The National Strategy:

Moving Forward

The 2002 Progress Report on Tobacco Control

Prepared by the Canadian tobacco control community:

The Working Group on Tobacco Control
of the Federal Provincial Territorial Advisory Committee on Population Health
in partnership with non-governmental organizations.

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Introduction

The average smoking rate across the ten provinces declined in 2001 to its lowest level—22 per cent—since regular monitoring began in 1965, when it was estimated that 50 per cent of Canadians smoked. While this report will point out other percentages that are not as pleasant to review, clearly Canada's ongoing efforts to reduce tobacco use are having an impact.

Since 1999, those efforts have been guided by a framework for action implemented when the federal, provincial and territorial ministers of health endorsed a revised tobacco control strategy: *New Directions for Tobacco Control in Canada: A National Strategy*. Developed with knowledge gained from previous efforts, the National Strategy emphasizes sustained, comprehensive, integrated and collaborative approaches to reducing tobacco use. It encourages shared responsibility among all levels of government—federal, provincial, territorial and local—and with non-governmental organizations.

The revised National Strategy retained three long-standing goals: prevention—keeping youth from starting to smoke; cessation—helping smokers to quit; and protection—ensuring smoke-free environments. To these goals, it added a fourth: denormalization—educating Canadians about the marketing strategies and tactics of the tobacco industry and the effects the industry's products have on the health of Canadians so that social attitudes toward tobacco will be consistent with the hazardous, addictive nature of tobacco products.

The National Strategy is based on a population health framework that takes into consideration social, economic and environmental factors that influence smoking trends, as well as personal health practices and coping skills, and the accessibility of appropriate services.

Within the context of the National Strategy, the Government of Canada announced in the spring of 2001, that it would invest $560 million (including $58 million in existing funds) in a new Federal Tobacco Control Strategy over the next five years. This amounts to almost five times the investment that was made in the previous initiative. These monies are distributed among Health Canada, the Department of the Solicitor General, the Royal Canadian Mounted Police, Justice Canada and the Canada Customs and Revenue Agency. Health Canada has responsibility for $480 million of the allocated funds.

Building on past experience and taking into consideration the principles outlined in the National Strategy, the Federal Tobacco Control Strategy sets out objectives for a 10-year period that include reducing the average smoking prevalence rate to 20 per cent, decreasing the number of cigarettes sold by 30 per cent, increasing retailer compliance with sales-to-youth regulations from 69 per cent to 80 per cent, reducing the number of people exposed to second-hand smoke, and exploring how to mandate changes to tobacco products so that they will be less harmful for those individuals who continue to smoke or who are exposed to smoke.

To make sure that Canada continues to move forward toward the ultimate goal of reducing the number of tobacco-related deaths and illnesses, measuring progress toward individual goals is a necessary component of the National Strategy. Given the length of time between the implementation of initiatives and their impact, key indicators must be identified and tracked regularly over a long period of time. In fact, it is not possible to present statistically significant measures for individual activities. It is the aggregate impact of individual interventions over time that will eventually become measurable.

The 2002 report is the National Strategy's second annual progress report. The first report identified information currently available, noted trend data and tried to establish, where possible, baseline data for previously unreported indicators. As much as possible, with the data available, the first progress report attempted to provide an overview of tobacco control in Canada. This second report takes a more focused approach by concentrating on prevalence and consumption statistics and by providing examples only of progress made by the wide variety of initiatives carried out across the country. Next year's report will again provide a broader view, as the reports alternate each year between comprehensive and more focused. Since statistical analyses of a full year of Canadian Tobacco Use Monitoring Survey (CTUMS) data are available in late spring, each report will, in general, include CTUMS data from the previous full year and examples of progress on initiatives, from spring to spring.

To stay within a shortened format, the federal, provincial and territorial governments were invited to submit just one or two items each. With the proliferation of tobacco control efforts throughout the country, the selection process was difficult and there are a number of upcoming initiatives that will be presented in next year's report. The Working Group on Tobacco Control of the Advisory Committee on Population Health (ACPH) chose items so that there would be examples representing each of the five strategic directions of the National Strategy and each of the provinces and territories. Since non-governmental organizations make substantial contributions to various aspects of tobacco control in Canada, this year the ACPH is pleased to be able to include examples of initiatives and activities of some of those organizations.

Ideally, this progress report would present only outcomes and results of initiatives, interventions and activities. However, throughout Canada there are still so many first steps being taken in tobacco control and so many of these still developing, that anecdotal material on these efforts is included with the expectation that future reports will be able to report outcomes. While a minimum number of examples have been chosen this year, they do represent a burgeoning growth in tobacco control initiatives nationwide. Momentum continues to build as governments, organizations and individuals work to achieve a society where as few Canadians as possible are addicted to tobacco products.

Tracking Key Indicators

This annual progress report to the Ministers of Health tracks changes in the prevalence of smoking in Canada (how many Canadians smoke) and in cigarette consumption (the average number of cigarettes smoked by daily smokers).

Prior to 1999, the collection of prevalence data was sporadic and inconsistent. In 1999, Health Canada initiated the Canadian Tobacco Use Monitoring Survey (CTUMS) to collect on an ongoing basis, up-to-date, reliable and comparable data on tobacco use in Canada. Statistics Canada, which conducts CTUMS for Health Canada, provides half-year (Wave 1 and 2) and yearly data provincially with a national roll-up, using a full-year sample size of about 20,000 respondents. About 50% of those surveyed are between 15 and 24 years of age. The turn around time for CTUMS data—six months—is much shorter than previously conducted surveys.

