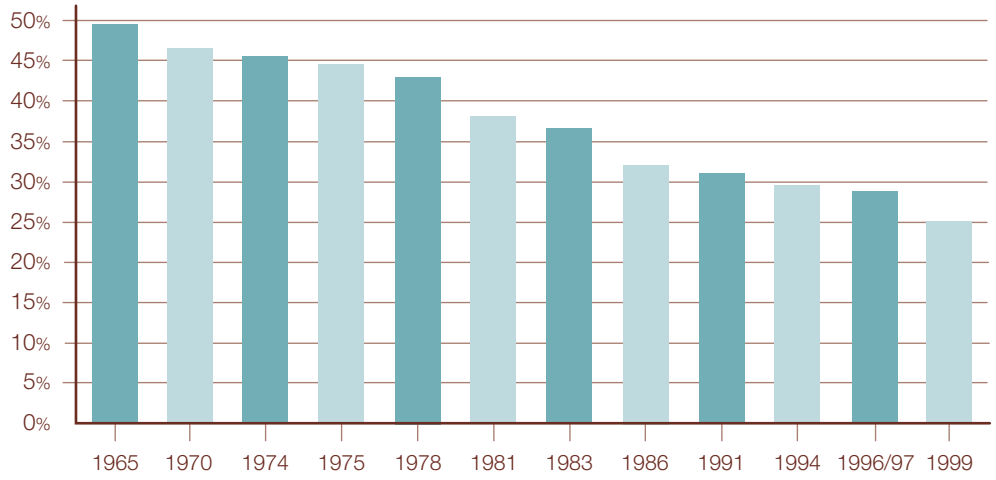
- prevalence (what percentage of Canadians smoke),
- consumption (how many cigarettes daily smokers smoke per day), and
- tobacco sales.

While each measure has its strengths and weaknesses, together they sketch the picture of tobacco use in Canada.

Smoking prevalence in Canada

The first *Moving Forward* report in 2001 included prevalence information from 1965 when regular monitoring of smoking began. The report highlighted the significant decline in the percentage of Canadian smokers from an estimated 50% in 1965 to 24% in 2000. These were encouraging figures. Certain years became particularly important milestones in the fight against tobacco use, for example: 1981 when prevalence dropped below 40% and 1994 when it dropped below 30% (See Figure 1A). These prevalence rates now represent a different era in tobacco control. Over the past five years, the CTUMS data indicate that although prevalence for the general population continues to decline, it is declining in smaller increments. We appear to be approaching a more difficult to reach population of Canadian smokers. *Moving Forward* will now tighten its focus to prevalence data collected since 1999 by CTUMS.

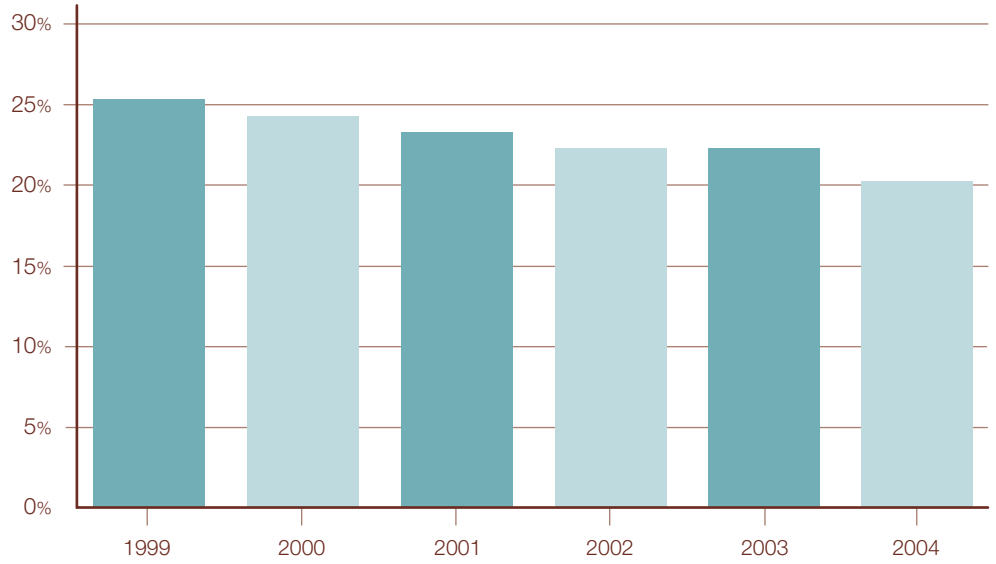
FIGURE 1A | Prevalence of Canadian current smokers, aged 15 years and over, 1965–1999[A]



[A] Data from 1965 to 1986 is not necessarily comparable because of variations in data collection methods.

Source: Labour Force Survey Supplement, 1965–1975, 1981–1986; Canada Health Survey, 1978; General Social Survey, 1991; Survey on Smoking in Canada, 1994; National Population Health Survey, 1996/97; Canadian Tobacco Use Monitoring Use Survey, 1999.

FIGURE 1B | Prevalence of Canadian current smokers, aged 15 years and over, 1999–2004



Source: Canadian Tobacco Use Monitoring Use Survey (Annual), 1999–2004.

OVERALL SMOKING PREVALENCE IN CANADA

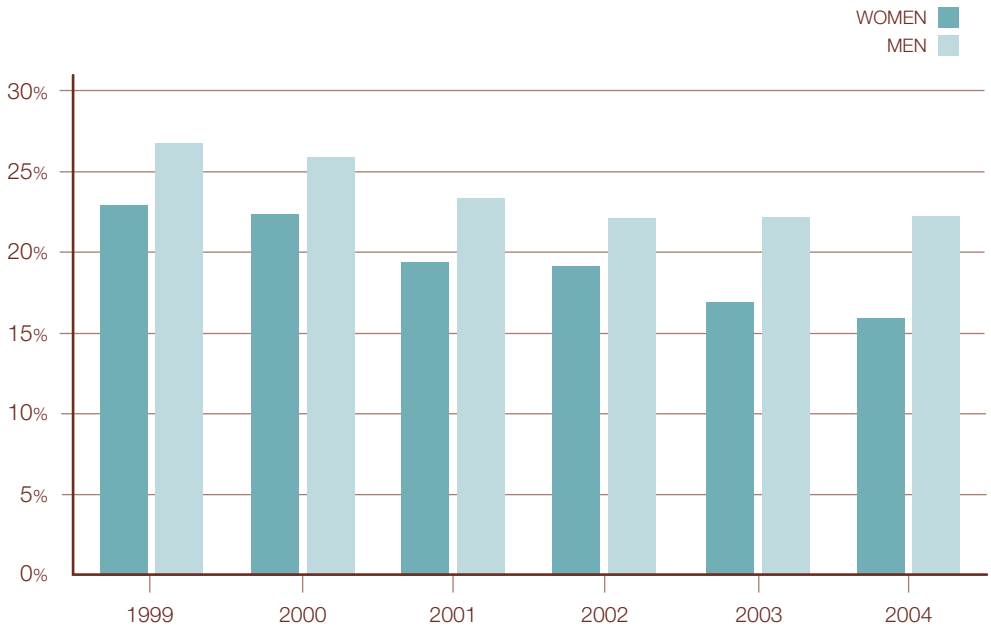
Although the downward trend in smoking prevalence in the provinces continues, we appear to have reached a point at which prevalence rates represent hard to reach populations. According to the latest results from CTUMS, for data collected in 2004, slightly more than 5 million people, representing 20% of the population aged 15 years and older, were current smokers. (Of these, 15% reported smoking daily, while 5% reported smoking occasionally.) This represents a slight decrease from last year's prevalence rate of 21% (Figure 1B).

According to the NTUMS results, 41% of the NWT population 15 years and older currently smoke cigarettes (with 29% reporting that they smoke daily). This is almost double the prevalence rate reported for the ten provinces. It should be noted that the NTUMS report includes data on Aboriginal tobacco use. The smoking prevalence among Aboriginal residents was over twice that of non-aboriginal residents—60% compared to 25%.

Approximately 22% of men aged 15 years and older were current smokers in 2004. Again, this represents a small decrease from last year's figure of 23%. This is still higher than the rate for women aged 15 years and older, which has declined slightly from 18% in 2003 to 17%. (Figure 2).

In NWT, men are more likely than women to be current smokers—44% compared to 38%.

FIGURE 2 | Prevalence of Canadian current smokers, aged 15 years and over, by sex, 1999–2004



Source: Canadian Tobacco Use Monitoring Use Survey (Annual), 1999–2004.

