The National Strategy:

Moving Forward

The 2003 Progress Report on Tobacco Control

2003

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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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Dedication

The 2003 Progress Report on Tobacco Control is dedicated with respect and gratitude to Barb Tarbox and Heather Crowe who courageously made their personal lives public so that Canadians, particularly young Canadians, could see the human costs of tobacco use.

Executive Summary

Canada has been a pioneer in tobacco control efforts, whose ultimate objective is to reduce the number of tobacco-related deaths and illnesses by reducing the number of people who use tobacco. Early efforts lowered the percentage of Canadians who smoked from an estimated 50% in 1965 to around 30% in the mid-90s. When the rate of decline slowed, a revised national tobacco control strategy was developed by the Steering Committee of the National Strategy to Reduce Tobacco Use in Canada in partnership with the Advisory Committee on Population Health under the direction of the Provincial/Territorial Conference of Deputy Ministers of Health. The revised strategy, *New Directions for Tobacco Control in Canada: A National Strategy*, was released in 1999.

The revised National Strategy called for regular progress reports as a necessary component of tobacco control activities. *The National Strategy: Moving Forward, The 2003 Progress Report on Tobacco Control* is the third such annual report.

These progress reports attempt to point out gaps in relevant data, to provide the most current information on a number of indicators, and to establish baseline data on previously unreported indicators as they become available. Unfortunately, data are not always available or updated annually. In addition, it is not always possible to present statistically significant measures. Furthermore, given the length of time between the implementation of an initiative and its impact, indicators must be tracked regularly over a long period of time. But because changes may not register as statistically significant from one year to the next, it is not practical to report on some indicators every year. For all these reasons, the content of the progress report has varied from year to year.

In the meantime, legislators, decision-makers, and program managers must devise regulations, allocate funds, and develop programs. In short, they must have feedback, whether it is quantitative or qualitative, statistical or descriptive. Each year, *Moving Forward* attempts to provide that feedback.

In addition to tracking key indicators—prevalence and consumption data for 2002—the 2003 report presents some data on domestic cigarette sales and provides a summary of current provincial and territorial tobacco tax rates.

As in past reports, this report offers information from the provinces, territories, non-governmental organizations, and the federal government on current activities and achievements in tobacco control efforts. In the first two reports this information was organized according to the National Strategy's five strategic directions: Policy and Legislation; Public Education; Building and Supporting Capacity for Action; Industry Accountability and Product Control; and Research, Evaluation, and Monitoring; and a special focus on First Nations, Inuit, and Métis. With so many tobacco control initiatives taking place throughout Canada, this year's *Moving Forward* concentrates on the first three strategic directions to be able to include more examples of those types of initiatives.

By sharing this information we save ourselves the time and cost of "reinventing the wheel". We learn through our experiences and from the examples of others. In 2001, for example, the progress report described the results of a two-year pilot project sponsored by the Canadian Cancer Society and the Ministry of Health of British Columbia and modeled after an Ontario Smokers' Helpline. This year's report notes that telephone helpline services now provide cessation information and support in all ten provinces and Yukon. These "quitline" services have proved to be cost-effective and popular methods of encouraging smokers to quit.

The progress report on the National Strategy for tobacco control provides a vehicle for input into the continuous learning process by identifying what works, as we strive to make Canada a safer place to live by reducing tobacco consumption.

Key Messages

Over time, we have learned through experience, and are still learning, what works and what doesn't work to control tobacco use.

- We have learned how to plan, propose, pass, implement—and, when necessary, defend in court—tobacco control legislation.
- We have learned to support that legislation with research, monitoring, and surveillance.
- We have learned to craft and target media campaigns that inform and persuade.
- We have learned to extend our tobacco education efforts to the very young.
- We have learned to share best practices, disseminate information, and work co-operatively.

We can again claim success, as the 2002 Canadian Tobacco Use Monitoring Survey (CTUMS) results confirm that the prevalence of smoking in Canada continues to decline.

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Introduction

Over the past three decades, patterns of tobacco use in Canada have altered dramatically. Only a short time ago, smoking was so common that the majority of Canadians, men and women, young and old, from all types of social backgrounds, offered each other "a smoke," carried lighters and matches everywhere they went, and placed ashtrays throughout their homes. Cigarettes were cheap, completely unregulated, and extensively advertised.

Three decades later, thousands of Canadians—over 45,000 each year—pay the price with their lives. For some the price is lung cancer, for others emphysema or another of the smoking-related diseases. Some of these people never bought a cigarette; they got their smoke second-hand.

Once tobacco control efforts got rolling, the percentage of Canadians who smoked began dropping: from an estimated 50% in 1965 to around 30% in the mid-90s. But the rate of decline slowed over time. To decide how best to move forward in reducing tobacco use, a revised national tobacco control strategy was developed by the Steering Committee of the National Strategy to Reduce Tobacco Use in Canada in partnership with the Advisory Committee on Population Health (ACPH). *New Directions for Tobacco Control in Canada: A National Strategy* was released in 1999.

The revised National Strategy laid out a framework for action. Federal, provincial, and territorial Ministers of Health endorsed the strategy, agreeing that the magnitude and complexity of the problem required sustained, comprehensive, integrated, and collaborative approaches.

Establishing comprehensive and integrated efforts hinges on forging collaborations at all levels. One example is the Federal Provincial Territorial Tobacco Liaison Committee. This committee provides advice to and brings issues before another federal-provincial-territorial group—the Advisory Committee on Population Health and Health Security (ACPHHS, formerly the ACPH), which advises the Conference of Deputy Ministers of Health. These multi-government collaborations also ensure that tobacco control is integrated into Canada's larger public health agenda.

Canada's tobacco control picture would be incomplete without the extensive work performed by non-governmental organizations (NGOs). As part of the fabric of any democracy, they raise public awareness, champion issues, provide independent research, and collaborate with and, at times, challenge governments. National and regional health-centred NGOs bring an informed and scientific perspective to the health risks of tobacco use. Professional associations, particularly those for health professionals, encourage their members to play a leading role in combatting tobacco use. Their contributions, and those of other NGOs, are invaluable.

The ultimate objective is to reduce the number of tobacco-related deaths and illnesses. Four goals were identified to achieve that objective: prevention—keeping youth from starting to smoke; cessation—helping smokers to quit; protection—ensuring smoke-free environments; and denormalization—changing Canadians' attitudes toward tobacco products and tobacco use.

To stay on track, the National Strategy included regular progress reports as a necessary component. *The National Strategy: Moving Forward, The 2003 Progress Report on Tobacco Control (Moving Forward)* is the third such annual report.

The progress reports attempt to provide the most current information on a number of indicators and to establish baseline data on previously unreported indicators as they become available. However, data are not always available or updated annually. For example, updates of health statistics that were published in the 2001 report are not available as this year's report goes to print. In addition to reporting what is known, the reports attempt to pinpoint gaps in the knowledge we need to combat tobacco use.

As can be imagined, given the length of time between the implementation of an initiative and its impact, indicators must be tracked regularly over a long period of time. In many instances, it is not possible to present statistically significant measures for individual activities. How can we measure statistically the ultimate success—children who grow up to be non-smokers—of a school curriculum that teaches third grade children how to see through the manipulation of tobacco advertising? And yet, legislators, decision-makers, and program managers must devise regulations, allocate funds, and develop programs. Quantitative or qualitative, statistical or descriptive, they must have feedback.

Because of the tremendous number of tobacco control initiatives taking place throughout the country, *Moving Forward* cannot possibly be a comprehensive document. Rather than limit the content of the report to a rigid format, the focus has shifted slightly each year. In this way, over a period of time, a more complete picture is presented. This year's report returns to a broader format for the Tracking Key Indicators section with the inclusion once again of some tobacco industry statistics and an overall view of tobacco taxation in Canada. Part Three concentrates on just three of the five Strategic Directions—Policy and Legislation, Public Education, and Building and Supporting Capacity for Action—so that more examples of what is taking place in each one can be included. In 2001 and 2002, *Moving Forward* had included achievements in the other two Strategic Directions—Industry Accountability and Product Control, and Research, Evaluation, and Monitoring.

The true measure of the National Strategy's progress is the continued decline in the number of Canadians who use tobacco and, in particular, in the number of youth who refuse to start smoking. The struggle to reduce smoking prevalence becomes more difficult as the percentage of Canadians who smoke decreases. But each year we learn more about how to achieve those goals. Tobacco control in Canada continues to move forward.

Tracking Key Indicators

Accurate information about trends in tobacco use, the health impacts of tobacco use, and the activities of the tobacco industry create the foundation for effective tobacco control strategies and policies. Canada's success in tobacco control depends on a continuous learning process that relies on our ability to use both quantitative and qualitative measures to assess, monitor, and improve tobacco control activities and programs.

Moving Forward tracks a number of key indicators of tobacco use annually and other relevant data as they are available. Traditionally, tobacco use has been measured in three ways: prevalence (what percentage of Canadians smoke), consumption (how many cigarettes daily smokers smoke per day), and tobacco sales. Each measure has its strengths and weaknesses, but together they complement each other.

While data on smoking trends in Canada have been collected since 1965, only since 1999 with the advent of the Canadian Tobacco Use Monitoring Survey (CTUMS) have up-to-date, reliable, comparable, and continuous data on tobacco use been available. 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. Particular attention is paid to the population most at risk for taking up smoking; about 50% of those surveyed are between 15 and 24 years of age.