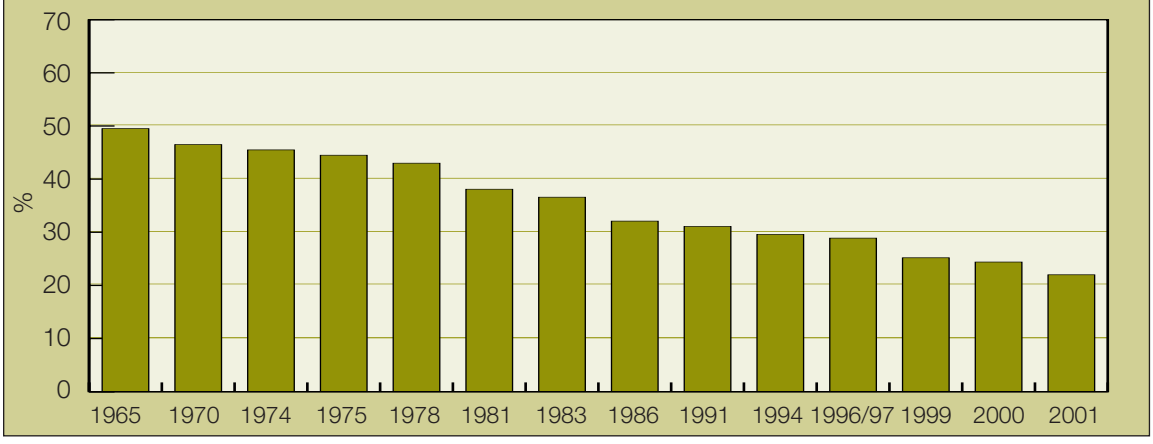
Historically, national surveys such as CTUMS have not collected data in the northern regions of Canada because of high cost. This created a data gap for a population in which tobacco use was suspected to be the highest in the country—perhaps as high as 62% for First Nations and 72% for Inuit.

To address this data gap, Health Canada developed the Northern Usage of Tobacco, Alcohol and Illicit Drugs survey. Initiated in 2002, this survey will provide data on tobacco use that will be similar to data provided by CTUMS. Data are collected in Yukon, Nunavut and Northwest Territories in two cycles per year.

Smoking prevalence in Canada

According to the 2001 CTUMS results, the Canadian smoking prevalence rate is the lowest since regular monitoring of smoking began in 1965 when it was estimated at 50%. Slightly more than 5.4 million Canadians, about 22% of the population aged 15 and older, smoked daily or occasionally in 2001. (Figure 1)

Figure 1 Prevalence of Canadian current smokers, aged 15 years and over, 1965–2001

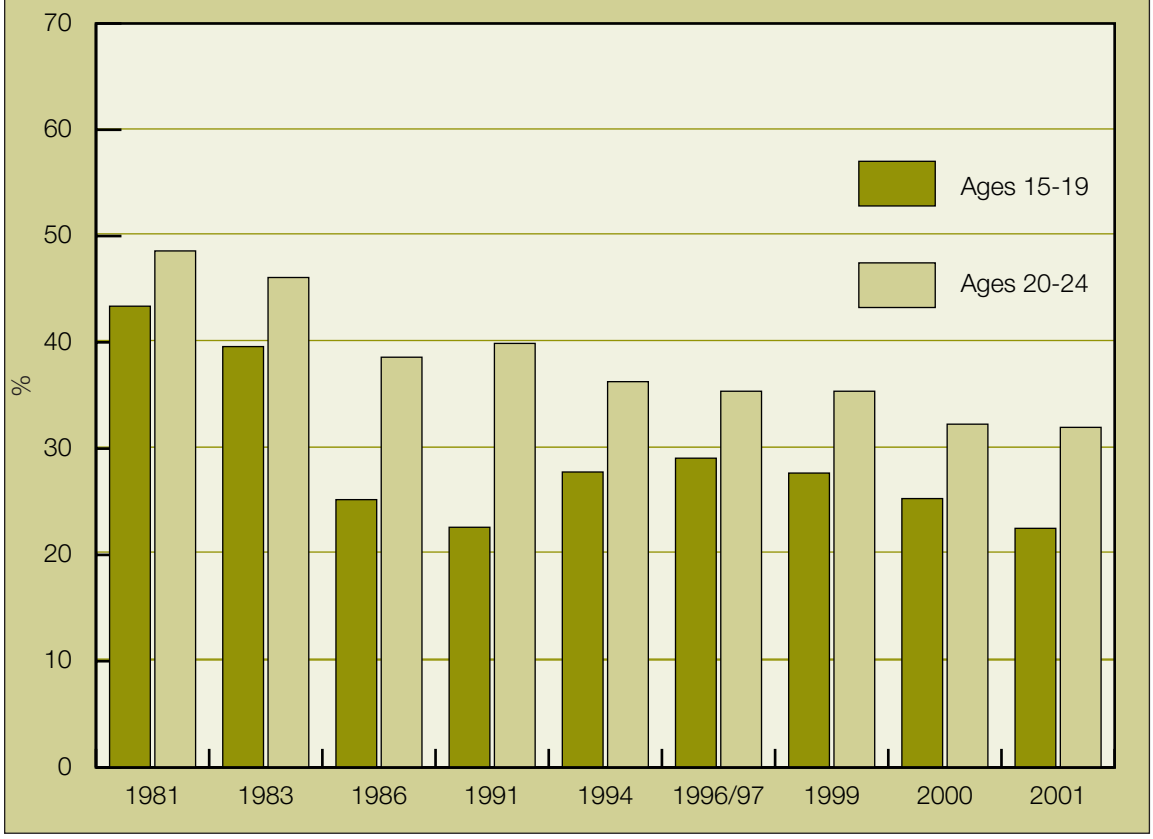


Sources: Labour Force Survey Supplement, 1965-1975, 1981-1986; Canada Health Survey, 1978; General Social Survey, 1991; Survey on Smoking in Canada,1994; National Population Health Survey 1996/97; Canadian Tobacco Use Monitoring Survey (Annual), 1999-2001.