SMOKING PREVALENCE AMONG YOUTH GROUPS

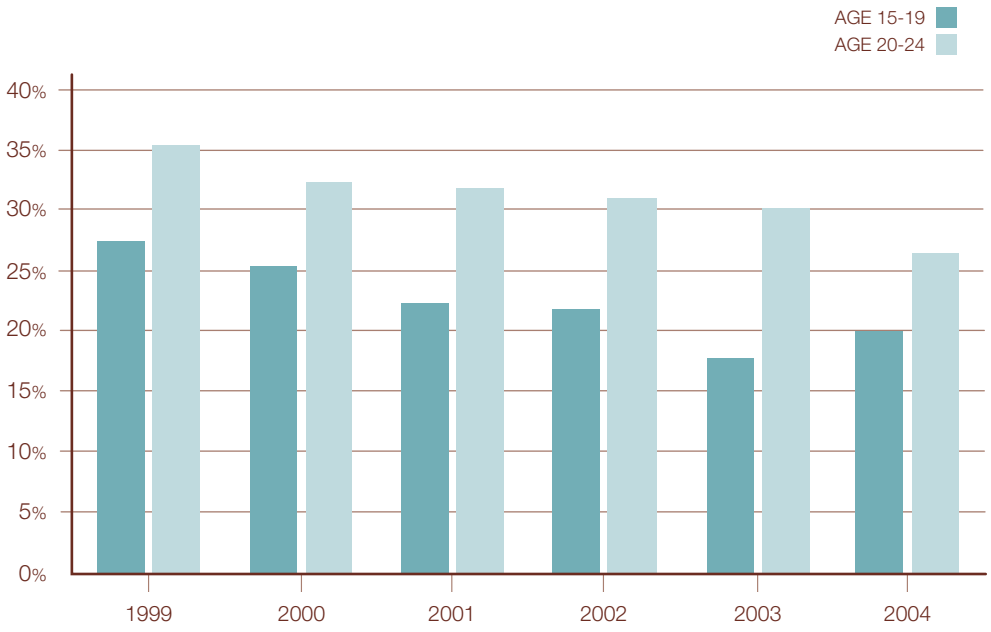
In the early 1980s, more than 40% of youth 15 to 19 years of age were smokers. By the early 1990s, this rate had decreased to just over 20%. Then during the 1990s, the rates increased and peaked at 28% in 1999. Since then, however, they have been decreasing. The 2004 figure remains unchanged since 2003 at 18% with 11% of youth reporting daily smoking and 7% occasional smoking. (Figure 3) Smoking among teenage girls has declined from 20% in 2003 to 18% in 2004. This is the lowest annual smoking rate for teenage girls since monitoring of smoking began in 1965.

According to NTUMS data, 43% of youth in NWT between 15 and 19 years of age currently smoke.

Historically, of all age groups, young adults aged 20 to 24 have had the highest prevalence rates. Although this remains true, there have been decreases from 35% in 1999 to 31% in 2002, and to 28% in 2004. (Figure 3). This is the lowest rate on record since Health Canada first reported prevalence rates for this age group. More men than women in this age group smoke: 30% compared to 25%.

Paralleling this trend, young adults between 20 and 24 years of age in NWT have the highest prevalence rate (53%) of any age group.

FIGURE 3 | Prevalence of Canadian current smokers, by youth age group, 1999–2004

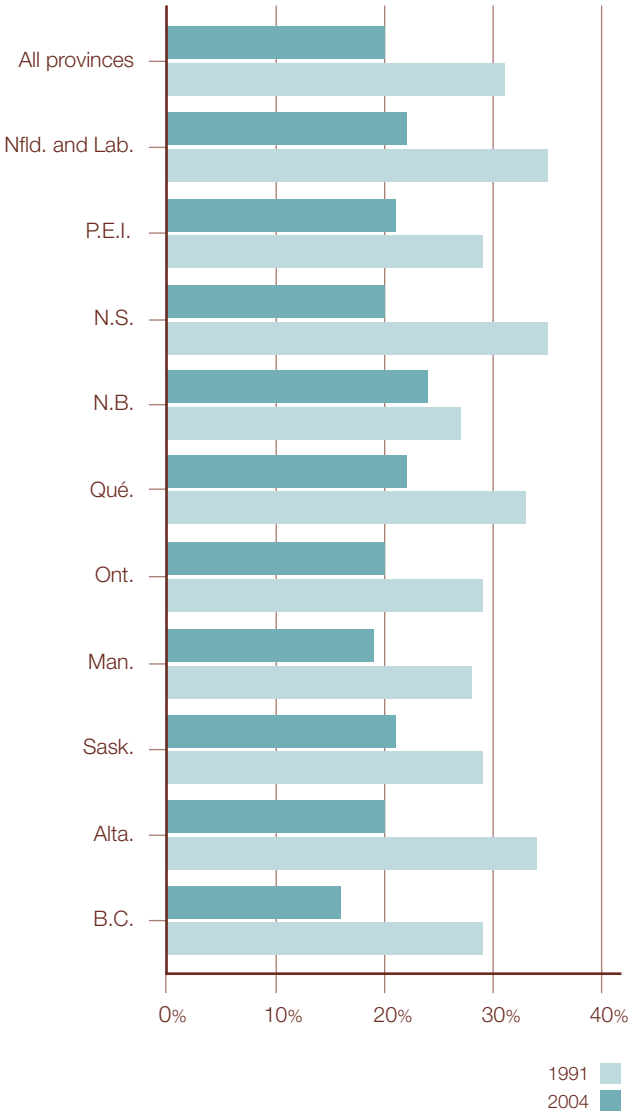


Source: Canadian Tobacco Use Monitoring Use Survey (Annual), 1999–2004.

PREVALENCE RATES ACROSS THE PROVINCES

Provincial prevalence rates for smokers 15 years and older continue to decrease. In 1991, five provinces had rates over 30%. By 2000, only one province had a 30% prevalence rate. According to the 2004 CTUMS figures, the highest provincial prevalence rate is 24% (New Brunswick). As encouraging as the decreasing rates, is the lessening of differences between the provinces. While Quebec recorded the largest decrease, from 25% in 2003 to 22% in 2004, and British Columbia continues to show the lowest prevalence rate at 15%, all provinces are now within 4% to 5% of the national average smoking rate. (Figure 4).

FIGURE 4 | Prevalence of Canadian current smokers, by province, 1991 and 2004



Source: General Social Survey, 1991; Canadian Tobacco Use Monitoring Survey, 2004

Cigarette consumption in Canada

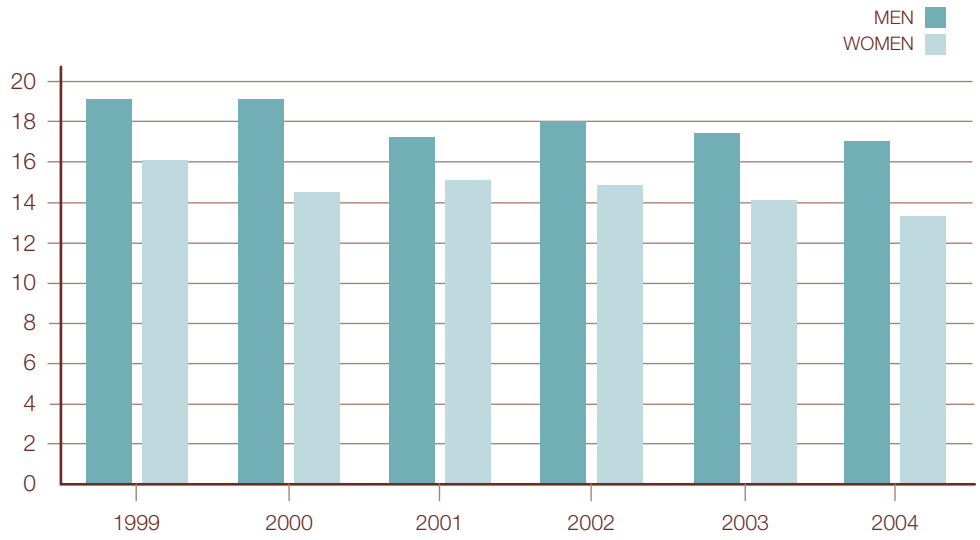
Tobacco sales data and cigarette consumption data provided by surveys provide different views on consumption, each with its strengths and weaknesses. In surveys, consumption is self-reported. Since smokers inevitably under-report tobacco consumption, consumption numbers tend to be lower than cigarette sales reported for the same time period. The difference between self-reported consumption figures and sales figures has been as much as 30% and may be higher since the social acceptability of tobacco use has declined.

OVERALL CIGARETTE CONSUMPTION IN CANADA

Since 1985, when daily smokers consumed an average of 20.6 cigarettes per day, Canadians have continued to report smoking fewer cigarettes per day. The number of cigarettes smoked per day has gradually but steadily declined to its current level of 15.2 per day as reported for 2004.

While consumption levels for daily smokers have declined for both men and women over the last twenty years, the decline has been more marked for men than for women, since men historically smoked substantially more cigarettes per day. However, men continue to smoke more than women: 16.4 cigarettes per day for men compared to 13.8 for women (Figure 5).

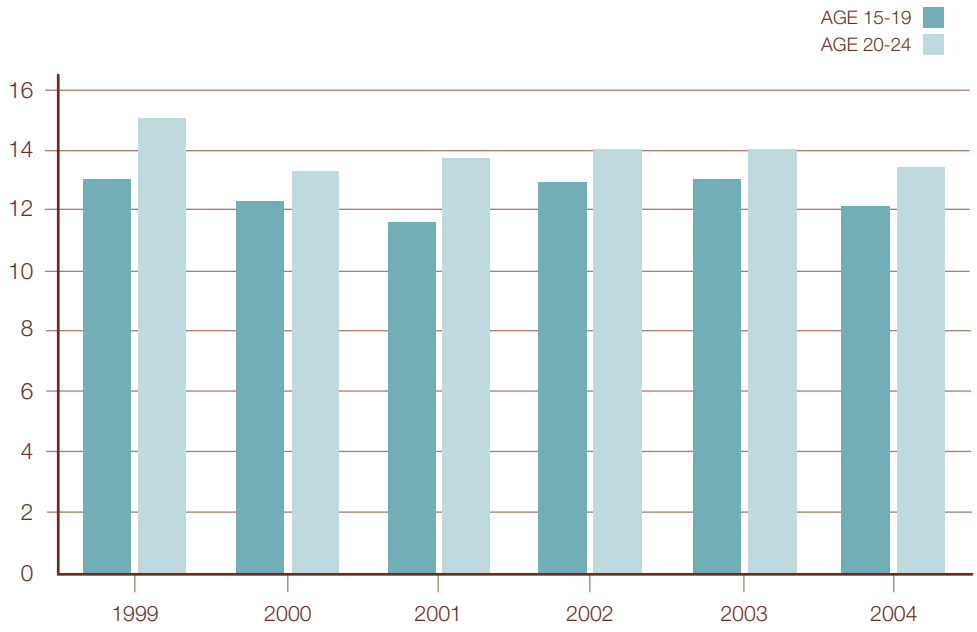
FIGURE 5 | Average number of cigarettes smoked daily by Canadian daily smokers, aged 15 years and over, by sex, 1999–2004[A]



[A] Provincial data only.