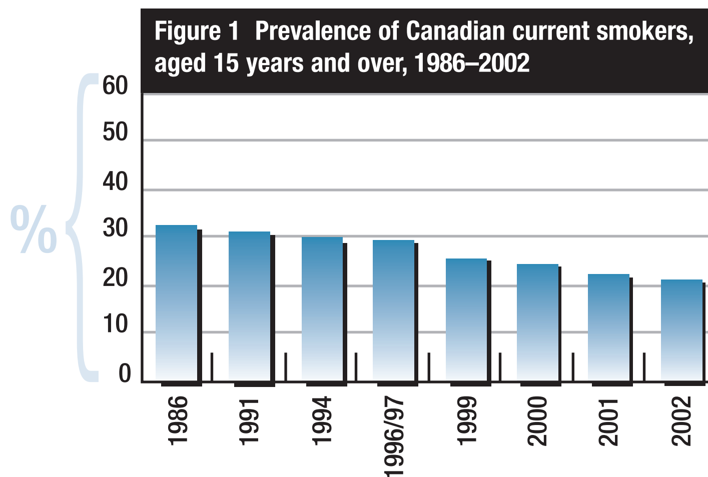
Data gaps still exist. The most common data collection method is the telephone survey. Because there are fewer households with telephones in the North, data collection is more difficult in Yukon, Northwest Territories, and Nunavut. For this reason the territories are typically not included in large surveys.

In addition, there are groups, which probably have a large percentage of regular and heavy smokers, that are not captured in surveys. These include those who are incarcerated or institutionalized, and homeless people of whom many are marginalized youth. It is ironic that cigarette advertising in many developing countries portrays smoking as a habit of those who are well off. The reality in Canada is that those with more education and better economic status are less likely to be smokers than those who are economically disadvantaged or socially marginalized.

Smoking prevalence in Canada

While change from one year to the next is now slight, smoking prevalence does continue to decline in Canada. Since regular monitoring of smoking began, the prevalence rate has decreased from an estimated high of 50% in 1965. In 2002, about 21% of the population aged 15 and older were current smokers, of which 18% reported smoking daily. This represents a slight decrease from last year's prevalence rate of 22% and from the 2000 figure of 24% (Figure 1).

Figure 1 Prevalence of Canadian current smokers, aged 15 years and over, 1986–2002

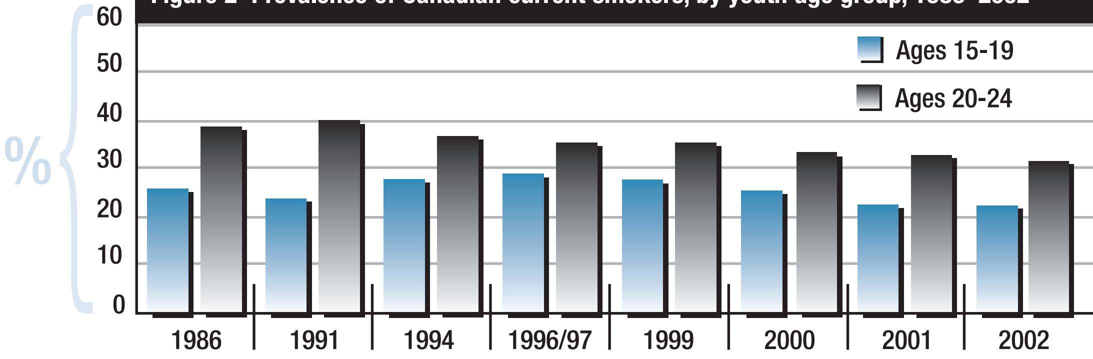


Sources: 1986, Labour Force Survey Supplement; 1991, General Social Survey; 1994, Survey on Smoking in Canada; 1996/97, National Population Health Survey; 1999–2002, Canadian Tobacco Use Monitoring Survey (Annual).

During the 1990s, smoking prevalence rates for youth aged 15 to 19 years increased—to a peak of 28% in the mid-90s—but have been edging down since then. The 2002 figure is 22% (16% daily, 6% occasional smokers) with 23% of teen girls reporting themselves as current smokers compared with 21% of teen boys.

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 32% in 2001 and to 31% in 2002 (23% daily, 8% occasional smokers). Prevalence rates for men and women are about the same in this age group (Figure 2).

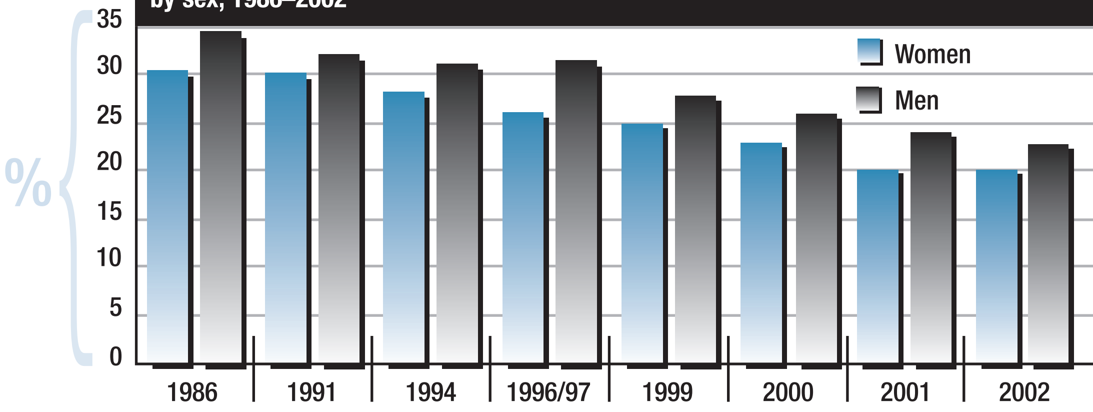
Figure 2 Prevalence of Canadian current smokers, by youth age group, 1986–2002



Sources: 1986, Labour Force Survey Supplement; 1991, General Social Survey; 1994, Survey on Smoking in Canada; 1996/97, National Population Health Survey; 1999–2002, Canadian Tobacco Use Monitoring Survey (Annual).

Approximately 23% of men aged 15 and older were current smokers in 2002. Again, this represents a small decrease from last year's figure of 24%. The rate for women aged 15 and older stayed at 20% after having declined from 23% in 2000 (Figure 3).

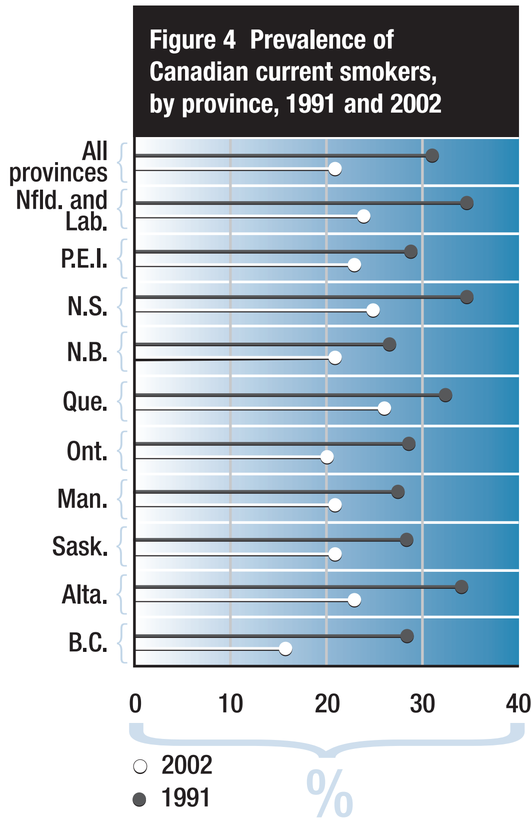
Figure 3 Prevalence of Canadian current smokers, aged 15 years and over, by sex, 1986–2002



Sources: 1986, Labour Force Survey Supplement; 1991, General Social Survey; 1994, Survey on Smoking in Canada; 1996/97, National Population Health Survey; 1999–2002, Canadian Tobacco Use Monitoring Survey (Annual).

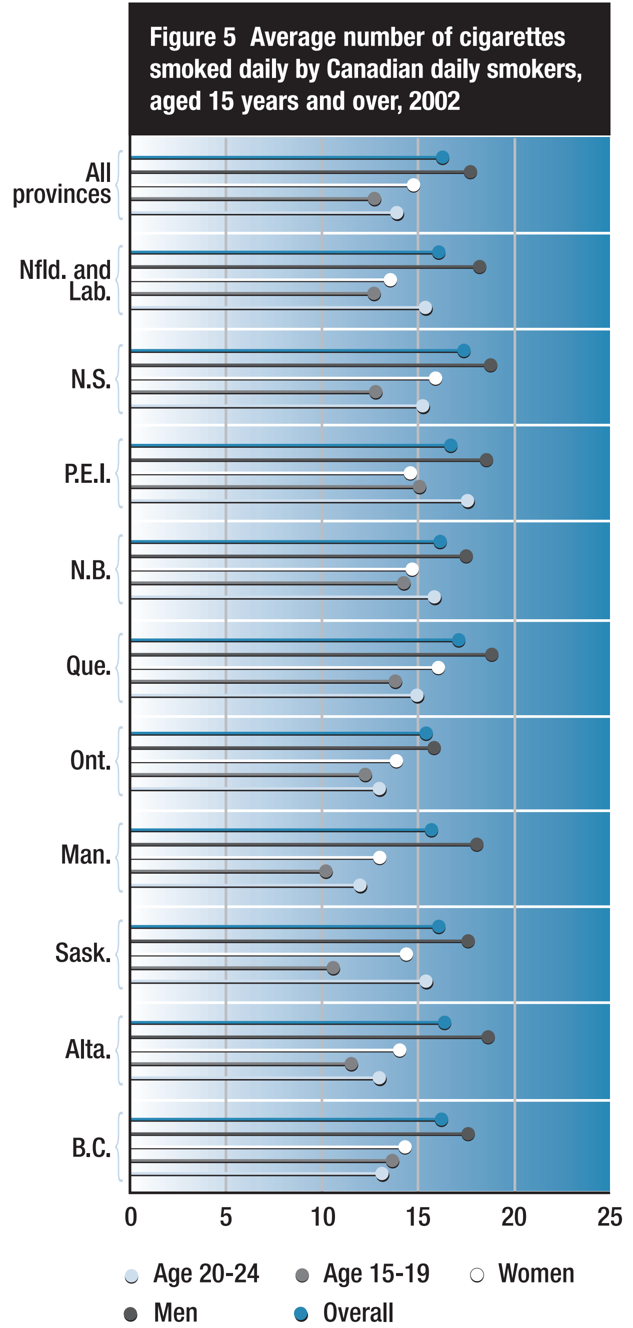
Overall, provincial prevalence rates for smokers aged 15 and older continue to decrease and the differences between provinces continue to lessen. British Columbia, which has reported the lowest prevalence rate for several years, edged down to 16%, while Quebec reported the highest prevalence rate at 26%. While the prevalence rate stayed the same for Ontario (20%) and Nova Scotia (25%), all the other provinces recorded decreases. The most notable decrease occurred in Manitoba where the prevalence rate dropped from 26% (2001) to 21% (2002). In Saskatchewan and New Brunswick the prevalence rate went from 25% to 21%. Decreases were recorded in Prince Edward Island (26% to 23%), Newfoundland and Labrador (26% to 24%), and Alberta (25% to 23%) (Figure 4).