While the overall smoking prevalence rate and those for men and women have exhibited a steady decline over the past 35 years, the prevalence rate for youth aged 15 to 19 years has not shown the same steady decline. During the 1990s, the rate for teens aged 15 to 19 rose to around 28%, but has been slowly declining in the past few years. (Figure 2) In 2001, about 22% of teens aged 15 to 19 reported that they smoked. More teen girls (24%) smoke compared to teen boys (21%).

While young adults aged 20 to 24 still have the highest smoking rate of any age group—32%—this is a slight decrease since the 2000 CTUMS survey. (Figure 2) In 1981, 47% of young adult men in that age group smoked, while in 2001 just under 35% reported smoking. In 1981, the rate for 20- to 24-year old women was even higher—50%, however, in 2001 that rate had dropped to 29%.

Figure 2 Prevalence of Canadian current smokers, by youth age group, 1981–2001

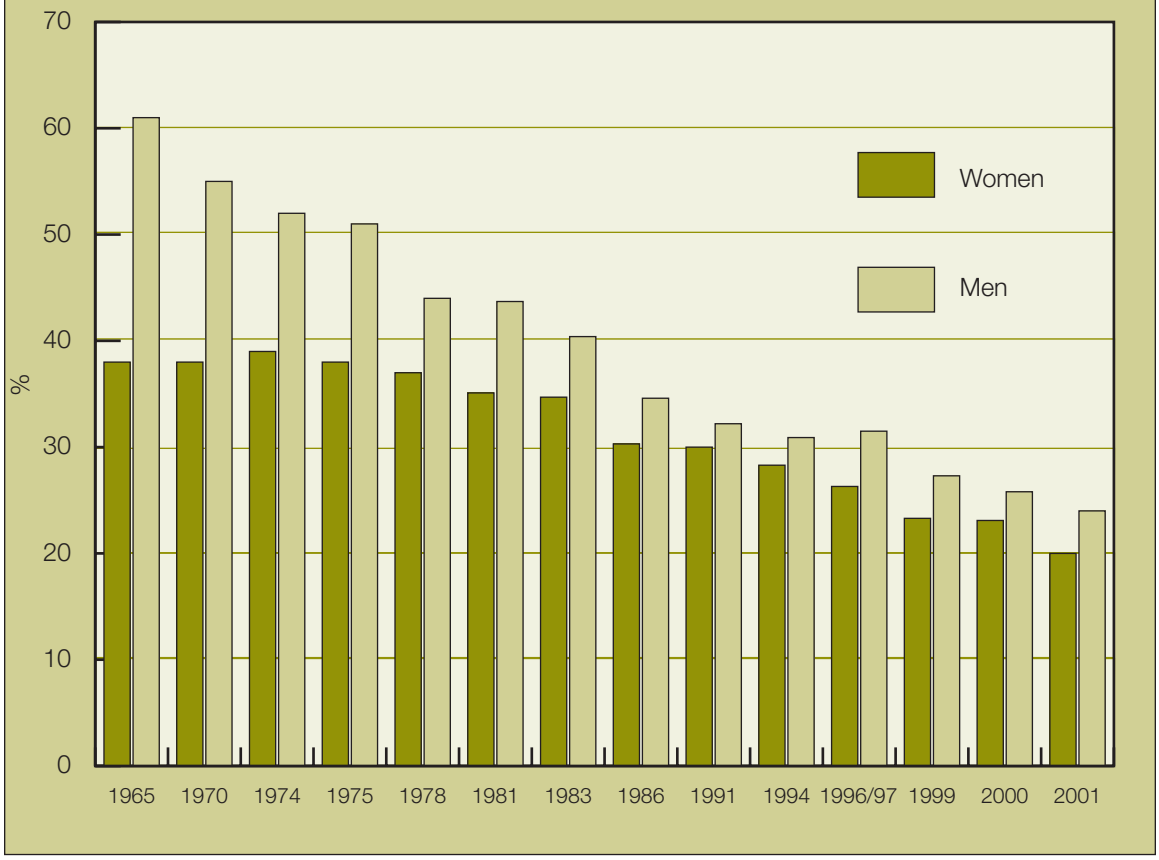


Sources: Labour Force Survey Supplement, 1981-1986; General Social Survey, 1991; Survey on Smoking in Canada, 1994; National Population Health Survey, 1996/97; Canadian Tobacco Use Monitoring Survey (Annual), 1999-2001.

In 2001, about 20% of women and 24% of men were smokers. Since the prevalence rate for male smokers has always been higher, the decline among male smokers has been greater than among female smokers. In 1965, men accounted for 61% of smokers while women accounted for 38%. (Figure 3)