Source: Canadian Tobacco Use Monitoring Survey (Annual), 1999–2004.

FIGURE 6 | Average number of cigarettes smoked daily by Canadian daily smokers, by youth age group, 2004[A]



[A] Provincial data only.

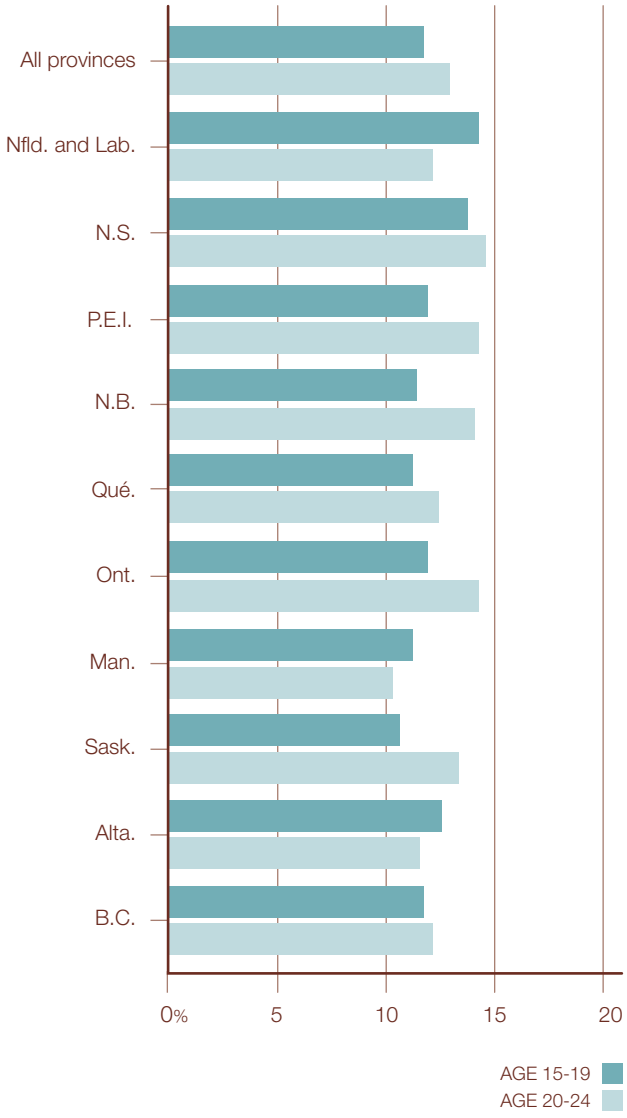
Source: Canadian Tobacco Use Monitoring Survey (Annual), 1999–2004.

In NWT, overall, daily smokers smoked an average of 14 cigarettes per day. Men smoked more cigarettes per day than women (15.9 versus 11.8). Non-aboriginal daily smokers smoked more cigarettes per day than aboriginal daily smokers (16.6 versus 12.3).

CIGARETTE CONSUMPTION AMONG CANADIAN YOUTH

Among 15 to 19 year olds, cigarette consumption was reported at 11.6 cigarettes daily, with boys and girls showing almost identical consumption rates (11.7 for boys and 11.6 for girls). Until 2004, boys had reported smoking more cigarettes per day than girls. In 2003, the figures were 13.0 for boys and 11.7 for girls.

FIGURE 7 | Average number of cigarettes smoked daily by Canadian daily smokers, by youth age group, by province, 2004[A]



[A] Provincial data only.

Source: Canadian Tobacco Use Monitoring Survey, 2004.

Among young adults aged 20 to 24, cigarette consumption for both sexes was reported at 12.8 cigarettes daily, with men smoking slightly more cigarettes per day (13.8) than women (11.6) (Figure 6).

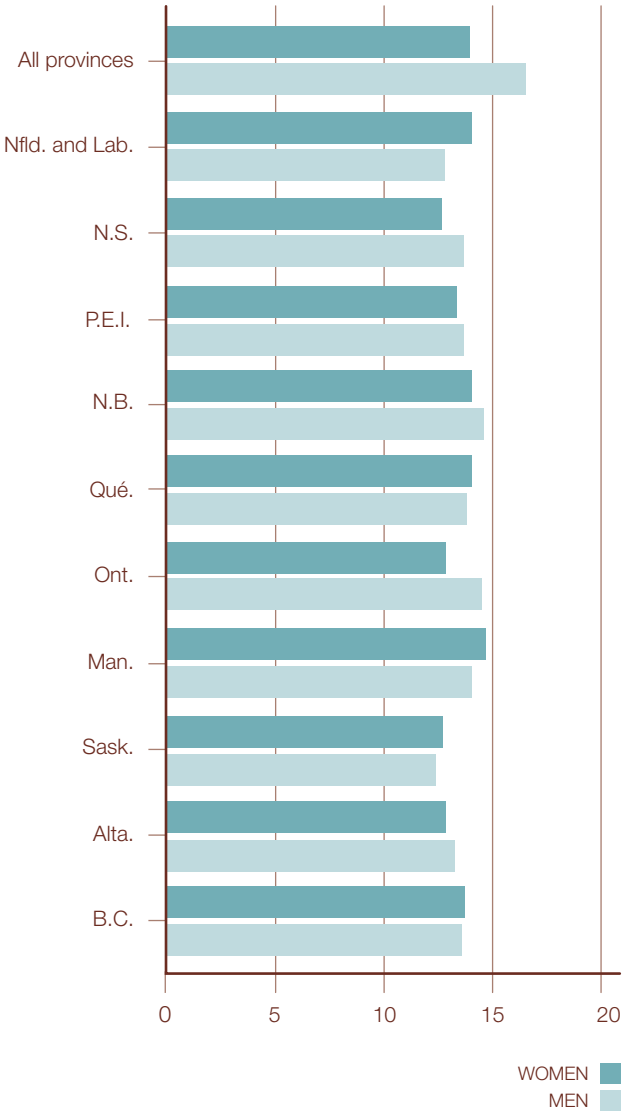
CIGARETTE CONSUMPTION BY PROVINCE

Cigarette consumption across the provinces is becoming more uniform. In 2004, the average number of cigarettes smoked per day by daily smokers ranged from 13.9 in Saskatchewan to 16.7 in New Brunswick. As expected, men reported smoking slightly more cigarettes per day than women with the greatest difference appearing in New Brunswick where men reported an average of 18.5 cigarettes smoked per day to 14.5 for women. For the 15- to 19-year old age group the range was 10.5 cigarettes per day in Saskatchewan to 14.1 in Newfoundland and Labrador. While it is more typical for 20 to 24 year olds to smoke more cigarettes daily than 15 to 19 year olds, in three provinces—Newfoundland and Labrador, Manitoba, and Alberta—they report smoking slightly fewer cigarettes per day. (Figures 7 and 8).

Tobacco industry statistics

Both provincially and federally, the Canadian tobacco industry is subject a number of reporting regulations. For example, in British Columbia the Tobacco Testing and Disclosure Regulation requires test results for the presence of up to 44 chemicals from both mainstream smoke from the puffing end and from sidestream smoke from the burning end. It also requires testing and reporting of two types of puffing: standard and intense.

FIGURE 8 | Average number of cigarettes smoked daily by Canadian daily smokers, aged 15 and over, by sex, by province, 2004[A]



[A] Provincial data only.

Source: Canadian Tobacco Use Monitoring Survey, 2004.

Federally, since the Tobacco Reporting Regulations were enacted under the *Tobacco Act*, tobacco manufacturers have been required to report levels of more than 40 different chemical compounds found in mainstream smoke (smoke inhaled by the smoker) and side stream smoke (second-hand smoke inhaled by non-smokers). Six of these chemicals must be reported on tobacco packaging.

Quarterly reports are required on product ingredients and promotional activities, and a semi-annual report is required on emissions. Manufacturers are also required to submit annual reports on sales, research, and information on constituents. Monthly reports on the sales of cigarettes, cigarette tobacco, and tobacco sticks are also required.

DOMESTIC CIGARETTE SALES

Although tobacco can be consumed in a number of ways, cigarettes account for the largest share of tobacco consumption. Although non-cigarette tobacco products, such as pipe tobacco, cigars, cigarillos, and smokeless tobacco account for a marginal portion of tobacco sales, there appears to be a slight increase in their use.