Figure 4 Prevalence of Canadian current smokers, by province, 1991 and 2002



Sources: 1991, General Social Survey; 2002, Canadian Tobacco Use Monitoring Survey (Annual).

Figure 5 Average number of cigarettes smoked daily by Canadian daily smokers, aged 15 years and over, 2002



Source: 2002, Canadian Tobacco Use Monitoring Survey (Annual).

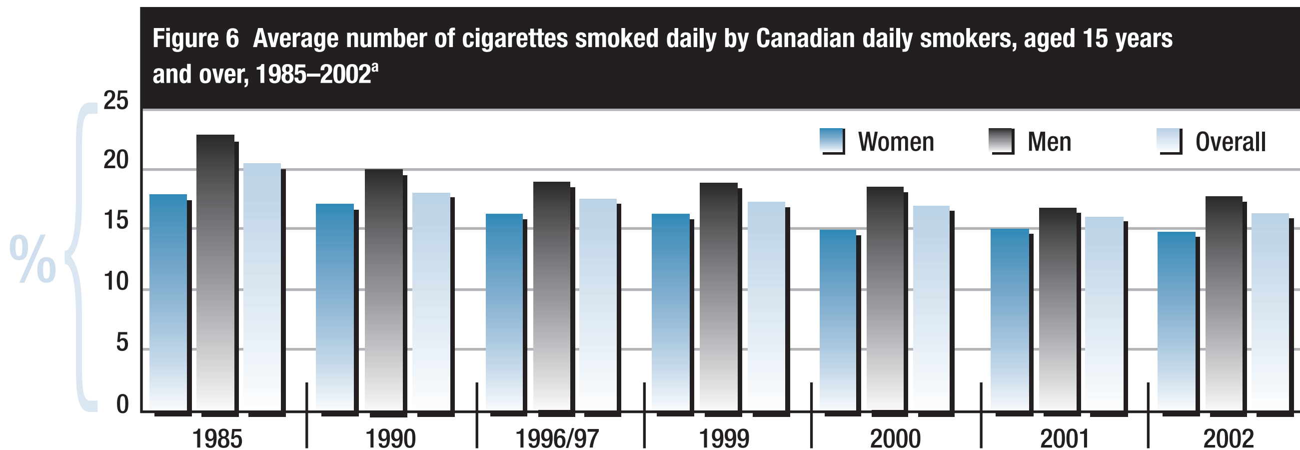
Cigarette consumption

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%. However, since under-reporting is consistent for both men and women, and among all age groups, some year-to-year comparisons can be made with a degree of accuracy.

There is no doubt that not only are fewer Canadians smoking now than two decades ago, they are smoking less. In 1985, daily smokers consumed an average of 20.6 cigarettes per day. Since then, the number of cigarettes smoked per day has gradually but steadily declined. While the average remained at 16.2 cigarettes per day during 2000 and 2001, it is marginally higher at 16.4 cigarettes per day in 2002 (Figure 5).

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: 18 cigarettes per day for men compared to 14.8 for women (Figure 6).

Figure 6 Average number of cigarettes smoked daily by Canadian daily smokers, aged 15 years and over, 1985–2002[a]

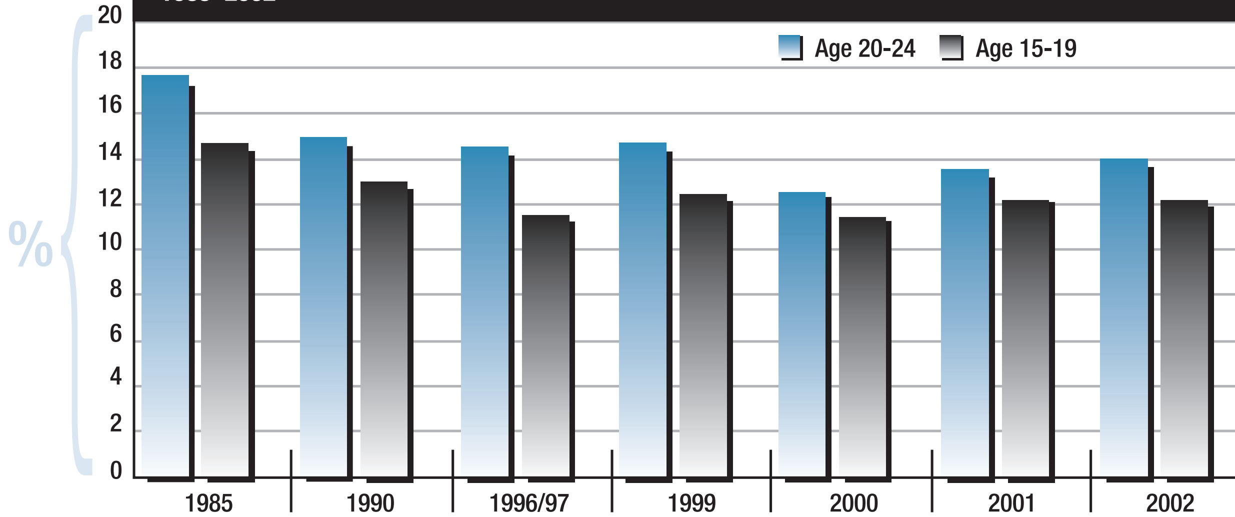


Sources: 1985 & 1990, Health Promotion Survey; 1996/97, National Population Health Survey; 1999–2002, Canadian Tobacco Use Monitoring Survey (Annual).

[a] Provincial data only.

Similarly, while fewer Canadian youths are smoking, consumption rates for daily smokers 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 14 cigarettes daily (Figure 7).

Figure 7 Average number of cigarettes smoked daily by Canadian youth (daily smokers), 1985–2002[a]



Sources: 1985 & 1990, Health Promotion Survey; 1996/97, National Population Health Survey; 1999–2002, Canadian Tobacco Use Monitoring Survey (Annual).

[a] Provincial data only.

Tobacco industry statistics

For many years the tobacco industry voluntarily released certain sales and revenue information. Then in 1994 Ontario placed a general reporting requirement in its legislation and in 1998 both British Columbia and Quebec placed more specific reporting requirements in their tobacco legislation.

In an effort to help individuals make a more informed choice about smoking, federal regulations were instituted that required manufacturers to report the levels of three chemicals found in smoke: tar, nicotine, and carbon monoxide. Then in June 2000, new Tobacco Reporting Regulations were enacted under the federal *Tobacco Act*.

In addition to requiring monthly reports on the sales of cigarettes, cigarette tobacco, and tobacco sticks, manufacturers are required to report levels of more than 40 different chemical compounds found in mainstream smoke (inhaled by the smoker) and sidestream smoke (inhaled by non-smokers). Six of these must be reported on tobacco packaging. The reporting requirements also include an expanded list of classes of tobacco products.

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.

Domestic cigarette sales

While tobacco can be consumed in a variety of forms, because cigarettes account for the largest share of tobacco consumption, information about cigarette sales adds detail to the picture of tobacco use and smoking patterns in Canada. 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. While manufacturers are required to report these figures monthly, they cannot be taken as representing consumer purchases over the short-term. However, monitored over the long-term (one year or longer), these data do reflect consumer behaviour. However, as explained below, cigarette sales figures between 1991 and 1993 must be interpreted carefully (Figure 8).

Figure 8 Domestic cigarette sales from the manufacturer to the wholesaler (billions of cigarettes), Canada,[a,b] 1980–2001

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

[a] Excise taxes and duties are not paid on these sales.

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

Tobacco tax rates

Increases in cigarette prices lead to significant reductions in cigarette smoking.