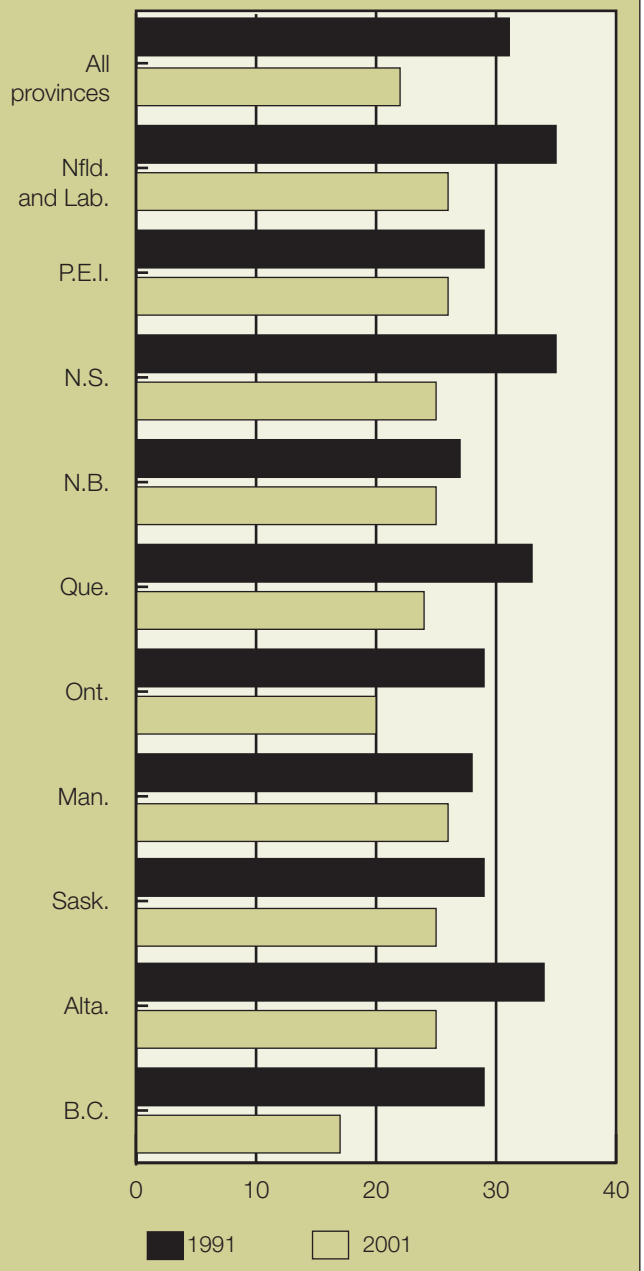
Differences in prevalence rates among the provinces are beginning to lessen. British Columbia has consistently reported the lowest prevalence rate, which in 2001 remained at 17%. The highest prevalence rates were reported in Manitoba, Newfoundland and Labrador, and Prince Edward Island, all at 26%. (Figure 4)

Figure 3 Prevalence of Canadian current smokers, aged 15 years and over, by sex, 1965–2001



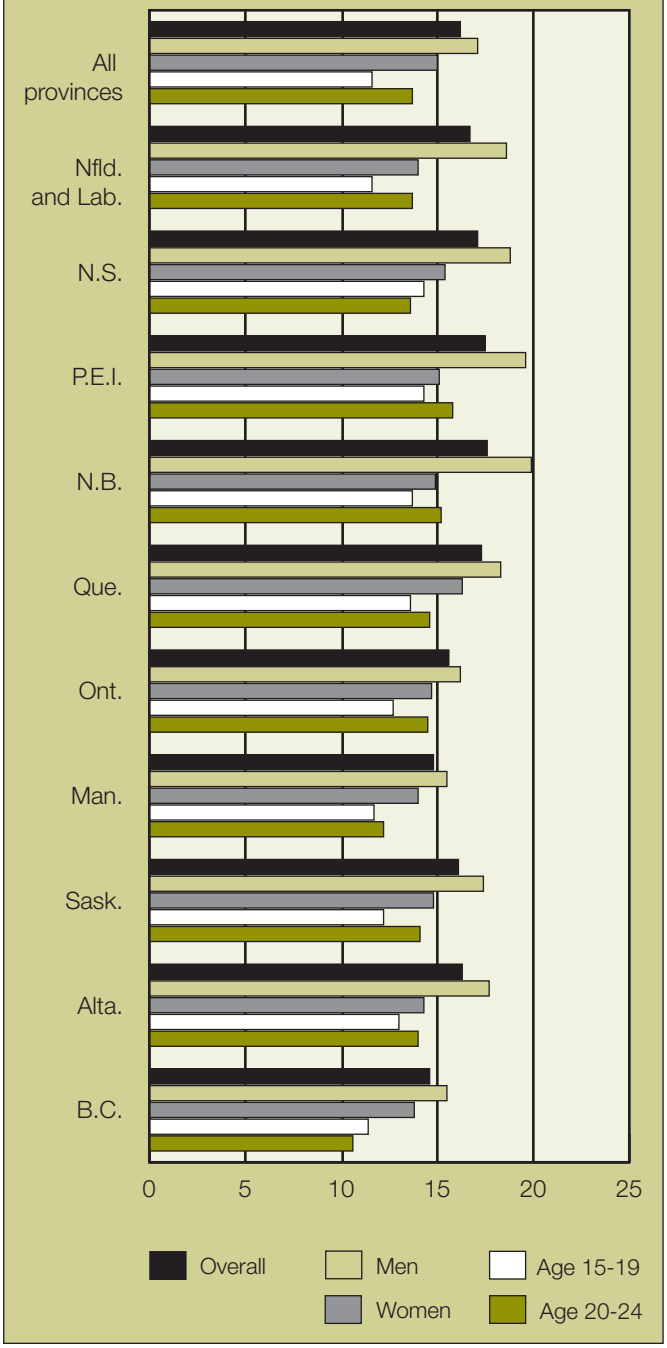
Sources: Labour Force Survey Supplement, 1965–1975, 1981–1986; Canada Health Survey, 1978; General Social Survey, 1991; Survey on Smoking in Canada, 1994; National Population Health Survey, 1996/97; Canadian Tobacco Use Monitoring Survey (Annual), 1999–2001.