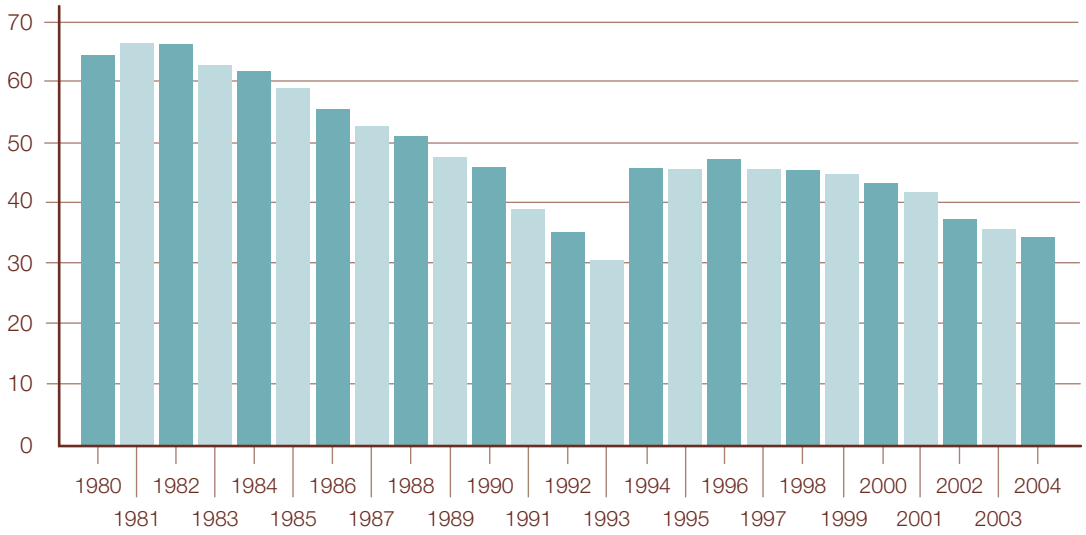
It should be noted that the domestic cigarette sales figures collected under the Tobacco Reporting Regulations are not retail sales figures but sales from the manufacturer to the wholesaler for which excise taxes and duties have been paid.

Cigarette sales figures should not be taken at face value. As can be seen in Figure 9, there was a sharp drop in reported cigarette sales between 1991 and 1993. However, this did not indicate a concomitant drop in cigarette consumption. During this period tobacco taxes were increased substantially. The resulting price increases, rather than contributing to reductions in consumption, triggered cigarette smuggling. In 1994, to alleviate uncontrolled sales, federal taxes were temporarily rolled back. They were then gradually increased over a five-year period, and a uniform federal tobacco tax rate was established countrywide. Since then, there has continued to be a steady decline in the number of cigarettes sold in Canada.

Smuggling and the more recent issue of counterfeit cigarettes continue to be matters of concern and merit further attention.

Taxation measures are coordinated among a number of federal government departments and agencies with coordination, management, and funding provided under the aegis of the Federal Tobacco Control Strategy. The Department of the Solicitor General and the Royal Canadian

FIGURE 9 | Domestic cigarette sales from the manufacturer to the wholesaler (billions of cigarettes), Canada, 1980–2004[A]



[A] May not represent 100% of sales in some years owing to occasional and marginal non-reporting.

Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

Mounted Police participate in efforts to monitor and assess tobacco contraband activity and related crime. The Department of Justice monitors and collects fines imposed on offenders and enforces tobacco contraband offences. The Canada Revenue Agency is responsible for collecting duties and taxes on tobacco products and for the interdiction of contraband tobacco both inland and at the border. The border includes customs land, marine, and air ports of entry, as well as sufferance and bonded warehouses inland.

Health effects of tobacco use

Smoking is still the number one preventable cause of death and disease in Canada. Each year over 45 000 Canadians die from tobacco-related causes. Some of these people never used tobacco—they were exposed to second-hand smoke. (According to the 2004 CTUMS, 15% of Canadian children from birth through 17 years of age are still regularly exposed to Environmental Tobacco Smoke.) While the emotional and social impact on the families involved cannot be measured, the economic cost to our health care system can be estimated, and it is significant.

Over the years, there have been discussions about the calculation of smoking-related mortality rates. However, even if different methods of calculation are used, the bottom line is that a substantial number of preventable deaths occur every year.

MORTALITY ATTRIBUTABLE TO SMOKING

Our most recent data indicate that in 1998, 47 581 Canadians died as a result of both active and passive smoking. Of these, 30 230 were men, 17 351 were women, and 96 were children under the age of one. (Table 1) One type of mortality that is not included in these numbers is death from fires started by smoking. While these deaths may be few each year, they too are preventable.

Some health consequences are not sex specific, that is, they affect both men and women. These include lung and other cancers, cardiovascular disease, stroke, chronic bronchitis and emphysema, for example. Some health consequences, however, are sex specific. Men who smoke are at risk for erectile dysfunction and reduced fertility, while women are at risk for increased cardiovascular disease while using oral contraceptives, reduced fertility, cervical cancer, early menopause, and bone fractures. Moreover, smoking during pregnancy can result in premature birth, malformation of the fetus, low birth-weight, and stillbirth.

TABLE 1 | Smoking attributable mortality (SAM), by disease category, by sex, Canada, 1998[A]

DISEASE CATEGORY	ICD-9	MALE	FEMALE	TOTAL
ADULT DISEASES (35+ YRS OF AGE)		**29 563**	**16 815**	**46 378**
Cancers		12 052	6 295	18 347
Lip, oral cavity, pharynx	140–149	610	207	817
Esophagus	150	761	244	1 005
Pancreas	157	415	540	955
Larynx	161	320	62	382
Trachea, lung, bronchus	162	9 067	4 884	13 951

DISEASE CATEGORY	ICD-9	MALE	FEMALE	TOTAL
ADULT DISEASES (35+ YRS OF AGE) (CON'T)				
Cervix uteri	180	—	136	136
Urinary bladder	188	467	161	628
Kidney, other urinary	189	413	62	475
Cardiovascular diseases		11 305	6 109	17 413
Rheumatic heart disease	390–398	41	55	96
Hypertension	401–405	145	153	298
Ischemic heart disease (IHD)	410–414			
Ages 35–64		2 171	489	2 660
Ages 65+		4 007	2 622	6 629
Pulmonary heart disease	415–417	120	80	200
Other heart disease	420–429	1 645	1 133	2 779
Cerebrovascular disease	430–438			
Ages 35–64		361	327	687
Ages 65+		1 310	455	1 765
Atherosclerosis	440	356	274	630
Aortic aneurysm	441	794	281	1 075
Other arterial disease	442–448	354	240	595
Respiratory diseases		6 206	4 411	10 618
Respiratory tuberculosis	010–012	20	6	26
Pneumonia/Influenza	480–487	1 418	1 364	2 782
Bronchitis/emphysema	491–492	751	473	1 224
Asthma	493	55	75	130
Chronic airways obstruction	496	3 963	2 494	6 457
PEDIATRIC SAM		**612**	**495**	**1 107**
Lung cancer pediatric SAM		218	143	361
Ischemic heart disease pediatric SAM		394	352	746
PEDIATRIC DISEASES (<1 YEAR OF AGE)		**55**	**41**	**96**
Low birth weight	765	17	15	31
Respiratory distress syndrome	769	8	6	14
Respiratory conditions—newborn	770	11	9	21
Sudden infant death syndrome	798.0	19	11	30
TOTAL		**30 230**	**17 351**	**47 581**
SAM as percentage of deaths from all causes[A]		27	17	21
Male-to-female SAM ratio				1.7

[A] In Canada, 113 007 males and 105 084 females died from all causes in 1998.

ICD-9 = International Classification of Diseases, 9th Revision, World Health Organization, Geneva.

Source: Makomaski Illing EM, Kaiserman MJ. Mortality Attributable to Tobacco Use in Canada and Its Regions, 1998. *Canadian Journal of Public Health*, Volume 95, No. 1, 2004.

The number of smoking-related deaths in Canada increased between 1989 and 1998, with a steep increase among women. During this period, smoking-related deaths rose from 38 357 to 47 581, which represents an increase of 9224. Women accounted for 6531 of those deaths. (Figure 10).

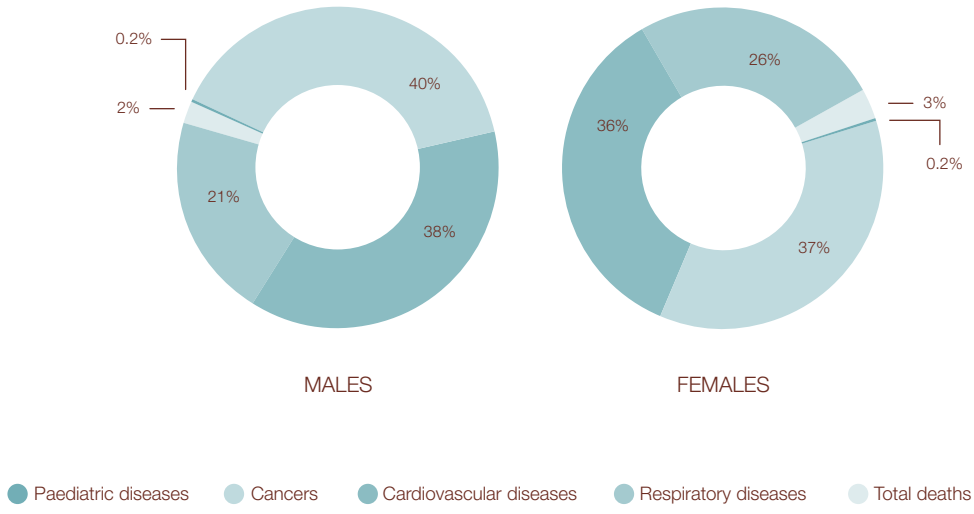
This difference between men and women in smoking-related deaths reflects the smoking behaviour of our population two to three decades earlier. Beginning in the mid-1960s, tobacco consumption decreased among men and this change was reflected by a levelling off in the mid-1980s and then a steady decrease in male lung cancer rates. Between 1989 and 1998, lung cancer was the leading cause of smoking-related deaths, whereas cardiovascular disease is now the leading cause of smoking-related death. Among Canadian women, smoking consumption peaked in the late 1970s and has been decreasing gradually over the past thirty years. Female lung cancer mortality rates more than quadrupled between 1969 and 1998, and can be expected to rise for the next few years before decreasing.