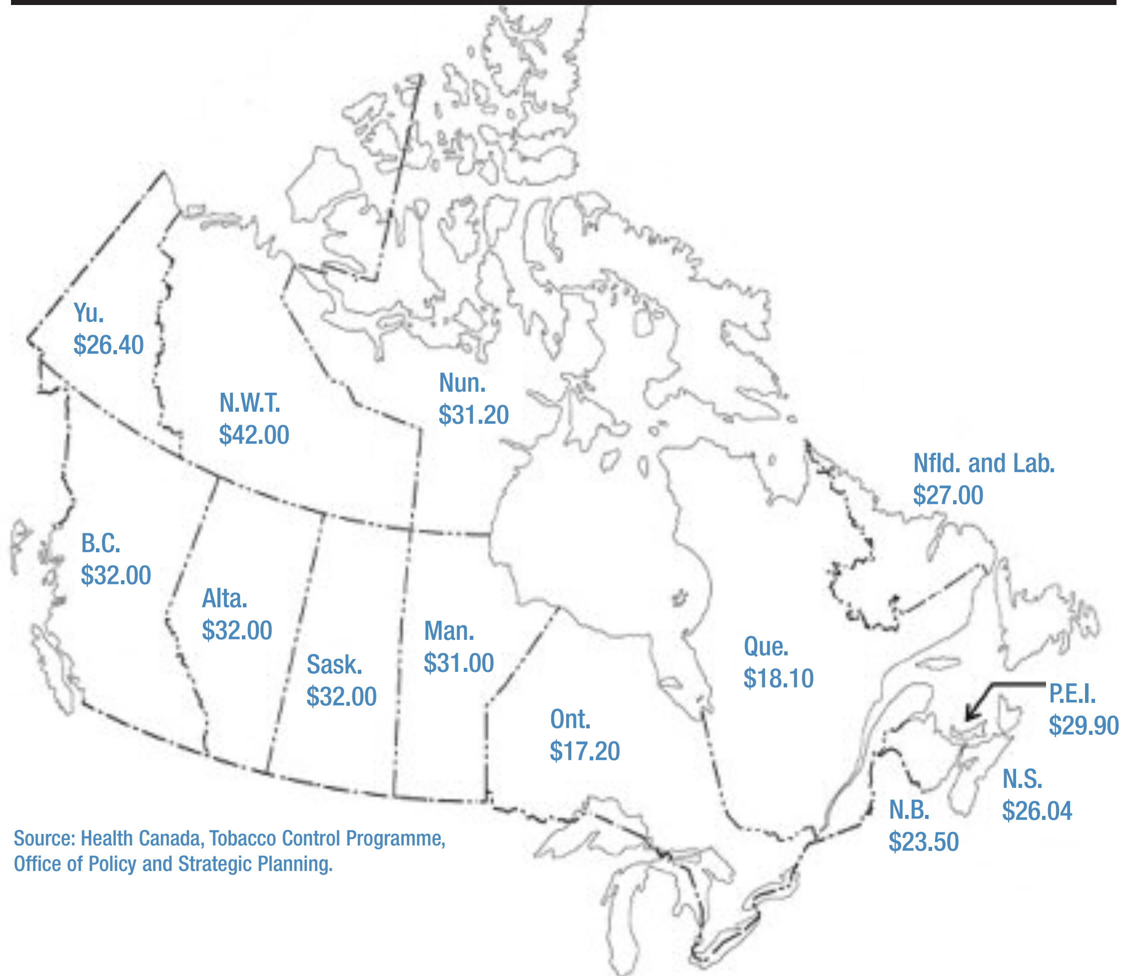
— United States Surgeon General, 2000

Tobacco taxation is a delicate balancing act. While higher tobacco prices contribute to reductions in consumption, price increases can overshoot their objective and trigger contraband. This situation occurred between 1991 and 1993 when the figures for domestic cigarette sales dropped substantially while the sale of contraband cigarettes escalated (Figure 8). In 1994, as part of the National Action Plan to Combat Smuggling, federal taxes were temporarily rolled back. Over the past five years, federal tobacco taxes have been gradually increased and a uniform federal tobacco tax rate has been established across the country.

Taxation measures have been coordinated with the efforts of a number of federal government departments and agencies such as Justice Canada, the Solicitor General, the Royal Canadian Mounted Police, and the Canada Customs and Revenue Agency.

As with all aspects of tobacco control, taxation efforts have gone forward with the collaboration of the provinces and territories (Figure 9). Throughout Canada, tobacco taxes now exceed their pre-1994 levels. Altogether, taxes now represent at least 70% of the price of cigarettes.

Figure 9 Provincial and territorial tobacco taxes per carton of 200 cigarettes as at April 30, 2003



Source: Health Canada, Tobacco Control Programme, Office of Policy and Strategic Planning.

Since the 2002 *Moving Forward*, the following provincial and territorial tax increases have been implemented.

On April 10, 2003, the government of **Prince Edward Island** announced a tax increase of $7.00 per carton of 200 cigarettes with a proportionate increase for other tobacco products.

In March 2003, **Newfoundland and Labrador** announced an increase in the tax on manufactured cigarettes from 13.5 cents to 15 cents per cigarette. The tax on fine-cut tobacco was increased from 11 cents to 15 cents per gram.

Nova Scotia implemented a tax increase of $5.00 per carton of cigarettes in April 2002 and a further increase of $5.00 per carton in January 2003.

In June 2002, **Quebec** raised its tobacco tax by $5.00 a carton.

Ontario's tobacco tax was raised by $5.00 per carton in the June 2002 budget.

As of April 23, 2003, **Manitoba** increased tobacco taxes by 1 cent per cigarette raising the price of a carton by $2.00. Tax rates on fine-cut and raw-leaf tobacco were also raised and, for the first time in a decade, the tax rate on cigars was raised (from 45% to 60% of the selling price).

On April 1, 2003 the **Northwest Territories** increased its tax on cigarettes by $8.80 per carton and 3 cents per gram on loose tobacco.

In July 2002, the **Yukon** government introduced a 4-cent tax increase on tobacco products. This raises the cost per carton by $8.00.

The government of **British Columbia** implemented a 1-cent increase in the per unit tax rate on tobacco on February 18, 2003. The increase applies to cigarettes, tobacco sticks, and loose tobacco. This raises the cost per carton by $2.00.

New Brunswick implemented tax increases in June and December 2002, which increased the cost per cigarette from 7.25 cents to 11.75 cents. This raised the cost per carton by $9.00.

Moving Toward a Smoke-Free Society

New Directions for Tobacco Control in Canada: A National Strategy identified four goals to help achieve a smoke-free society: prevention, cessation, protection, and denormalization. Because reducing the use of tobacco products is such a complex problem, these goals encourage all those working in tobacco control to break the problem down into manageable segments.

Prevention

A large factor in Canada's progress against smoking can be attributed to the growing number of quitters. In fact, ex-smokers now outnumber smokers. Unfortunately, unless youth can be convinced to never begin smoking, the market for tobacco products renews itself every generation.

While many avenues are pursued to achieve this goal, restricting sales of tobacco products to youth is crucial. Under the federal *Tobacco Act*, it is illegal to furnish tobacco products to anyone under the age of eighteen. Provincial legislation in six provinces sets the age limit at 19.

Table 1 Retailer compliance monitoring, by province, January–December 2002

	Compliance checks[a]
Nfld. and Lab.	2 666
P.E.I.	615
N.S.	1 117
N.B.	3 390
Que.	7 043
Ont.	6 688 [b]
Man.	1 336
Sask.	954 [b]
Alta.	2 366
B.C.	13 590
Yu.	84
N.W.T.	37
Nun.	0 [c]

Source: Health Canada, Tobacco Control Programme, Office of Regulations and Compliance

[a] A retailer may undergo one or more checks.

[b] Data from 2001.

[c] Inspections are slated to begin in 2003.

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 2002 over 33,000 compliance checks were performed (Table 1). The collection of compliance information varies by province; some is collected by federal inspectors and some by provincial inspectors.

In addition, Health Canada has obtained retailer behaviour information since 1995 through surveys conducted by ACNielsen. The challenge of advancing compliance has been reflected in marginal annual increases, but the percentage of retailers refusing to sell cigarettes to underage Canadians has now surpassed 70% (2002, 71.2%).

Cessation

The addictive properties of nicotine make quitting tobacco use a difficult lifestyle change for the majority of smokers to attempt. However, over the past two decades a substantial amount of cessation knowledge has been accumulated through medical, psychological, and behavioural research.

While no single approach is suitable for everyone, the proliferation of cessation programs could benefit, at this point in time, from a more coordinated approach. To this end, in January 2003, Health Canada formed a National Advisory Committee on Cessation composed of representatives from provincial and federal governments and non-governmental organizations, and health intermediaries. This committee will examine options, provide support, and encourage the development of a coordinated national approach to cessation.

Among the more recent cessation tools, web-based programs and quitlines are providing information, motivation, and support to smokers throughout Canada. All ten provinces are currently served by toll-free quitlines. To maximize their benefits, there is now a national network of quitlines.

While the number of users of web-based cessation services and quitline services can be tracked, information on their effectiveness in helping Canadians quit smoking does not yet exist. However, the University of Waterloo's Centre for Behavioural Research and Evaluation is conducting a three-year rigorous evaluation of their effectiveness with support from Health Canada.

Protection

Last year, over 1,000 Canadians died from causes attributable to tobacco use even though they themselves did not smoke. Research over a 50-year period has established that cigarette smoke contains more than 4,000 chemicals, including carbon monoxide, formaldehyde, benzene, and hydrogen cyanide.

Although most provinces and more than 300 Canadian municipalities and regional governments now have some form of non-smoking legislation or bylaw, protection has focused on day cares, schools, retail stores, government workplaces, and public transport. Restaurants and bars are still exempted from many of these bylaws. As a result, more than 3 million Canadian workers are without protection from second-hand smoke and another 8 million have only partial protection.

Recently, extensive national and provincial media campaigns have helped inform Canadians of the risks of smoking and of second-hand smoke. This is one area where the efforts of individuals such as Barb Tarbox and Heather Crowe can make a difference. Barb Tarbox, a former international model, began smoking in the seventh grade. When she learned that she was dying of lung cancer, she committed herself to reaching as many Albertan youth as possible with her passionate message against smoking. At 57, Heather Crowe developed lung cancer—although she never smoked, she spent her working years breathing second-hand smoke in the restaurants where she worked.

By courageously telling their stories to the public, these women showed the personal pain behind the impersonal statistics. Barb Tarbox persisted in her efforts until she was physically unable to continue. Although she passed away in May 2003, her legacy will be manifested in those youth who will never forget her and who will choose health over tobacco.

Denormalization

The goal is to make tobacco use socially unacceptable. Efforts toward denormalization operate on three different levels. Information on the hazardous, addictive nature of tobacco use clearly categorizes smoking as thoroughly undesirable. Individuals, particularly adolescents, are encouraged to view tobacco use as socially unacceptable. And finally, Canadians are being educated about the marketing strategies and tactics of the tobacco industry. Adolescents especially need to be informed about the industry's marketing techniques so that they will not be as susceptible to the links made by advertising between smoking and popularity, attractiveness, and rebellion against conformity.

The 1997 *Tobacco Act* restricted all tobacco product promotion, including a ban on lifestyle advertising and a prohibition of sponsorship promotions as of October 2003. It is prohibited to offer free tobacco products, and sales promotions are restricted. In addition, there are now five provinces whose legislation contains various forms of advertising, display, or promotion restrictions.