Figure 4 Prevalence of Canadian current smokers, by province, 1991 and 2001



Sources: General Social Survey, 1991; Canadian Tobacco Use Monitoring Survey (Annual), 2001.

Figure 5 Average number of cigarettes smoked daily by Canadian daily smokers, aged 15 years and over, 2001



Source: Canadian Tobacco Use Monitoring Survey (Annual), 2001.

Cigarette consumption

Not only are fewer Canadians smoking now, than two decades ago, they are smoking less. In 1981, daily smokers consumed an average of 20.6 cigarettes per day. Since then, the daily consumption of cigarettes has gradually declined, although it has remained about the same as last year at 16.2 cigarettes per day. (Figure 5)

While daily consumption levels have declined steadily 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. (Figure 6)

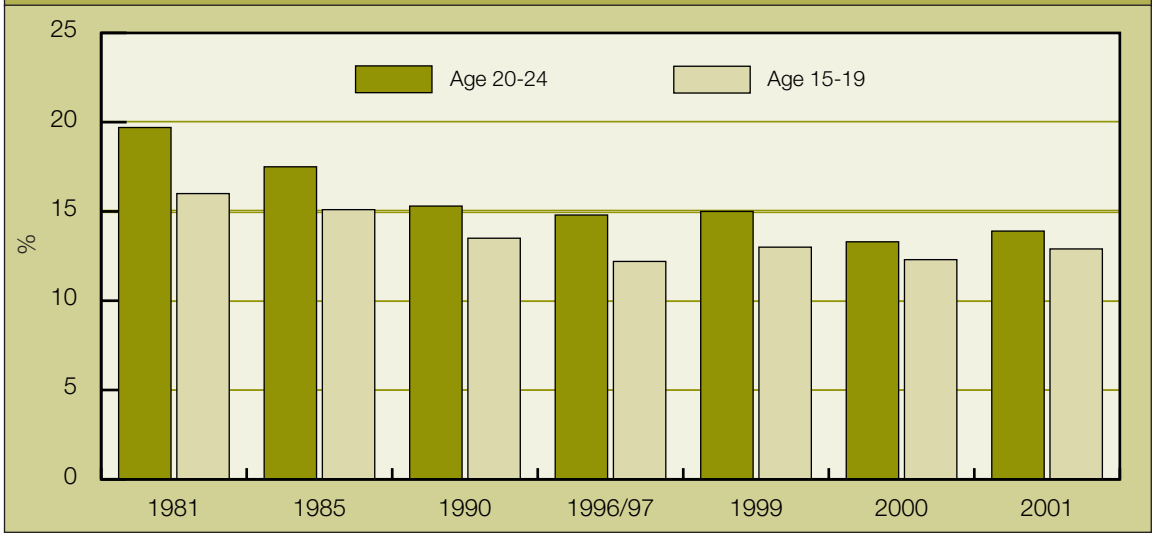
Similarly, while fewer Canadian youth are smoking, consumption rates are almost the same as last year. Among 15 to 19 year olds, cigarette consumption was reported at 12.9 cigarettes daily, while among young adults aged 20 to 24, consumption was reported at 13.9 cigarettes daily. (Figure 7)

Figure 6 Average number of cigarettes smoked daily by Canadian daily smokers, aged 15 years and over, 1981–2001*

* Provincial data only.

Sources: Labour Force Supplement, 1981; Health Promotion Survey, 1985 and 1990; National Population Health Survey, 1996/97; Canadian Tobacco Use Monitoring Survey (Annual), 1999-2001.

Figure 7 Average number of cigarettes smoked daily by Canadian youth (daily smokers), 1981–2001*



* Provincial data only.

Sources: Labour Force Supplement, 1981; Health Promotion Survey, 1985 and 1990; National Population Health Survey, 1996/97; Canadian Tobacco Use Monitoring Survey (Annual), 1999-2001.

Progress in Strategic Directions

Reducing tobacco use is a complex challenge that requires a multifaceted approach. The National Strategy has identified four goals—prevention, cessation, protection and denormalization—to aid in developing effective interventions and activities. Most initiatives, even when designed to address a single goal, have multiple impacts. Legislation that establishes smoke-free environments, for example, protects non-smokers from second-hand smoke (protection), but it also helps smokers who are trying to quit (cessation) and impresses upon youth that smoking is an undesirable behaviour (prevention).

Because most tobacco control initiatives have these overlapping impacts, it is easier to group initiatives by strategic direction. The National Strategy identifies five strategic directions that provide the basis for planning, implementing and evaluating collaborative action. These strategic directions help identify appropriate interventions or actions to achieve prevention, cessation, protection and denormalization goals.

The five strategic directions are:

- 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

Each year, the number of national, provincial, territorial and local tobacco control initiatives increases. Furthermore, as our knowledge base grows, more of these initiatives are built on the success of previous efforts. The following examples illustrate the type of efforts and achievements made in support of the National Strategy's five strategic directions.

Policy and Legislation

New and strengthened tobacco control legislation, newly developed tobacco control strategies, additional tobacco tax increases and first steps toward bringing smoke-free environments to Canada's North highlight this year's initiatives in the Policy and Legislation Strategic Direction.

Tobacco control legislation

The modern era of federal tobacco control legislation began in 1989 with the *Tobacco Products Control Act*, which prohibited the advertising of tobacco products. The tobacco industry immediately launched a constitutional court challenge of the Act. In 1995, after the case worked its way through the judicial system, the Supreme Court struck down key components of the Act. However, the Court provided clear guidance on constitutional limitations in the field of tobacco promotion. These directions were closely followed in developing the *Tobacco Act*.