Because of the significant decline in smoking prevalence and consumption over the past 40 years, the rate of smoking-related deaths will begin to decline. The implementation of a broad range of tobacco control measures, from regulation to education, over the past thirty years, has made it possible for us to look forward to a decline in the number of smoking-related deaths.

Tobacco use, health determinants, and health disparities

The National Strategy is based on a population health framework. A population health framework takes into consideration a wide range of health determinants that influence smoking trends. We now recognize that these health determinants interact in complex ways to affect an individual's health. The determinants of health can include income and social status, gender, education, ethnic origin, as well as biological and genetic traits.

FIGURE 10 | Proportion and number of deaths attributable to smoking in Canada, by sex, 1998



Source: Makomaski Illing EM, Kaiserman MJ, Mortality Attributable to Tobacco use in Canada and its Regions, 1998. *Canadian Journal of Public Health*, Volume 95, No. 1, 2004.

Canadians are among the healthiest people in the world, but some groups of Canadians are not as healthy as others. Major health disparities exist throughout the country. These health disparities are not randomly distributed, rather they are differentially distributed between specific populations (for example, Aboriginal peoples), by gender, by educational attainment and income, and by other markers of disadvantage or inequalities of opportunity.

The most important consequences of health disparities are avoidable death, disease, and disability. The consequences of health disparities affect Canadian society as a whole and are inconsistent with Canadian values.

Health disparities are apparent in patterns of tobacco use. For example, according to the 2003 CTUMS data, as a percentage of overall smokers in Canada, among the lowest income groups 33.7 percent of women and 44.5 percent of men are current smokers; in the highest income groups, 21.2 percent of women and 22.1 percent of men are current smokers. The 2004 CTUMS data show that of current smokers 43% have less than or have completed secondary school, while 35% have completed college or university.

GENDER, SEX, AND TOBACCO USE

When investigating health disparities between men and women, health experts now recognize a distinction between gender and sex. Sex refers strictly to the biological and physiological characteristics that define men and women. Gender refers to the socially constructed roles, behaviours, activities, and attributes that society considers appropriate for women and men. People typically learn these roles and behaviours as they grow up and learn to identify them as either "feminine" or "masculine."

In 2004, Health Canada commissioned a review of current research literature on gender and tobacco use. *Gender and Tobacco Use: An Annotated Bibliography* culled research published between 2000 and 2005 from select high-income countries such as Australia, Canada, the European Union, New Zealand, and the United States. In total, 65 publications were included in the annotated bibliography.

While most researchers are cautious about their results, it seems more and more likely that women and men begin smoking for different reasons. There is also evidence to suggest that they quit for different reasons, and that cessation strategies need to be tailored to gender, as well as to age.

Biopsychosocial factors appear to be strong motivators for women and teenage girls to begin and continue smoking. In fact, a number of studies have noted that the most common predictor for smoking among female youth are weight concerns, especially the "drive for thinness."

Smoking as a way of reinforcing social image, bonding with peers, and controlling moods, seems to be more important to teenage girls than to teenage boys. Researchers also suggest that girls have fewer social resources to build positive self-images than boys have.

The tobacco industry has certainly capitalized on its knowledge of what motivates young people to take up smoking. It has portrayed smoking as emblematic of independence, glamour, and equality, advertising heavily in female-oriented magazines. It has also created brand images to exploit niche markets. For example, in addition to creating and promoting certain "light" brands as glamorous and sophisticated to appeal to teenage girls, it has also promoted other brands as exciting and adventuresome to appeal to young, working class men and women.

Some studies show lower quitting rates among women. We already know that one size doesn't fit all when it comes to cessation programs. What works for adults does not work for youth. In addition, it may be that cessation interventions should take greater account of the variations in women's life stresses, such as pregnancy, sole parenting, and menopause.

Both cessation and prevention interventions may need to address the biopsychosocial factors previously mentioned, as well as issues of self-esteem. While the research to date is indicative of possible changes to tobacco control strategies and techniques, further research and analysis is needed. There is a need, particularly in contexts where an explicit commitment to reducing health disparities exists, for clear and practical evidence-based guidance on how to adequately incorporate gender into policies and programs.

MOVING TOWARD A SMOKE-FREE SOCIETY

In 1999, Canada issued a revised tobacco control strategy, *New Directions for Tobacco Control in Canada: A National Strategy*. The revised strategy retained three long-standing tobacco control goals: prevention—keeping youth from smoking uptake; cessation—helping smokers quit; and protection—ensuring smoke-free environments. To these it added a fourth goal: denormalization—educating Canadians about the tobacco industry's marketing strategies and tactics, and about the health impacts of tobacco use.

Prevention

While there are a growing number of quitters in Canada, if we cannot convince young people to never start, the market for tobacco products will continue to renew itself.

While many avenues are pursued to achieve this goal, restricting sales of tobacco products to youth is crucial. Federally and in all provinces there are age limits for selling tobacco to discourage smoking among youth.

TABLE 2 | Retailer compliance monitoring, by province and territory, January–December 2004

	COMPLIANCE CHECKS[A]
Nfld. and Lab.	1 198
P.E.I.	584
N.S.	1 310
N.B.	1 967
Qué.[B]	4 045
Ont.	5 408
Man.	824
Sask.	1 383
Alta.	1 812
B.C.	14 123[C]
Yu.	83
N.W.T.	60
Nun.	0
TOTAL	**30 367**

[A] A retailer may undergo one or more checks.
[B] These compliance checks were conducted between April 1, 2004, and January 15, 2005.
[C] Following the Lagarde Best Practice model, each retailer receives at least one inspection and two compliance checks per year.
Source: Health Canada, Tobacco Control Programme, Office of Regulations and Compliance.

Compliance is verified and enforced through inspections and compliance checks. With an estimated 65 000 tobacco points-of-sale in Canada (including the territories), ensuring compliance is a major effort. In 2004 over 30 000 compliance checks were performed. (Table 2). The collection of compliance information varies by province and territory, some is collected by federal inspectors and some by provincial inspectors. In addition, some provinces make more than one visit per retailer, and some visits are educational rather than actual compliance checks.

In Nunavut, compliance efforts have begun with signs that must be displayed wherever tobacco is sold. These have been created to help retailers comply with regulations. In addition, a Tobacco Toolkit in English, French, Inuktitut, and Inuinnaqtun has been sent to every tobacco retailer.

Cessation

Quitting is a formidable task—tobacco is highly addictive. However, over the past two decades we have learned a great deal about the medical, psychological, and social aspects of tobacco use.

Among the more recent cessation tools, web-based programs and quitlines are providing information, motivation, and support to smokers throughout Canada. All provinces and Yukon now have toll-free quitlines, and all are part of a national network of quitlines.

Cessation interventions are becoming increasingly varied as we learn to tailor them to the needs of specific groups, whether that be youth, pregnant women, or users of spit tobacco. More cessation material is being translated, not just into Canada's two official languages, but into languages as diverse as Farsi, Punjabi, Chinese, Vietnamese, and Spanish.

Protection

Fifty years of research has established that cigarette smoke contains more than 4000 chemicals, including carbon monoxide, formaldehyde, benzene, and hydrogen cyanide. This health-destroying combination affects not just smokers, but everyone near them. The health of non-smokers exposed to cigarette smoke is just as compromised as that of smokers. Last year, over 1000 non-smoking Canadians died from causes attributable to tobacco.

While most provinces and territories, and more than 300 Canadian municipalities and regional governments now have some form of non-smoking legislation or bylaw, there are still gaps in protection. Most of these affect the more than 3 million Canadian workers who work in restaurants and bars. This past year, New Brunswick provided protection from second-hand smoke in indoor work places by introducing its *Smoke-free Places Act*. Saskatchewan amended its *Tobacco Control Act* to require that enclosed public places be smoke-free and to provide municipalities with jurisdiction to enact bylaws to restrict smoking in outdoor places such as open air sports grounds and entrances to public places.

Compliance with smoke-free legislation is regulated in a variety of ways depending on the jurisdiction and may involve coordinated activities. For example, in New Brunswick the *Smoke-free Places Act* is jointly enforced by Public Health Inspectors, Liquor License Inspectors, and Occupational Health Inspectors. Between October 2004 and March 2005, they handled 156 reported violations: 56, 75, and 25, respectively.

Through the efforts of individuals such as Heather Crowe, the risks of second-hand smoke are now more widely known and acknowledged. Although Heather Crowe never smoked, she spent all her working years breathing second-hand smoke in the restaurant where she worked. At 57, she developed lung cancer. Her story is far more compelling than any statistics could be.

Denormalization

Denormalization requires a multi-pronged approach. First, information on the hazardous and addictive nature of tobacco use clearly categorizes smoking as thoroughly undesirable. Second, individuals, particularly adolescents, are encouraged to view tobacco use as socially unacceptable. And finally, Canadians are being educated about the tobacco industry's marketing strategies and tactics. Even very young children need to understand marketing techniques so that they will not be as susceptible to the spurious links made by advertising between smoking and popularity, attractiveness, and rebellion against conformity.