Progress in Strategic Directions

The 2003 progress report presents brief reports from the provinces, territories, non-governmental organizations, and the federal government that represent activity and achievements in three of the National Strategy's five strategic directions. This year's *Moving Forward* reports on: Policy and Legislation, Public Education, and Building and Supporting Capacity for Action. In 2001 and 2002, *Moving Forward* had included achievements in the other two strategic directions: Industry Accountability and Product Control, and Research, Evaluation, and Monitoring.

While the National Strategy has identified four goals—prevention, cessation, protection, and denormalization—most initiatives, even when intended to address a single goal, often have overlapping impacts. For example, legislation that establishes smoke-free environments provides protection from second-hand smoke; it also supports smokers who are trying to quit and reinforces the notion that smoking is an undesirable behaviour.

The strategic directions help identify the most appropriate types of interventions or actions for achieving prevention, cessation, protection, and denormalization goals. They provide the basis for planning, implementing, and evaluating actions.

With so many tobacco control initiatives taking place in Canada, *Moving Forward* can present only a few examples that illustrate the types of efforts and achievements being made. In most cases, the impact of these initiatives will not be measurable for some time nor is it possible to definitively link a change in statistics with an individual initiative. But their aggregate impact is reflected in the continually decreasing smoking prevalence and tobacco consumption rates, and in the growing acceptance in Canada of non-smoking as the norm.

Policy and legislation

Legislation plays a critical role in reducing the demand for tobacco products by limiting the tobacco industry's marketing practices and supporting a social environment that discourages uptake and encourages quitting. Since the earliest days of tobacco control efforts, all levels of government have enacted various types of legislation to reduce tobacco use. Each enactment has encouraged other jurisdictions to enact similar or stronger statutes, regulations, or bylaws. Similarly, one jurisdiction's experience in defending legislation in court has blazed a trail for others to follow.

Tobacco control legislation

The **Prince Edward Island** *Smoke-free Places Act* came into effect in June 2003. The Act protects the public and workers from the harmful effects of second-hand smoke. It prohibits smoking in public places and workplaces, except in places that are permitted to have a designated smoking area. Designated smoking areas must be either a fully enclosed room with a negative air

pressure or an outdoor area. They are all no-service areas and workers are not obligated to enter them. Public support for passage of the Act was strong—84% of all those polled and 60% of smokers polled were in favour of it.

In August 2002, amendments to **Manitoba's** *Non-Smokers Health Protection Act* received royal assent. Effective January 2004, the Act will prohibit the display of tobacco and tobacco-related products that are visible to children in retail stores. A wide variety of other advertising restrictions were included and fines will be increased substantially from $1,000 to $3,000 for a first offence, and from $5,000 to $15,000 for subsequent offences.

In January 2003, the government of **Northwest Territories** released a discussion paper on legislative options to control tobacco use and began a public consultation process with the intention of placing tobacco control legislation before the legislature in 2004.

Nova Scotia's *Smoke-Free Places Act* came into effect in January 2003. It restricts smoking in most workplaces and public places in the province.

Nunavut has tabled Bill 33, the *Nunavut Tobacco Control Act*, which will place restrictions on advertising, access, and involuntary exposure to second-hand smoke. It has passed first and second reading.

Quebec examined 3,305 complaints filed under the terms of its *Tobacco Act* and issued 814 sanctions.

In April 2003, **Alberta** enacted the *Prevention of Youth Tobacco Use Act*, which makes it illegal for youth under the age of 18 to use or have possession of tobacco in a public place. Offenders are subject to a $100 fine.

Saskatchewan's tobacco control legislation bans the display of tobacco products and advertising in retail establishments where youth are permitted access. In May 2002, Rothmans, Benson and Hedges Inc. filed a suit against the Government of Saskatchewan stating that *The Tobacco Control Act* violates the *Canadian Charter of Rights and Freedoms*. The company further claimed that the provincial legislation conflicts with federal legislation, in which case federal law should prevail. In September 2002, the Court of Queen's Bench ruled that the Act does not conflict with the federal legislation. Rothmans, Benson and Hedges Inc. was granted right of appeal in October 2002. The appeal went before the Court of Appeal in February 2003.

The federal *Tobacco Act*, which received royal assent in 1997, was challenged in court by three major Canadian tobacco manufacturers. They challenged the constitutionality of the Act and its regulations to impose restrictions on advertising and to require tobacco manufacturers to print pictorial health warnings on cigarette packages. Hearings began in January 2002 and ended in September 2002. In its December 2002 decision, the District of Montreal's Quebec Superior Court upheld the Act and its regulations. The three tobacco manufacturers announced in January 2003 that they would appeal the decision. Meanwhile, the Act stays in force and **Health Canada** continues to consider the implementation of new initiatives to reduce tobacco use.

Developing and implementing strategies

Between April 1, 2002 and March 31, 2003, **Ontario** allocated $10 million in support of its tobacco control efforts. Of this amount, $1.2 million was provided to projects for building and supporting community action (such as retailer and community education programs to reduce the supply and sales of tobacco products to youth), to support the implementation of smoke-free bylaws, and to support community education about the hazards of second-hand smoke.

Alberta launched its Tobacco Reduction Strategy with an allocation of $11.7 million. Of this amount, $2 million is funding 40 tobacco control projects for 18 months, as of October 2002. A Community Grant Steering Committee with representation from the Alberta Alcohol and Drug Abuse Commission, Regional Health Authorities, the University of Alberta Research Faculty, and the Interdepartmental Committee on Tobacco Reduction, screened 57 proposals.

The Workers' Compensation Board of **Northwest Territories** and **Nunavut** has initiated a public consultation process after announcing in February 2003 that it intends to eliminate the health hazard of second-hand smoke from indoor workplaces within one year.

The **Manitoba** Minister of Health established an All Party Task Force to recommend ways and means of protecting Manitobans from environmental tobacco smoke. Public meetings began in April 2003.

Nunavut has developed a five-year Tobacco Reduction Strategy that has been presented for approval.

Establishing smoke-free environments

The 1985 *Non-Smokers' Health Act* prohibited smoking in federal and federally-regulated workplaces, on inter-provincial transit, and on airplanes. Most provinces have enacted laws restricting smoking in public places, and over 300 municipalities are currently at different stages in passing smoke-free bylaws. These acts, regulations, and bylaws differ considerably so that there is no consistent standard of protection from one area to another.

On April 15, 2003, the City of Iqaluit, **Nunavut** joined the ranks of municipalities with smoke-free bylaws. In August 2002, Nunavut's Department of Health and Social Services had provided assistance for an opinion survey. Of the 500 randomly contacted residents surveyed, 95% believe that second-hand smoke is dangerous; 91.9% believe that there should be smoke-free places in Iqaluit; and 56.2% of smokers said that if bars were smoke-free they would still patronize them.

As of May 2003, 69.1% of **Ontario's** population are protected by municipal bylaws that regulate smoking in public places, including restaurants and bars.

Brandon, **Manitoba** accessed a Municipal Fund established by the government of Manitoba to assist municipalities with public education efforts when establishing no-smoking bylaws. Brandon now has a complete ban on smoking in all enclosed public places. The Municipal Fund, with a total of $125,000, is part of Manitoba's Tobacco Control Strategy.

As of July 2002, the City of Dawson, **Yukon**, put into effect a bylaw that creates smoke-free space in those establishments that cater to minors.

To help towns and cities introduce effective non-smoking bylaws, **Health Canada**, through its **Tobacco Control Programme**, collaborated with the **Federation of Canadian Municipalities** to produce and pilot test a resource kit, "Smoke-Free Public Places: You Can Get There." Ten communities are currently testing the kit.

Contributing to international tobacco control guidelines

As a nation, Canada has learned that tobacco control is everyone's responsibility—even globally. Recognizing this, Canada played a significant role in negotiations to achieve the first international health treaty—the Framework Convention on Tobacco Control. The Convention strengthens tobacco control measures by requiring that all signatory countries implement tobacco control strategies. It also provides a common basis for international collaboration on difficult cross-border issues such as cigarette smuggling and tobacco advertising.

Throughout the process, Canada's involvement included the provinces, territories, and national non-governmental organizations. The two meetings held in preparation for the international negotiations were hosted in Canada by **Nova Scotia** and **British Columbia**, in 1996 and 1998, respectively. **Health Canada** brokered the agreement whereby NGO observers attended the negotiations; assisted NGOs from some developing countries to travel to Geneva; and included an NGO representative on the delegation.

The Canadian delegation was very active throughout the six Intergovernmental Negotiating Body sessions held between October 2000 and March 2003. Because of Canada's extensive tobacco control experience, representatives from other countries often approached our delegation for technical background and advice. There are few countries that can claim Canada's comprehensive, collaborative approach, as well as science-based regulatory authority for tobacco. When agreement was difficult to reach in plenary and informal sessions, Canada, in conjunction with a number of other countries, often helped develop consensus language.

In the final hours of negotiations, Canada worked to ensure that the Convention text specifies that health warning messages on packaging must meet a minimum size requirement and be rotating, large, clear, visible, and legible. Canada's graphic health warnings are increasingly being accepted worldwide as the standard for cigarette packaging.

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 all Canadians. A growing number of cessation programs and aids are available from a variety of sources, frequently through collaboration between government and non-governmental organizations.

Information and mass media campaigns

The **Heart and Stroke Foundation of Ontario** conducted an interim evaluation of a province-wide mass media campaign that began in 1999. Of 600 Ontarians surveyed, 82% said that the ads were credible and believable and 68% (up from 65% in 2000) agreed that the government should regulate smoking in public places to protect non-smokers. In 2000, 70% of those surveyed believed that smoking is a personal choice and should not be regulated, while the 2002 results show that only 57% agree with that statement.

The **Canadian Cancer Society's** Cancer Information Service on tobacco-related subjects received 3,394 calls. This does not include calls from British Columbia, Ontario, or Quebec, which have separate information services.

Saskatchewan provided funding to the Saskatchewan Coalition for Tobacco Reduction for a public education campaign targeted at hospitality workers, managers, and patrons of restaurants and bars. Posters featuring Heather Crowe's message calling for protection for workers from second-hand smoke have been posted in restaurants and bars throughout the province. Heather Crowe is a non-smoker who developed lung cancer from second-hand smoke in her workplace.