In 1997, Bill C-71, the *Tobacco Act*, became law. Once again, the tobacco industry immediately launched a constitutional challenge.

Health Canada began its defence, at trial, of the *Tobacco Act* in Quebec Superior Court in Montreal in January 2002. The **Canadian Cancer Society** is participating in the trial to defend the legislation.

In 2002, through amendments to the *Smoke-free Environment Act* and its regulations, **Newfoundland and Labrador** became the first province in Canada to totally ban smoking in food establishments and places where youth under the age of 19 are allowed.

Saskatchewan's *The Tobacco Control Act* was proclaimed in 2002. In addition to legislating the sale and use of tobacco, the Act emphasizes protecting people from second-hand smoke and reducing young people's exposure to tobacco promotion. The advertising and display provisions of the Act make it illegal to display or promote tobacco or tobacco-related products in a retail outlet where anyone under the age of 18 is allowed.

In **British Columbia**, an amended Occupational Health and Safety Regulation came into effect in 2002. Under the amended Environmental Tobacco Smoke Regulation, hospitality and gaming establishments that choose to allow smoking on their premises must provide separate smoking rooms. If employees do not consent to work in a smoking room, they are protected from discrimination. Workstations cannot be located in a smoking room and workers can enter the room intermittently to perform their duties, but cannot work more than 20 per cent of a shift in a smoking room. Smoking rooms must be structurally separate and can be no more than 45 per cent of total floor space in hospitality settings and 65 per cent in bingo halls. Air from smoking rooms must either be ventilated directly to the outside or cleaned through a system that meets a minimum standard of 95 per cent operating efficiency at a 0.3 micrometre particle size. The amended regulation does not override local regulations that prohibit smoking in public places.

Developing and implementing strategies

In 2001, **Nova Scotia** announced a comprehensive Tobacco Control Strategy that was developed with stakeholder consultation. Funding of $1 million for 2001-2002 was allocated for initiating the strategy, which contains seven key components: taxation, legislation and policy, cessation and treatment, community-based programs, youth prevention, media and public awareness, and monitoring and evaluation.

Manitoba unveiled a multi-year Tobacco Control Strategy in 2002 that focuses on youth, including establishing a Youth Advisory Committee. Other highlights include one-time funding to municipalities to support smoke-free bylaws, the introduction of amendments to the *Non-Smokers Health Protection Act* to regulate the display, and advertising and promotion of tobacco products in retail outlets where minors are allowed, and consideration of litigation against the tobacco industry to recover tobacco-related health care costs.

In 2002, the **Northwest Territories** announced an interdepartmental Tobacco Control Strategy that coordinates the efforts of the departments of Health and Social Services; Justice; Municipal and Community Affairs; Education, Culture and Employment; and Finance; and the Workman's Compensation Board. The Strategy's objectives include developing tobacco information units for the school health curriculum, making tobacco cessation counselling available in NWT communities, funding nicotine replacement therapy and producing a discussion paper on possible legislation.

In 2001, the Minister of **Alberta** Health and Wellness established an interdepartmental committee to develop a plan to reduce tobacco use in Alberta. "Reducing Tobacco Use in Alberta: A Comprehensive Strategy", with input from the ministries of Aboriginal Affairs and Northern Development, Children's Services, Human Resources and Employment, Justice, Learning, Municipal Affairs, Health and Wellness, and the Alberta Alcohol and Drug Abuse Commission (AADAC), was released in 2002. The Strategy calls for a comprehensive approach with $11.7 million of funding, $8.7 million of which will be spent by AADAC on education and cessation activities.

In 2001, **Quebec** launched its tobacco control strategy, *Plan québécois de lutte contre le tabagisme 2001-2005* in conjunction with an increase in its annual tobacco control funding from $5 million to $15 million. An additional $3 million has been allocated for efforts to monitor and control tobacco smuggling.

Implementing tax increases

Because higher prices deter tobacco use, particularly among youth, the National Strategy places a priority on a long-term joint federal-provincial-territorial strategy for increasing Canadian tobacco taxes. It is estimated that a 10 per cent increase in price results in a 4 to 6 per cent decrease in sales. The Department of Finance, with **Health Canada**, ensures that Canada's tobacco product taxation policy is consistent with the Government's health objectives.

In 1994, tobacco taxes were significantly rolled back as part of the National Action Plan to Combat Smuggling. Since then there have been several federal and provincial increases, most recently in April 2001 and in November 2001. The November 2001 federal-provincial tax increases re-established a uniform federal tobacco tax rate across the country. To support these tax changes, the Federal Tobacco Control Strategy allocated an additional $74 million over five years to federal departments and agencies to improve their ability to monitor and assess the effectiveness of these tax measures in reducing tobacco smuggling. These resources will also help determine the size and timing of future tax increases.

Other federal changes in November 2001 included tax increases on exported tobacco products, fine-cut tobacco, tobacco sticks, and on tobacco products delivered to duty-free shops, sold as ships' stores or imported by Canadian residents returning to Canada. All jurisdictions have also increased tobacco taxes substantially in their 2002/03 budgets.

Establishing smoke-free environments

Municipalities throughout Canada have been passing and strengthening bylaws that provide the public with an ever-increasing number of smoke-free public places. Among the most recent efforts are those taking place in **Nunavut** where Health and Social Services is working with the City of Iqaluit to draft Nunavut's first municipal smoke-free bylaw.