The 1997 *Tobacco Act* comprehensively restricted all tobacco product promotion, including a ban on lifestyle advertising and sponsorship promotions. It is prohibited to offer free tobacco products, and sales promotions are restricted. Six provinces now have legislation that contains restrictions against various forms of advertising, display, or promotion of tobacco products.

PROGRESS IN STRATEGIC DIRECTIONS

The National Strategy's goals—prevention, cessation, protection, and denormalization—are interconnected, so that many tobacco control initiatives have overlapping impacts even when they are designed to address a single goal. For example, legislation that establishes smoke-free environments protects people from the effects of second-hand smoke and supports those who are trying to quit. It also encourages denormalization. For example, legal action in British Columbia has for many years drawn the public's attention to the health hazards associated with tobacco use and how the industry has strategically worked to deceive them. British Columbia's efforts encourage other provinces to pursue cost recovery litigation. This can result in a coordinated and unified approach that reduces duplication. Because of these overlapping impacts, it is easier to group initiatives by strategic direction.

The five strategic directions are

- policy and legislation;
- public education;
- industry accountability and product control;
- research, evaluation, and monitoring; and
- building and supporting capacity for action.

The growth and development of tobacco control initiatives over the past five years makes it impossible to present more than a small sample of them to illustrate the types of efforts being made.

Policy and legislation

Canada is internationally recognized for its success in legislating the tobacco industry. At all levels—federal, provincial, territorial, and municipal—successful tobacco control legislation has been passed and implemented. Each year, legislation is added or refined. Developing policies and strategies also play a critical role in tobacco control.

At the time of the first *Moving Forward* in 2001, Canada was taking part in efforts led by the World Health Organization to develop an international convention on tobacco control. Canada was among the first 40 countries to successfully ratify the Framework Convention on Tobacco Control, the first global public health treaty. It went into force on February 27, 2005.

ENACTING AND AMENDING LEGISLATION

In June 2004, **New Brunswick** introduced the *Smoke-free Places Act*, which came into force on October 1, 2004. Smoking will no longer be permitted on school grounds, in retail stores, community halls, conference centres, sports arenas, educational buildings, bingo halls, bars, restaurants, and all indoor workplaces. The Act does not allow designated smoking rooms in any public or work places other than residential facilities (e.g., nursing homes, special care homes) or in tourist accommodation rooms designated for smoking.

On December 6, 2004, the **Newfoundland and Labrador** government announced a smoking ban in bars, clubs and bingo halls would become a reality following province-wide consultations. The consultations, held from February 2 to 25, 2005 assisted government in determining target dates for implementation and allowed individuals and organizations to offer their perspective and provide input on the best approach to achieve government's goal. The new Smoke Free Environment Act, 2005, banning smoking in bars and bingo halls, should take effect July 1, 2005.

In 1998, **Quebec's** *Tobacco Act* came into force with a requirement that the Minister of Health and Social Services report to the government by October 2005. In preparation for presenting measures to strengthen the Act, a public consultation was held between January 11 and February 25, 2005.

Effective October 1, 2004, **Manitoba** introduced a province-wide smoking ban in those enclosed public and indoor work places where the government has clear jurisdiction.

Saskatchewan amended its *Tobacco Control Act* in June 2004. It now includes provisions that require enclosed public places to be smoke-free as of January 1, 2005, and provisions that provide municipalities with jurisdiction to enact smoke-free bylaws in outdoor places such as open-air sports grounds and entrances to public places. The Act and its Regulations also prohibit the provision of cigarettes to anyone under the age of 18 and ban the display and promotion of tobacco products in places where youth have access and where tobacco is sold. They also specify fines and suspensions for retailers and employees who sell tobacco products to individuals under 18 and for individuals and proprietors who smoke or allow smoking in enclosed public places.

In **Alberta**, the *Prevention of Youth Tobacco Use Amendment Act* and Regulation was proclaimed in September 2004. It prohibits the possession or use of tobacco in a public place by youth under the age of 18. It exempts Aboriginal youth who are using tobacco as part of a traditional ceremony, youth test shoppers checking retailer compliance, and youth selling tobacco as part of a job.

New tobacco control legislation was introduced in the **Ontario** legislature in December 2004. The *Smoke-Free Ontario Act* is intended to prohibit smoking in enclosed public and work places beginning in May 2006.

In 2004, public hearings were held across **Prince Edward Island** to solicit input from Islanders about retail sales of tobacco products. Many private citizens and organizations made presentations to the Standing Committee on Social Development, which then proposed amendments to strengthen the *Tobacco Sales to Minors Act* and to prohibit tobacco sales in designated places. The amended legislation received Royal Assent on December 16, 2004. To reflect the more encompassing nature of the amended legislation, the Act will be renamed the *Tobacco Sales and Access Act*.

IMPLEMENTING TAX INCREASES

On March 30, 2005, **Newfoundland and Labrador** increased tobacco taxes by $2.00 per carton of 200 cigarettes and by $5.00 per 200 roll-your-own cigarettes (100g). This is an initial step toward closing a loophole that allows roll-your-own cigarettes to be taxed at a lower rate than cigarettes.

Since November 2003, **Ontario** has increased tobacco taxes three times, for a total increase of $6.25 per carton. This moves Ontario's tobacco taxes closer to the national average.

DEVELOPING POLICIES AND STRENGTHENING STRATEGIES

Newfoundland and Labrador has renewed its Tobacco Reduction Strategy and set priorities for 2005 through 2008. The Strategy, lead by the Alliance for the Control of Tobacco, in partnership with the Department of Health and Community Services and other key partners, will develop and implement strategies to decrease smoking rates among youth and young adults, to reduce exposure to second-hand smoke, and to develop a coordinated approach to cessation.

In January 2005, **Nova Scotia** released its first Tobacco Control Strategy Progress Report. The report summarized progress in implementing all seven elements of the province's Tobacco Control Strategy between October 2001 and March 2004. During this time action had been taken on all elements of the Strategy, and smoking rates among youth and adults had declined.

On May 31, 2005, **Ontario** announced $50 million for fiscal year 2005–2006 for an enhanced and comprehensive tobacco control strategy—the Smoke-Free Ontario Strategy. This is the largest tobacco control investment in the province's history.

In **Alberta**, the Aboriginal Tobacco Use Strategy was implemented to address tobacco use among off-reserve Aboriginal people. Over the 2004–2005 fiscal year, 16 tobacco reduction grants were awarded to Aboriginal community groups off reserve for prevention, reduction, cessation, and protection activities. A variety of resources were developed within this Strategy, including the video *The Sacred Use of Tobacco*, produced by an Elder on the Guiding Circle. This video is now available to Aboriginal groups.

PROVIDING SMOKE-FREE SPACES

In **Nova Scotia**, the Capital Health District Health Authority established a 100%-tobacco-free policy for its mental health facilities. In January 2005, smoking rooms in its mental health facilities were closed, and tobacco products are no longer permitted in the units. This policy was developed and implemented by a committee of mental health professionals with assistance from Addiction Prevention and Treatment Services. They considered many key factors in patient care and comfort, and developed withdrawal management protocols and set up tobacco intervention support groups. Staff received training, families were provided open forums, and patients were given increased recreation opportunities, equipment, and events. Nicotine replacement therapies are also available.

COURT RULINGS

On January 19, 2005, the Supreme Court of Canada ruled in **Saskatchewan's** favour and concluded that there is no conflict between the provincial *Tobacco Control Act* and the federal *Tobacco Act*. This ruling upheld section 6 of Saskatchewan's legislation and allowed for the display of tobacco and tobacco related products to be banned in those establishments accessible to youth.

In May 2004, the **British Columbia** Court of Appeal unanimously upheld the province's right to sue the tobacco industry and concluded that the *Tobacco Damages and Health Care Costs Recovery Act* is constitutional.

Public education (information, mass media, programs, and services)

The intent of this strategic direction is to ensure that Canadians have access to information about tobacco and services that foster prevention, cessation, protection, and denormalization.

SERVING DIVERSITY

We are beginning to provide information and services, not only in Canada's two official languages, but in the mother tongues of our diverse population.

In Manitoba, **Health Canada** funded a bilingual health resource centre that produced a French-language DVD/video using performers doing stand-up comedy. The performers are all ex-smokers who tell about their experiences in becoming non-smokers.

In **British Columbia**, QuitNow by Phone, a partnership with the British Columbia Lung Association and Clinidata Corporation, is now open seven days a week, 24 hours a day so that callers can seek help when they need it most. Callers can also access the service in their language of choice through a translation service that provides translation in over 130 languages. Callers to QuitNow by Phone have access to specially trained registered nurses who counsel callers based on a stepped care protocol designed by Dr. Paul McDonald from Waterloo University.

In the British Columbia/Yukon region, **Health Canada** funded the translation of a brochure on quitting smoking into six languages: Farsi, Punjabi, French, Chinese, Vietnamese, and Spanish.

Between 2003 and 2004, the **Canadian Cancer Society–New Brunswick Division** and the **New Brunswick Anti-Tobacco Coalition** launched the "Yes I Do Mind" bilingual media campaign to encourage non-smokers to "Speak Up" for 100% smoke-free spaces legislation. The initiative's toll-free line and website received over 36 000 responses. When the *Smoke-free Places Act* went into effect in October 2004, two bilingual media campaigns were launched: "Your Favourite Places are Getting Even Better"—to support local hospitality businesses—followed by the "Enjoy Smoke Free NB" campaign.