The **British Columbia-Yukon Division of the Canadian Cancer Society** conducted a similar campaign during 2002–03, also featuring Heather Crowe and targeting workers, managers, and patrons of restaurants and bars. The message to restaurant and bar owners was: since the majority (over 80%) of British Columbians are non-smokers, going smoke-free will not damage your business.

The **Alberta Alcohol and Drug Abuse Commission** implemented a wide variety of media promotions between October 2002 and March 2003, while its Resource Development Unit produced and distributed quit brochures, posters, and a tobacco basics handbook to support the media campaign.

In July 2002, **Alberta** launched ASTEP (Alberta Spit Tobacco Education Program) to educate adults and youth on the dangers of using spit tobacco. The campaign targets small rural rodeos and community events.

In February 2003, **Newfoundland and Labrador's** Alliance for the Control of Tobacco, with funding from **Health Canada**, launched phase one of a three-year environmental tobacco smoke mass media campaign.

In January 2003, **Nova Scotia**, with funding support from **Health Canada**, launched a three-year tobacco public awareness campaign, which targets youth and young adults. The first year's activities include developing new television advertising, a Web site, posters for high school washrooms, and grassroots media training.

Cessation promotion and programs

Prince Edward Island completed its "Quit Smoking Program" pilot in January 2003. Participants in this intensive individual or group-counselling program are eligible for up to $75 in assistance for nicotine replacement therapies or Zyban. An initial evaluation revealed that 28% of the 730 participants stopped smoking and another 14% reduced the amount they smoked. Participants ranged in age from 18 to 82 with an average age of 45. A final evaluation will take place after a six-month follow-up.

“You’re Pregnant—It’s Time to Quit Smoking,” a 10-page booklet, was produced by the government of **Nunavut**. It distributed a total of 6,000 copies, with copies available in English, French, Inuktitut, and Innuinaqtun.

Saskatchewan Health has provided Health Regions with three tobacco cessation resources: Kick the Nic, designed especially for youth; The Nicotine Quit Kit; and the Quit and Stay Quit Nicotine Cessation Program, both intended for adult smokers.

Quebec implemented its province-wide cessation program with a combination of activities and supports, including a Quit and Win contest, a Web site to support quitting, a free quitline, and the operation of 100 cessations centres throughout the province.

The Anti-Tobacco Coalition in **New Brunswick** is promoting a coordinated and integrated network of supports available to help smokers quit. Brochures to enable providers to support clients who wish to quit, have been distributed to all providers in this Cessation Network. This includes Regional Health Authority staff in addictions; community health centres; the Extra-Mural program; Clinical Tobacco Intervention program participants (dentists, physicians, dental hygienists, pharmacists, nurses, etc.); Public Health staff; the Victorian Order of Nurses; the Canadian Cancer Society; and the New Brunswick Lung Association, etc.

Creating incentives

The **Northwest Territories/Nunavut Branch of the Canadian Public Health Association** ran a Quit and Win contest for the first time in the Northwest Territories. Over 550 smokers enrolled in the contest, which maintained a positive focus on the health benefits of quitting. An evaluation was conducted after the required three-month smoke-free period. Of the participants who responded by mail, 60% reported being smoke-free after the contest ended. Of the participants surveyed by telephone, 40% were still smoke-free after the three-month contest.

The 2002 Quit and Win contest in **Ontario** had 15,365 entrants—an increase of 4,565 over 2001.

Quitlines

Ontario’s Smokers’ Helpline, which is operated by the **Ontario Division of the Canadian Cancer Society**, received 7,132 calls between April 2002 and February 2003. This is an increase over last year’s 6,994 calls. New clients accounted for 90% of the calls.

In the fall of 2002, the **Newfoundland and Labrador Lung Association**, with funding from **Health Canada**, and in partnership with the Department of Health and Community Services and the **Alliance for the Control of Tobacco**, expanded and enhanced its Smokers’ Helpline services to provide increased hours of operation and a web-based support forum.

A number of new quitlines were established in 2002-03 and cessation information and support are now available in all ten provinces and Yukon.

Through federal, provincial, and territorial collaboration, a national network of quitlines has been established and is guided by a Federal Provincial Territorial Steering Committee.

On November 1, 2002, **New Brunswick's** Anti-Tobacco Coalition, with funding from **Health Canada**, launched a Smokers' Helpline with mass media promotion and ongoing promotion to health care providers through the Cessation Network. Between November 2002 and March 2003, 583 callers have used the Helpline. Counsellors from the Smokers' Helpline have access to the Cessation Network database of service providers from all regions of the province who can provide individual or group cessation counselling. As of March 31, 2003, 71 cessation providers have joined the Cessation Network.

The **Alberta Alcohol and Drug Abuse Committee** launched a toll-free Smoker's Help Line in October 2002.

In November 2002, the **Nova Scotia Division of the Canadian Cancer Society**, with funding support from **Health Canada**, launched the Nova Scotia Smokers' Helpline with a press conference that received extensive media coverage. This was followed up with a promotional campaign.

In January 2003, **Yukon**, introduced a *Smokersline* Web site and an information phone line to provide Yukoners with easy access to quit information and resources.

The **Prince Edward Island Reduction Alliance** launched its Smokers' Helpline during National Non-smoking Week with promotions throughout January. Workshops and promotional material were provided for professionals who advise people on quitting.

Go smoke free!

The Smoke-Free Homes Committee of the **Prince Edward Island's** Tobacco Reduction Alliance ran a successful social marketing and community engagement campaign in the fall of 2002. Overall, 6% of Island households pledged to make their homes smoke-free while over 30% of households in some communities participated.

In the 2001–02 school year, fewer than ten schools in **New Brunswick** had 100% tobacco-free environments (buildings and school grounds). By the 2002–03 school year, with support from the Tobacco Free Schools working group of the Anti-tobacco Coalition, all 51 of the province's English-language and 13 of its 21 French-language high schools are, or have set a date to become, 100% tobacco free. To further support this effort, the Department of Health and Wellness put in place a three-year grant program for schools that had developed an action plan to be 100% tobacco free. Of the province's 72 high schools, 57 met these criteria and received grants in 2002–03.

On the opposite coast of Canada, **British Columbia** joined the World Health Organization in putting the spotlight on tobacco-free sports. A province-wide invitation invited youth, athletes, sports teams, schools, universities, and community sports organizations to accept a tobacco-free sports challenge.

Especially for youth

In October and November 2002, **Ontario's** TeenNet, which runs web-based prevention and cessation information programs that are developed by youth for youth, ran its "Smoking Zine" intervention with over 1,500 Toronto-area high school students in grades 9 through 11. The first follow-up survey was conducted in January and February 2003.

Yukon's YESNET (Yukon Educational Student Network) now has links to tobacco-awareness Web sites. The Department of Health and Social Services also sponsored a speaking tour featuring Georgina Lovell, author of *You are the Target. Big Tobacco: Lies, Scams—Now the Truth*. Several rural schools were included by videoconference. In all, 1,100 students heard Ms. Lovell.

In January 2003, "No More Butts," a peer-led, group-based cessation program tailored to high school students was implemented in **Nova Scotia's** high schools.

In **Saskatchewan**, tobacco prevention education units were developed for grades 3, 5, and 6. In grade 3, students will learn how to resist media messages and, in grade 5, about the harmful effects of tobacco. Grade 6 students will learn about the addictive nature of tobacco.

The **Alberta Lung Association** was contracted to implement BLAST—Building Leaders for Action in Schools Today—which targets students in grades 7 through 9 and provides guidance and funding for youth-led tobacco reduction projects. Alberta also funded cancerhead.com, with 17 episodes for web distribution that are aimed at 12- to 17-year olds.

In **Newfoundland and Labrador**, the Alliance for the Control of Tobacco, the Department of Health and Community Services, and the Department of Education partnered to develop a tobacco prevention education resource for a new Healthy Living 1200 course for high schools. Introduced in September 2002, the "Smoking Sucks" education resource helps students analyze and evaluate the impact of smoking on their health and well-being. It includes advertisments developed for the "Smoking Sucks" media campaign, fact sheets, and a teacher's lesson plan. All 160 high schools in the province were sent a copy of the "Smoking Sucks" education resource and ten copies were sent to the school district offices.

Building and Supporting Capacity for Action

The National Strategy recognizes that we must increase the ability of organizations, communities, and governments to take action. Collaboration creates synergy and disseminates knowledge and skills. Participants, particularly non-governmental organizations, often bring complementary strengths to government-led endeavours.

New Brunswick launched the Anti-Tobacco Coalition in October 2001. One of its key goals was to increase the number of individuals taking action to support anti-tobacco activities. Over the span of one year, active participants in the Coalition have grown from fewer than ten at the launch to 105 individuals

present at the second annual meeting, who represented a wide variety of organizations. The Coalition's first annual progress report described 39 actions: 24 completed and 15 either in process, ongoing, or planned.

By the third quarter of 2002–03, the **Ontario Tobacco-Free Network**, which works with 75 coalition groups province-wide, had made 755 contacts, including various boards of health, community health centres, various levels of government, and major health care organizations.

The government of **Québec** and **Health Canada** provided financial support for the first international conference on tobacco control for French-speaking countries, which was held in September 2002. La première conference internationale francophone sur le contrôle du tabac was organized by l'**Association pour la santé publique du Québec** and la **Coalition québécoise pour le contrôle du tabac.**

Québec also provided support for the Centre de documentation sur le tabac et la santé and to **Nunavut** for a no-smoking media campaign.

Saskatchewan and **Health Canada** funded the Saskatchewan Coalition for Tobacco Reduction to organize a conference. Held in March 2003, "Take Five: Practical Strategies in Tobacco Reduction in Saskatchewan" focused on strategies, community action, and resources.