Policies developed by non-governmental organizations

At the 2001 Annual General Meeting, the membership of the **Canadian Public Health Association** (CPHA) passed a resolution concerning smokeless tobacco. The resolution calls for: the surveillance of smokeless tobacco usage by Canadians, especially youth; funding for smokeless tobacco research initiatives, and prevention and cessation programs; a significant increase in the taxes on smokeless tobacco; and a strengthening of the enforcement of the regulations to prevent sales to minors. This resolution was proposed and carried because smokeless tobacco poses a significant and preventable health risk, particularly to children and youth. Resolutions of this sort give professional associations the authority to take action on an issue when appropriate and as the occasion arises. On behalf of its members, the CPHA has written about this issue to the federal, provincial and territorial ministers of health and published the resolution in its digest.

Smokeless tobacco includes tobacco products such as snuff, "plug", chewing tobacco and tobacco in gauze bags. The nicotine from these products is absorbed into the bloodstream directly through tissue lining the mouth or nostrils.

Contributing to international tobacco control guidelines

The Framework Convention on Tobacco Control is the first international health treaty, and ratification is expected in 2003. Canada is a very active participant in this process and consults the provinces, territories and non-governmental organizations as the negotiations progress. The **Heart and Stroke Foundation of Canada** (HSFC) chairs a National Coalition Against Tobacco subcommittee that coordinates the input from Canada's NGO community to the Framework Convention on Tobacco Control. Along with subcommittee members the Canadian Cancer Society, Physicians for a Smoke-Free Canada and the Non-Smoker's Rights Association, the HSFC works with international NGOs and ensures a Canadian NGO presence at international negotiating sessions.

Public Education (Information, Mass Media, Programs and Services)

The Public Education Strategic Direction is intended to make information, services and programs available and accessible to Canadians. A wide range of cessation programs and aids are currently available to Canadians through a growing number of sources. A number of mass media information campaigns were conducted this past year and there were numerous activities tailored to meet the needs of young people. This year's report also highlights information campaigns tailored to health care professionals, who are often in a position to support their patients in cessation efforts.

Public awareness

Canada's territories were the sites of new media activities in tobacco control in 2002. **Yukon's** Department of Health and Social Services partnered with the Kwanlin Dun First Nation to hire a youth tobacco reduction and prevention worker in 2000–2001. Activities included providing a high school quit smoking program, quit smoking kits to individuals and youth agencies on request, school presentations, a poster contest, and displays at a youth conference. The Health Promotion Unit also delivered two tobacco prevention programs to high school students. A public education campaign will be initiated in 2002. In **Nunavut**, Health and Social Services has designed an aggressive media campaign to inform its residents of the effects of tobacco and the tactics of the tobacco industry. Both audio-visual and print materials were prepared in Inuktitut and in English.

Health Canada's tobacco control Web site, "gosmokefree", has been extensively redesigned. Its interactive "On the Road to Quitting" program allows smokers to register for one month of daily e-mail quit messages. As of spring 2002, nearly 1800 Canadians had subscribed to the service and 75 per cent of the program's 260 graduates reported that they were able to quit.

Reaching out to youth

From Canada's east coast, in Nova Scotia, and Newfoundland and Labrador, to Yukon in the north, and Saskatchewan and British Columbia in the west, efforts to educate youth about the dangers of tobacco use continued and expanded. **Ontario** launched a Youth Tobacco Team in 2001. The Team is developing grassroots tobacco control advocacy among teens.

Training for health care professionals

The **Canadian Pharmacists Association** has developed practice tools to help pharmacists provide smoking cessation services, including Helping Your Patients Quit Smoking: A Smoking Cessation Guide for Pharmacists, and Smoking Cessation: Pharmacist Workshop Kit, a 4-hour training program.

In 2001, the **Canadian Dental Association** sent every dentist in Canada a comprehensive package on tobacco cessation that included among its many items information on how dentists can help patients to reduce or quit tobacco use, a placard for the reception area inviting patients to ask about quitting, a resource sheet with contact information for patients, and a copy of the *Journal of the Canadian Dental Association* that featured a collection of clinical articles on smoking cessation.

Industry Accountability and Product Control

The Industry Accountability and Product Control Strategic Direction is intended to regulate the manufacturing, marketing, and sale of tobacco products. Regulations require the means for ensuring compliance and, when necessary, enforcing compliance.

British Columbia's computerized enforcement and compliance database became fully functional in 2001. The database allows inspectors to determine the most appropriate type of action to gain compliance by tracking individual retailer

compliance as well as compliance levels by type of operation. To help retailers educate staff about their responsibilities, British Columbia produced a tool kit of information and training material.

Research, Evaluation, and Monitoring

While effective tobacco control requires work in all the five strategic directions, knowledge forms the foundation for planning interventions and activities in the other four, whether it is the result of research programs, pilot projects—a form of applied research—evaluation of already existing programs and services, or monitoring changes to assess progress.

Research

The **National Cancer Institute of Canada** supports tobacco control research through nearly $500,000 in planning grants and fellowships. The fellowships support graduate and post-graduate training in tobacco control research. The planning grants support the development of research proposals that can compete for large-scale, major research funding.

The **Centre for Behavioural Research and Program Evaluation** co-sponsored (with the Canadian Tobacco Control Research Initiative and Health Canada) a workshop for provincial decision-makers and program evaluators to share information on program surveillance and evaluation. Workshops of this type, which foster relationships between provinces and between sectors, are a step toward identifying the "best" components of comprehensive tobacco control efforts.

Evaluation and monitoring

In 2001, the Smoke-Free Homes Committee, a subcommittee of the **Prince Edward Island** Tobacco Reduction Alliance, began a two and a half year evaluation project funded by the **Canadian Institutes of Health Research**. The project will evaluate the effectiveness of a social marketing campaign about second-hand smoke in homes. Baseline data has been collected from 709 homes in one community and from 715 homes in a control group community where there is a smoker in the household and at least one child. After a social marketing campaign has been implemented in the fall of 2002, a post-survey will be conducted to assess the campaign's effectiveness.