Nunavut launched a radio media campaign on harm reduction, awareness, and cessation methods. Each PSA had two women throat singers chanting "quit smoking" in the background, which put tobacco reduction in a culturally familiar framework for Nunavummiut.

MEETING THE NEEDS OF SPECIFIC GROUPS

Programs are becoming more sophisticated as they address the particular needs of very specific groups. As mentioned in the section on gender, sex, and tobacco use, pregnancy is a life stress that places certain demands on women. Services are being developed that are tailored to women's needs during pregnancy.

In **Nunavut**, special "quit kits" were prepared for pregnant women that include information about the effects of tobacco use on themselves and their babies, tips on quitting, and where to turn for help, along with useful items such as a water bottle, toothbrush, toothpaste, and baby bibs.

The Cessation in Pregnancy Advisory Committee in **Alberta** helped develop several resources, including the Small Steps Matter self-help booklet for pregnant women who smoke, the video "A Time to Quit" and discussion guide, and a Continuing Medical Education course on tobacco reduction through the College of Family Physicians of Canada.

A partnership between **Health Canada**, the **University of British Columbia**, the **B.C. Centre for Excellence for Women's Health, Dalhousie University**, and **British Columbia** is responsible for *Expecting to Quit*, which examines the effectiveness of strategies for smoking cessation both during pregnancy and into the postpartum period.

Cigarettes are not the only route to tobacco addiction. Boys playing on sports teams are at high risk of using spit tobacco and need deterrents to its use.

The **Alberta** Spit Tobacco Education Program (ASTEP) provided funding to seven offices to carry out community initiatives to reduce the use of spit tobacco. The funding produced resources with spit tobacco messaging and supported local spit tobacco reduction activities with sports teams, whose members are at high risk of using spit tobacco. Members of the Alberta Dental Hygienists Association received a self-study guide about the harms associated with spit tobacco. The guide also suggests ways to teach their patients about spit tobacco harm.

CREATING INCENTIVES

Prince Edward Island launched its first Quit and Win–Don't Start and Win Campaign with 2905 Islanders registered to stay smoke free for the month of May 2004. Of these, 329 pledged to quit, which is 1.4% of P.E.I. smokers. A campaign highlight was the teen response: 10% of P.E.I.'s teen smokers entered Quit and Win. Evaluation results showed that over 70% of participants were able to quit for the campaign month, with over 30% still smoke free at the three-month follow-up. The contest used P.E.I.'s toll-free quit smoking line as the point of contact, which tripled the calls to the Smokers' Helpline that month.

Quebec's 2005 Quit and Win (J'arrête, j'y gagne) campaign attracted 32 015 participants.

INFORMATION AND MASS MEDIA CAMPAIGNS

In Fall 2004, the **Newfoundland and Labrador Alliance for the Control of Tobacco** implemented the "Let's Shut the Last Door on Second-Hand Smoke" mass media campaign. The campaign asked the entire population of Newfoundland and Labrador to "speak up" in support for 100% smoking bans in all indoor public places and workplaces, in particular in bars and bingo halls. Over 10 000 posters were distributed through doctors and nurses, and schools, hospitals, unions, and other organizations. The website registered 24 000 votes for a complete ban on smoking in all public places and workplaces. More than 2500 people called the toll-free number to voice their support. Most significantly, in December, when it announced that it would move forward with a smoking ban in all indoor public places and workplaces, the government quoted the campaign's slogan.

Nova Scotia launched "Smoke Free Around Me" to spread the word about the dangers of second-hand smoke in homes. It was augmented by a brochure and a Smoke-free Home window cling that was mailed to every household in the province. This campaign was originally developed by Public Health Services in Guysborough Antigonish Strait and the Cape Breton District Health Authorities. The evaluation was so positive that it was expanded to cover the entire province.

The **Alberta** Tobacco Reduction Strategy includes an ongoing public awareness campaign, which develops public awareness messages for mass media delivery. According to preliminary evaluations by IPSO Reid, over the past three years it has been very successful, far exceeding the usual recall for health messaging.

The **Heart & Stroke Foundation of BC/Yukon** is the force behind: "Drifting Tobacco Smoke in Multi-Family Dwellings: A Project for Raising Awareness and Disseminating Information on Protecting People from Exposure to Second-Hand Smoke in the Home." This project raises awareness about unwanted second-hand smoke drifting into private residences from neighbouring units in multi-family dwellings. Information is distributed to communities on what can be done to minimize or eliminate drifting smoke.

IT'S A BLAST!

BLAST—Building Leaders for Action in Schools Today—and similar programs for youth have discovered the attraction of camps, conferences, and weekends away. Teens learn, bond, and have fun while they grow in their commitment to stay smoke free.

For students in grades 7 through 9, **Northwest Territories** held its third BLAST Conference. The two-day conference offers tobacco education as well as leadership and planning skills. Students return to their communities to help educate their peers and reduce tobacco use. This youth leadership model has resulted in a variety of youth projects including three weekend tobacco conferences hosted by schools.

Nunavut's youth group, MYATT, (Minister's Youth Action Team on Tobacco) held its annual workshop. Members were trained in minimal contact intervention techniques to use in their communities in everyday situations with friends and family.

In **Alberta**, BLAST camps were held in four locations with a total of 270 students participating. Students learned about tobacco reduction, team building, leadership, personal empowerment, and advocacy. Thirty-four projects were funded.

The **Saskatchewan** Youth Conference was held in November 2004 in a rural setting and attracted 79 grade 6 through 9 youth and adults. Several youth travelled as much as 13 hours from northern reserves to attend. Participants were offered sessions on smoke-free school zones, the negative health effects of tobacco, leadership, and self esteem.

In a rural camp setting, 59 youth from grades 9 through 12 participated in the **Manitoba** Youth Conference in November 2004. During the weekend, they participated in sessions that covered information about the tobacco industry, the negative health effects of tobacco, Manitoba's tobacco control legislation, and positive self images. There were sessions available in French as well.

ESPECIALLY FOR YOUTH

Young Spirits: Proud to be Tobacco Free is a three-year anti-tobacco initiative with funding from **Health Canada**. The two components are a school-based element for grades 5 through 9 students encouraging them to develop and implement an anti-tobacco project, and a Saskatchewan-wide radio advertising campaign, with production assistance from Missinipi Broadcasting Corporation. This year's radio campaign ran from mid-January to the end of March 2005. This is the last year of the initiative.

The **Medical Society of P.E.I.**, a member of the P.E.I. Tobacco Reduction Alliance, completed a very successful education initiative, Staying Smoke Free. Physicians deliver a tobacco prevention presentation to every grade 6 class in the province. A brochure and two videos accompany the presentations, one for students and one for their parents. In the videos, local teens, including members of the SWITCH prevention clubs, speak directly to youth and parents.

On January 28, 2005, in Montréal, **Quebec**, 500 high school students attended "Etre allumé," a multidisciplinary presentation showcasing ten Quebec artists. Musique Plus broadcast a one-hour version three times, and the show was carried on the Internet through the website of Les Gangs allumées. Les Gangs allumées are youth throughout Quebec who organize tobacco control projects—around 300 projects a year.

Targeted to 12 to 15 year olds, **Ontario's** "stupid.ca" website has received more than 500 000 unique visits. This website is part of a multi-media youth prevention campaign that includes television and magazine ads. In addition to winning several national and international awards for advertising and website design, 84% of the 12 to 15 year olds surveyed said that stupid.ca was highly effective at delivering key messages about youth smoking prevention and the dangers of smoking. Recall was strong with 51% spontaneously recalling stupid.ca at the end of the ad campaign.

Between September and December 2004, **Manitoba** offered its Review & Rate Program in 800 schools. Over 31 000 students from grades 6 through 12 viewed 12 anti-tobacco TV ads and voted for the one they thought the most effective. The top scoring ad, with over 8009 votes, was run by Manitoba TV stations during March 2005.

The **Northwest Territories' "Don't be a Butthead, Be Smokefree"** campaign was a major tobacco control activity in 2004 and 2005. A humorous character, "Butthead," spreads a serious message to youth between 8 and 14 years old. The focus is on motivating children who do not smoke to stay smoke free for life. A key objective was to obtain 500 youth commitments to stay smoke free—over 2200 youth responded with written commitments. The campaign was augmented by a website, a teacher's kit, a video, and an interactive display. Another campaign component targeted parents through newspaper, radio, and television advertising.

In **Quebec**, 34 000 high school students "rocked out" during 92 performances of "In Vivo," a rock theatrical created to spread the word about the effects of tobacco use.

In 2002, the **New Brunswick** Department of Health and Wellness, supported by the Department of Education initiated a grant-to-schools program to help reduce tobacco use by students, and to help schools become 100% tobacco free as required by legislation effective October 2004. Over the three-year grant period, 97% of high schools have accessed funding—about $250,000 in all. Because research indicates that student involvement is important in influencing health choices and behaviour, a key criteria for eligibility is a comprehensive school health approach—active student and student group participation. Schools have developed innovative and creative approaches often involving various classes, as well as joint student–teacher–parent activities. These initiatives have been so successful that the grant program has been extended.

Building and supporting capacity for action

The Smoke Screening program is a joint initiative of **Northwest Territories**, **Yukon**, and **Nunavut**. First conducted in 2003, it was so popular that it was repeated in 2004–2005. The program has had an enthusiastic response again this year with 3924 student ballots returned and 78 out of 98 schools from all three territories participating. Students in grades 6 through 12 viewed 12 of the best tobacco education TV ads from around the world and voted for the one they felt is most effective. This process generates good classroom discussion on a variety of issues related to tobacco use and has received very positive feedback from teachers.