Cancer Care Ontario supported and facilitated a planning process for the Ontario Tobacco Strategy Steering Committee that resulted, in November 2002, in a three-year plan with goals and objectives to help coordinate Ontario's tobacco control strategy.

The **Alberta Alcohol and Drug Abuse Commission** has hired 25 Community Tobacco Reduction Counsellors to help communities develop local resources, cessation supports, school-based tobacco education, and regional networks.

To enhance communication between different levels of government and between **Health Canada** and its NGO collaborators, Health Canada sponsored the Third National Conference on Tobacco or Health, which was held in December 2002. Close to 600 participants travelled to Ottawa to share their knowledge of tobacco control and to network with other members of the tobacco control community. Costs were offset for 50 participants by a Health Canada bursary.

Youth-to-youth

Manitoba has joined the growing list of provinces that have established Youth Advisory Committees to ensure that tobacco control initiatives speak to youth and reflect their interests and concerns.

The 14 youth members of **Nunavut's** "Minister's Youth Action Team on Tobacco" began their work by gathering in Iqaluit for their first face-to-face meeting for five days in March 2003.

Training

In the fall of 2002, the **Newfoundland and Labrador Lung Association**, with funding from **Health Canada**, developed an Adult Cessation Facilitator Training Guide. The guide is being distributed to health and community organizations through regional training workshops.

New Brunswick's Clinical Tobacco Intervention (CTI) program for health professionals, an integrated component of the Cessation network, is led by the **New Brunswick Medical Society** with participation from a variety of other health professional organizations. Ten individuals, who can provide information/training sessions throughout the province, were trained in December 2002. Between December 2002 and March 2003, 32 health professionals, who interact with tobacco users, attended these sessions on CTI's "Ask-Advise" program.

In September 2002, **Saskatchewan** established a Tobacco Retailer Training Editorial Advisory Committee to provide guidance and advice on education and training for retail owners, managers, and staff regarding tobacco sales to minors, and tobacco advertising and display. In addition, Saskatchewan Health and Saskatchewan Justice held a two-day workshop on ticketing and prosecutions related to the advertising and sales provisions of *The Tobacco Control Act*.

Yukon's Health Promotion Unit sponsored sessions for physicians and allied health professional to learn new skills for cessation counselling.

Conclusion

Science and medicine have wrought wonders with their ability to identify the causes of disease, to devise cures, and to develop preventive measures. How much easier it would be to eliminate tobacco use if its uptake could be explained by a single isolated cause. Unfortunately, despite the physiological aspect of tobacco use—the addictive nature of nicotine—it cannot be cured or prevented solely through the application of scientific research methods because tobacco use is entwined in social behaviour and embedded in a social context.

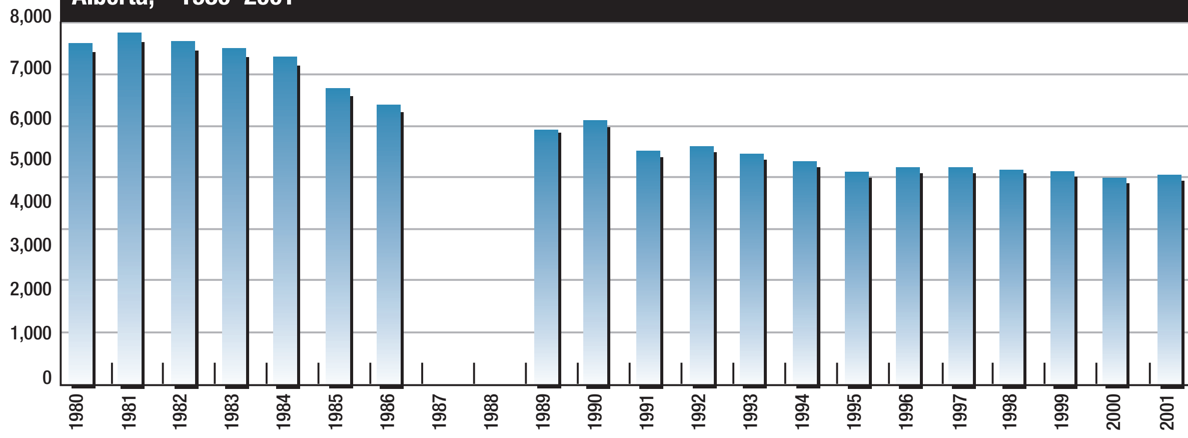
Despite the daunting complexity of this problem, Canada has managed to significantly reduce the percentage of Canadians who use tobacco. Over time, we have learned through experience, and are still learning, what works and what doesn't. We have learned how to plan, propose, pass, implement—and when necessary, defend in court—tobacco control legislation. We have learned to support that legislation with research, monitoring, and surveillance. We have learned to craft and target media campaigns that inform and persuade. We have learned to extend our tobacco education efforts to the very young. And we have learned that tobacco control is everyone's problem: we must share best practices, disseminate information, and work co-operatively.

This third progress report on the National Strategy for tobacco control provides a vehicle for input into the continuous learning process by identifying what works, as we strive to make Canada a safer and healthier place to live by reducing tobacco consumption.

Appendix A:

Domestic Cigarette Sales from the Manufacturer to the Wholesaler by Province and Territory, 1980–2001

Figure A-1 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Alberta,[a-c] 1980–2001



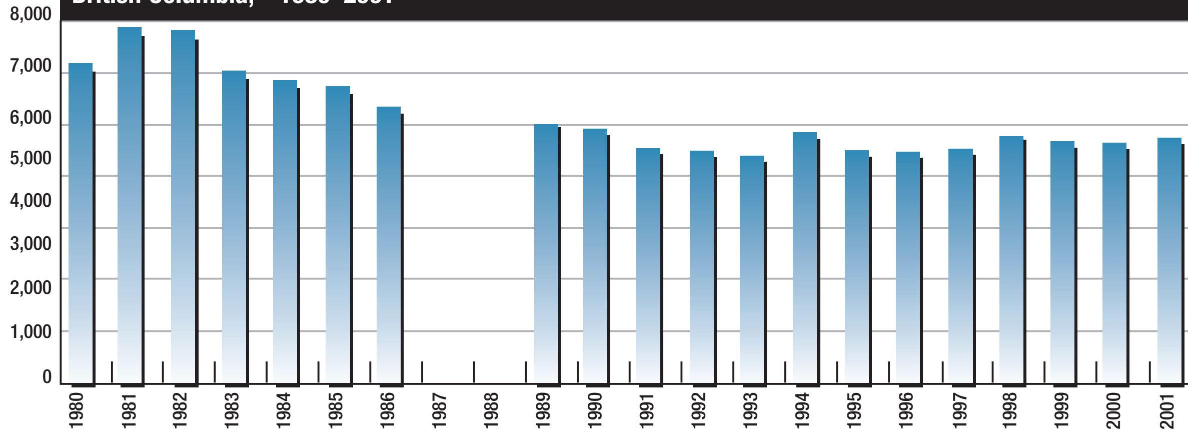
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-2 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), British Columbia,[a-c] 1980–2001



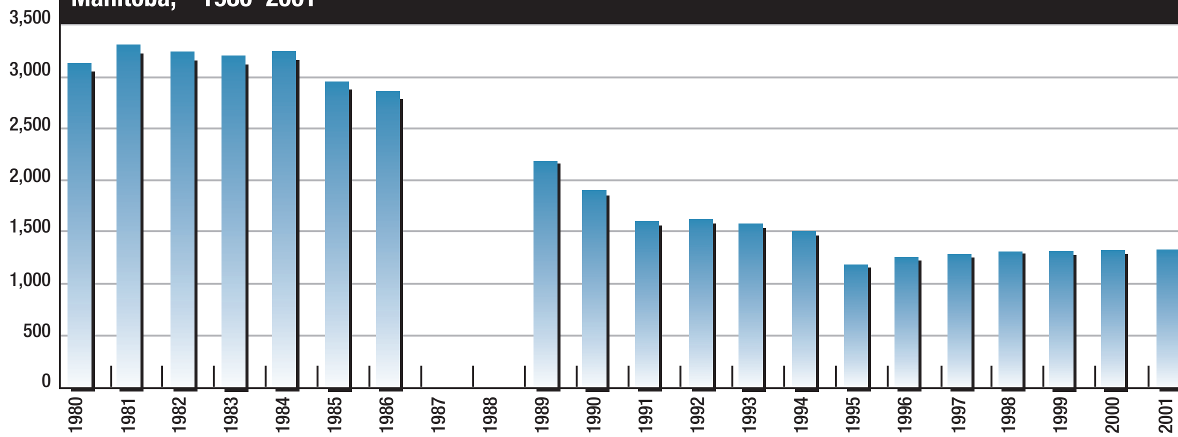
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-3 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Manitoba,[a-c] 1980–2001



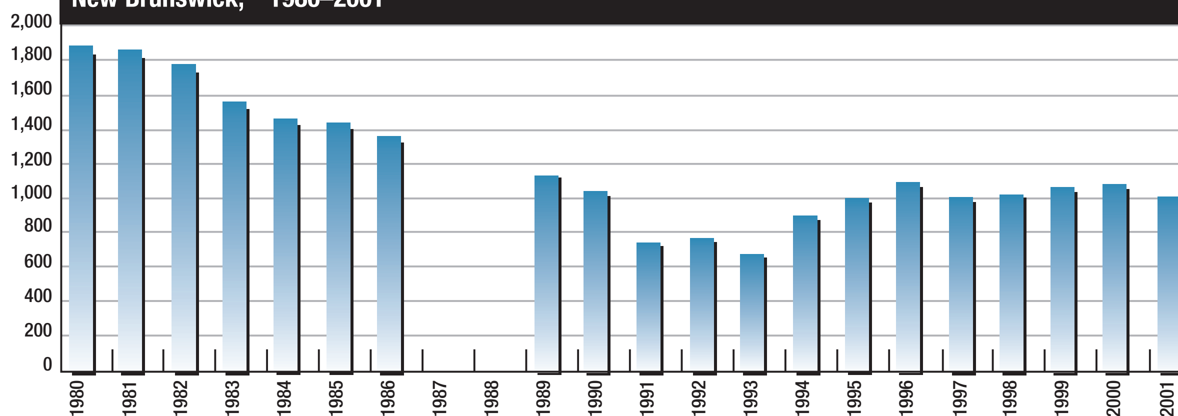
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-4 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), New Brunswick,[a-c] 1980–2001