The **Canadian Tobacco Control Research Initiative** (CTCRI) is a collaboration between Health Canada, the Canadian Cancer Society, the National Cancer Institute of Canada, and the Social Sciences and Humanities Research Council of Canada. In partnership with Health Canada, the CTCRI administers the National Working Group on Best Practices, which has developed a working model for identifying, implementing and evaluating best practices. This model was used successfully to evaluate youth cessation programs and to develop a guide for decision-makers and practitioners implementing such programs. In 2002, the CTCRI, in cooperation with the U. S. Centers for Disease Control and Prevention and the U. S. National Cancer Institute, published the guide, *Guide to Youth Tobacco Cessation*, which will be distributed throughout Canada and the United States.

In April 2001, the CTCRI and the **Canadian Institutes of Health Research** (CIHR) convened a two-day Canadian Tobacco Control Research Summit. Tobacco control researchers, practitioners and policy developers identified 11 key themes or areas for research. A report is available from the CIHR.

Pilot projects

Manitoba successfully completed an innovative Teen Cessation Pilot Project and will expand it throughout the province to reach more teenagers.

Building and Supporting Capacity for Action

Collaboration, partnership, sharing—whatever form it takes, bringing people, communities, organizations, and governments together creates synergy, disseminates knowledge and skills, and results in time and cost savings. Adapting an already existing and successful program saves having to reinvent the wheel. Workshops, conferences and training sessions not only convey information, they motivate and inspire people to take action.

In 2001, **New Brunswick** launched the New Brunswick Anti-Tobacco Coalition, a group composed of representatives of government and non-governmental organizations, as well as individuals, committed to working collaboratively to implement the goals and objectives of New Brunswick's Anti-Tobacco Strategy. An Implementation Committee has been formed to coordinate activities and an annual meeting will be held to review progress and update objectives.

The **Canadian Council for Tobacco Control** operates the National Clearinghouse on Tobacco and Health Program, which has developed a Virtual Library that provides original content, and Internet links and information to assist Canada's tobacco control community. The Virtual Library is supported by a 1-800 information line.

The **Quebec Coalition for Tobacco Control**, a coalition of 750 member organizations, produced an economic impact study early in 2001 as part of its efforts to ensure a higher government investment in tobacco control. In 2001, Quebec announced that it would allocate an additional $10 million to tobacco control. This additional funding places Quebec among the provinces with the highest per capita spending on tobacco control in Canada.

Health Canada's Tobacco Control Programme works with provincial and territorial governments and NGOs to identify mutual objectives and priorities that align with the goals of the Federal Tobacco Control Strategy. Based on these areas of mutual interest, the Tobacco Control Programme provides funding to promote and support capacity development in the areas of prevention, cessation, protection and harm reduction. These activities include research, evaluation, best practices, training, public education, information dissemination and promotion at national, provincial, territorial and regional levels.

First Nations, Inuit, and Métis

Until the inception of the Northern Usage of Tobacco, Alcohol and Illicit Drugs survey in 2002, there was no regular data collection mechanism to track tobacco use among First Nations and Inuit peoples. However, there were indications that prevalence rates among these peoples are much higher than among the general population. In 2002, for example, the Inuit Health Commission conducted a study among young people in the communities of Nain, Hopedale, Postville and Rigolet and found that 62 per cent of the youth in those communities were regular or occasional smokers. While First Nations and Inuit communities must confront higher risk factors, their tobacco control efforts must also take into account cultural factors such as the traditional use of tobacco in some aboriginal cultures. For these reasons, although it is not one of the five strategic directions, the National Strategy recognizes that separate strategies must be developed with local leadership using collaborative, community-based mechanisms.

In 2002, **Saskatchewan** broadcast a training workshop, "Tobacco Cessation: An Integrated Approach" from Saskatoon to 22 sites in Saskatchewan, and 13 sites in British Columbia, Alberta, Manitoba, and Newfoundland and Labrador. Featured during that workshop was "Tobacco Addiction and Recovery: A Spiritual Journey", a cessation program from the **Nechi Training, Research and Health Promotions Institute** designed specifically for aboriginal adult and adolescent smokers.

The **Manitoba** Department of Health is in the process of developing a comprehensive Aboriginal Tobacco Control Strategy tailored to the needs of aboriginal peoples.

Cancer Care Ontario's aboriginal unit has conducted a needs assessment of Ontario's First Nations with funding from the Ontario government.

Conclusion

This second progress report on the National Strategy to Reduce Tobacco Use, even in its abbreviated format, provides ample evidence of the efforts of governments and non-governmental organizations to move Canada ever closer to becoming a society where as few people as possible are addicted to tobacco products. By continuing to monitor these efforts and by sharing information on best practices, successful endeavors can be replicated, coordinated and strengthened. Areas of tobacco control that need innovative approaches or more resources can be identified, and as these newer approaches are put into practice, eventually fewer Canadians will suffer the adverse consequences of tobacco use.

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Appendix B: List of Contributing Non-Governmental Organizations

Canadian Cancer Society

Canadian Council for Tobacco Control

Canadian Dental Association

Canadian Medical Association

Canadian Public Health Association

Canadian Tobacco Control Research Initiative

Cancer Care Ontario

Centre for Behavioural Research and Program Evaluation

Heart and Stroke Foundation of Canada

Quebec Coalition for Tobacco Control

National Cancer Institute of Canada

Non-Smokers' Rights Association

Physicians for a Smoke-Free Canada