To mobilize six groups of health professionals in **Quebec**, the government has, through the Institut national de santé publique du Québec, allocated $60,000 per profession to develop appropriate cessation training and tools. The health professionals include doctors, dentists, pharmacists, nurses, dental hygienists, and inhalation therapists.

The **Saskatchewan Coalition for Tobacco Reduction** initiated a tobacco-free school zones project that focuses on a comprehensive approach to controlling tobacco use by youth through policy development, support for cessation and smoke-free spaces, and increased awareness of the tobacco industry's activities. Saskatchewan Health provided funding for a conference in 2004 to bring youth together and prepare them to undertake this work in their schools.

In August 2004, the **Newfoundland and Labrador** Department of Health and Community Services collaborated with the Department of Education to complete the *Smoke-free Spaces Activist Toolkit* CD-ROM pilot project. The outcomes of this school-based project demonstrated that youth took a leadership role in implementing action plans that developed partnerships, created awareness, and affected positive change in their schools and communities. While increasing general awareness about the dangers of second-hand smoke was prominent, there were also activities related to changing policy. This project enabled students and adults to build capacity at the local level around the issue of second-hand smoke. They demonstrated that with a combination of enthusiasm, vision, and leadership, youth and adults working together could make a difference.

In **Ontario**, Cancer Care Ontario used its Aboriginal Tobacco Strategy to mobilize and engage Aboriginal communities in culturally-appropriate tobacco control strategies to promote tobacco-wise communities. Expanded funding allowed four additional communities to work on pilot projects in prevention, policy development, public education, and cessation.

The **New Brunswick Advisory Council on Youth** and the **New Brunswick Anti-Tobacco Coalition** have joined forces to establish a network of youth (ages 15 to 24) province-wide to help with tobacco control efforts. The official launch of the Youth Against Tobacco Network took place at the New Brunswick Student Leadership Conference in November 2004. Over 100 enthusiastic youth took part by brainstorming tobacco use issues and solutions. Participants were challenged to initiate tobacco awareness projects to their schools and communities.

Partners for Rural Family Support sponsor Youth Empowerment Strategies (YES) in rural Saskatchewan. There are 14 active YES teams in 10 communities with approximately 100 youth involved. The goal of the project is to promote healthy lifestyles, provide tobacco awareness information to youth, foster leadership skills, and teach the peer-to-peer instruction model.

In 2003 in **Nova Scotia**, the Cole Harbour Soccer Club (CHSC), in partnership with Capital Health, implemented a tobacco-free policy. Evaluation showed that the initiative was successful in achieving a high level of awareness, comprehension, and acceptance of the tobacco-free soccer message and policy among parents, players, and coaches. In 2004–2005, based on the success of the CHSC policy work, a number of community organizations partnered to develop a new resource: *Tobacco-Free Sport and Recreation: How to Get There*.

In support of provincial smoke-free legislation, **Health Canada** hosted one-day workshops in Manitoba and Saskatchewan to showcase the Health Canada document: "Towards a Healthier Workplace: A Guidebook on Tobacco Control Policies." These workshops support people who are creating or strengthening tobacco control policies in their workplaces.

Community Health Representatives in **Nunavut** received training in minimal contact intervention techniques to use with clients in everyday situations in their communities. Nunavut's entire tobacco control team consists of only two positions a Tobacco Control Facilitator, a position recently created and a Tobacco Reduction Specialist.

The British Columbia provincial government works closely with NGOs, Health Authorities, and other stakeholders under the **ActNow** banner, which promotes tobacco reduction as well as good nutrition, physical activity, and healthy pregnancy initiatives. One ActNow partner is the **BC Healthy Living Alliance**, a coalition of organizations whose representatives include CEOs and executive directors from major provincial health promotion and chronic disease prevention organizations. The Alliance recently released "The Winning Legacy," which is a prevention plan for improving the health of British Columbians by 2010.

Industry accountability and product control

The Canadian Cancer Society, Nova Scotia Division, Capital Health and **Nova Scotia Health Promotion** partnered to conduct an environmental scan of tobacco industry marketing and promotion tactics in Nova Scotia. The scan focused on tactics that target youth and young adults. Bars, nightclubs, and retail stores in six communities were included. The results of the scan have been used to educate communities in order to inform more effective tobacco control policies and programs to reduce smoking among youth and young adults.

New health warning signage regulations came into effect in **British Columbia** on April 15, 2005. The Tobacco Sales Regulation was amended to include five new graphic health warning signs.

Research, evaluation, and monitoring

The **Canadian Tobacco Control Research Initiative** (CTCRI) is a collaboration between a group of Canadian agencies and government departments. Current major funding partners are the six Canadian Institutes of Health Research, the National Cancer Institute of Canada, the Canadian Cancer Society, and Health Canada. With an annual budget of over 3.5 million dollars it is the largest national initiative funding tobacco control research.

In June 2004, CTCRI awarded 5 million dollars to 18 successful teams of 77 investigators for research to be conducted between 2004 and 2009. This is the largest sum of grants given to tobacco abuse and nicotine addiction research in Canada in a single strategic initiative.

In December 2004, CTCRI launched an innovative multi-year grants program to support community-based, multi-sectoral research related to nicotine addiction. Among the target groups for this program are Aboriginal communities, women, and children and youth.

In 2004, with assistance from Health Canada, **Northwest Territories** Department of Health and Social Services, and Bureau of Statistics completed the first Northern Tobacco Use Monitoring Survey. The data collected is comparable to data collected through CTUMS and will help give direction to tobacco control strategies and programs for NWT.

British Columbia is involved in a number of research activities including the Youth Access to Tobacco Research Project, which includes an environmental scan of youth access programs in other jurisdictions, an assessment of youth access to tobacco within the province broken down by age sub-sets (13 to 15 year olds and 16 to 19 year olds), identification of programming gaps, and recommendations for program, policy, or legislative improvement. To foster an exchange of knowledge between researchers and practitioners, B.C.'s **Clean Air Coalition**, in partnership with Health Canada, B.C.'s Ministry of Health, and the B.C. Cancer Agency, supports a "Breakfast Club."

A survey, commissioned by the **Newfoundland and Labrador Alliance for the Control of Tobacco** (ACT) in April 2005, indicates that residents of Newfoundland and Labrador are exposed to less second-hand tobacco smoke than ever before. The survey was designed to measure the success of a three-year mass media campaign (*Second Hand Smoke—It Kills*). The campaign was develop by ACT and funded by **Health Canada**. The results are encouraging, indicating that exposure to second-hand smoke has decreased significantly, particularly among children. Some key findings:

- In 2003, 31.7% of smokers indicated they smoked in the presence of children. In 2005, that number dropped to 9%.
- Eighty percent of respondents agree with the provincial government's plan to ban smoking in all public places, including bars and bingo halls.
- Ninety percent of smokers polled recall seeing anti-smoking ads in the past year, an encouraging statistic, as the campaign targeted smokers.

During the 2004–2005 fiscal year, **Health Canada** and the Drug Strategy and Controlled Substance Programme tested messages on tobacco and marijuana designed to help youth develop skills to resist pressure to smoke tobacco and/or marijuana. The target group was youth aged 10 to 19. Findings indicate that messages on tobacco and marijuana should be separated.

In **New Brunswick**, the University of New Brunswick Faculty of Education, which is a member of the New Brunswick Anti-Tobacco Coalition research network, organized data-collection activities for Health Canada's National Youth Smoking Survey in conjunction with a Pan-Canadian network of researchers. A sample of students in grades 5 through 9 from 24 schools were surveyed during the 2004–2005 school year. Each educational jurisdiction received personalized smoking profile reports to support knowledge transfer and action at the school level.

CONCLUSION

In 2001, the first *Moving Forward* reported that British Columbia had completed a two-year pilot project—a quitline. This quitline, one of the first in Canada, became the foundation for B.C.'s present quitline, which now offers callers their choice of languages—130 of them.

By 2003, there were smoker's quitlines in every province and Yukon. Ontario logged 7132 calls between April 2002 and February 2003—around 22 calls a day. In 2005, the quitline in B.C. was receiving more than 300 calls a month. Over the past five years, quitlines have become a valuable and easily available aid to smokers who want to quit.

As of 2005, there is now a national network of quitlines. Some quitlines even operate 24-hours a day, seven days a week.

It has been the same story with so many other tobacco control initiatives: an idea evolves into a pilot project, a pilot project becomes a program; it spreads to other communities where it is improved, refined, and expanded. Youth conferences and camps, media campaigns, websites, Quit and Win Contests, school programs—all have benefited from cooperation, collaboration, and partnering.

In other tobacco control arenas, the story is much the same. Every time a jurisdiction successfully introduced a tobacco control strategy or policy, legislation or regulations, it became easier for another jurisdiction to consider taking a similar action.

Five years, especially in the context of tobacco control, is a very short time. Yet during that period we have gained knowledge, developed resources, and created tools. We have steadily and systematically gathered data—comparable data suitable for research. The National Strategy released in 1999 has taken us further down the road to a healthier society.

Yet, as noted in Tracking Key Indicators, as the prevalence rate declines at a slower pace, Canada appears to be approaching a more difficult to reach population of Canadian smokers. With data from the North and with an analysis of health disparities, we know that there can be systematic variations in the distribution of tobacco use. Perhaps it is time to once again revisit our national strategy and target those harder to reach populations using tactics specifically designed to meet their needs.

APPENDIX A:

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