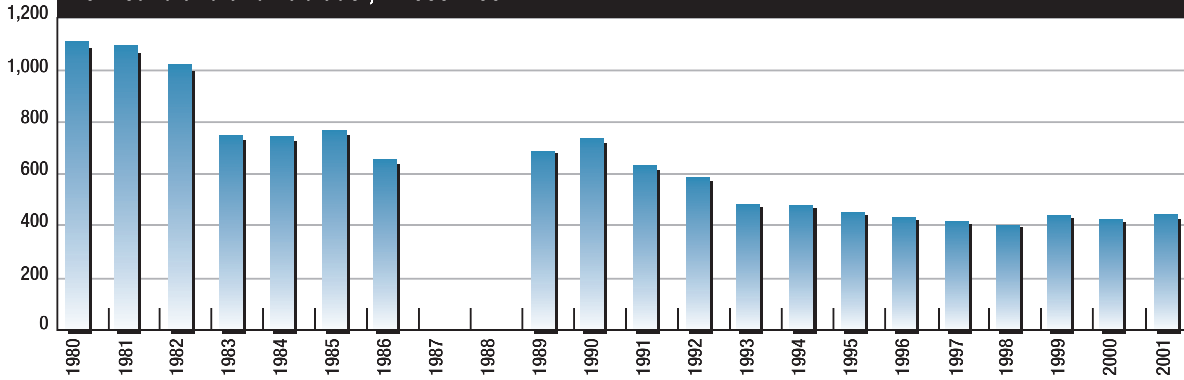
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-5 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Newfoundland and Labrador,[a-c] 1980–2001



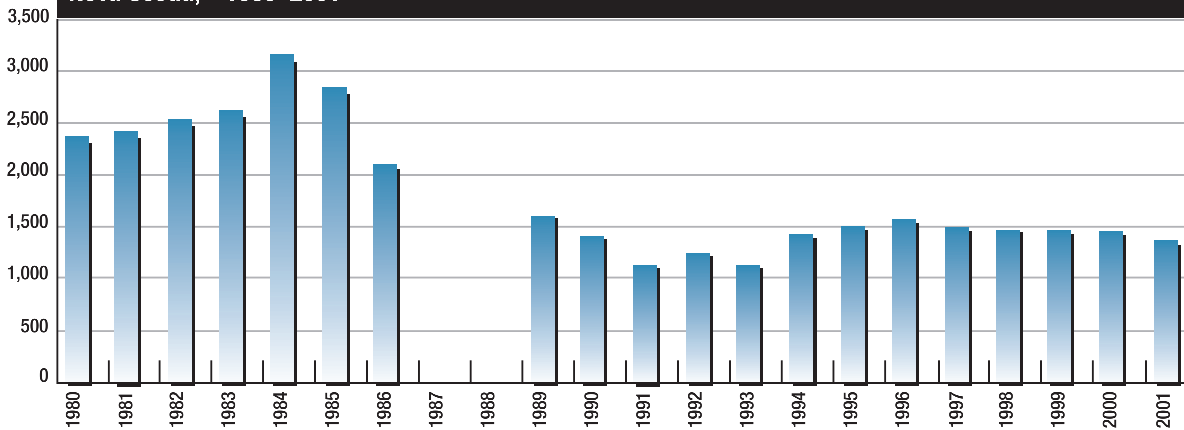
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-6 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Nova Scotia,[a-c] 1980–2001



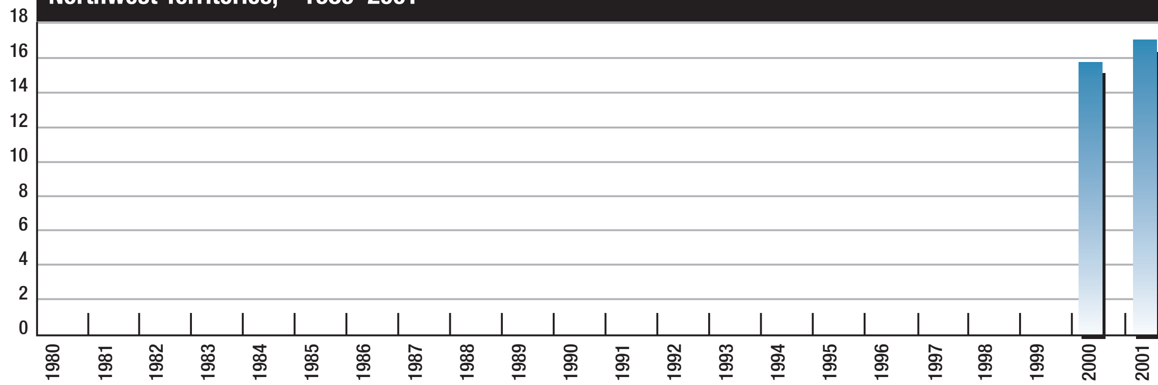
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-7 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Northwest Territories,[a-c] 1980–2001



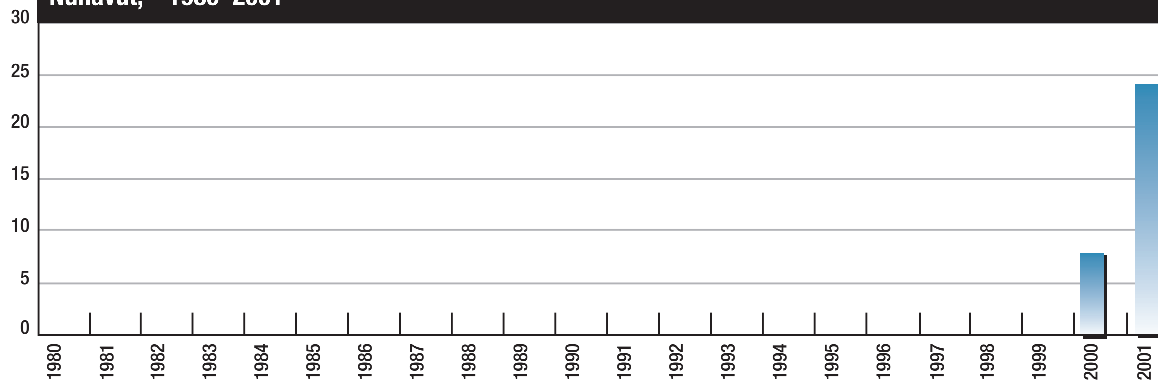
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Sales statistics for the Northwest Territories were not separately reported before 2000.

Figure A-8 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Nunavut,[a-c] 1980–2001



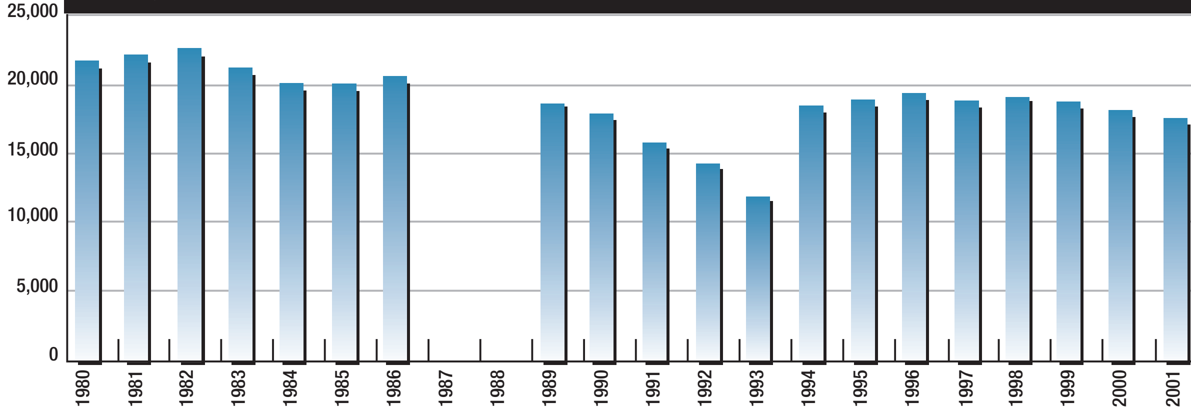
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Sales statistics for Nunavut were not separately reported before 2000.

Figure A-9 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Ontario,[a-c] 1980–2001



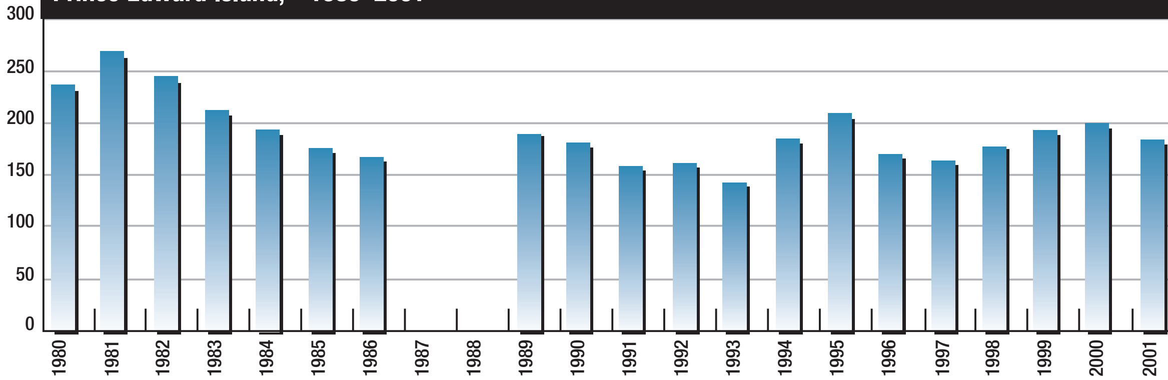
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-10 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Prince Edward Island,[a-c] 1980–2001



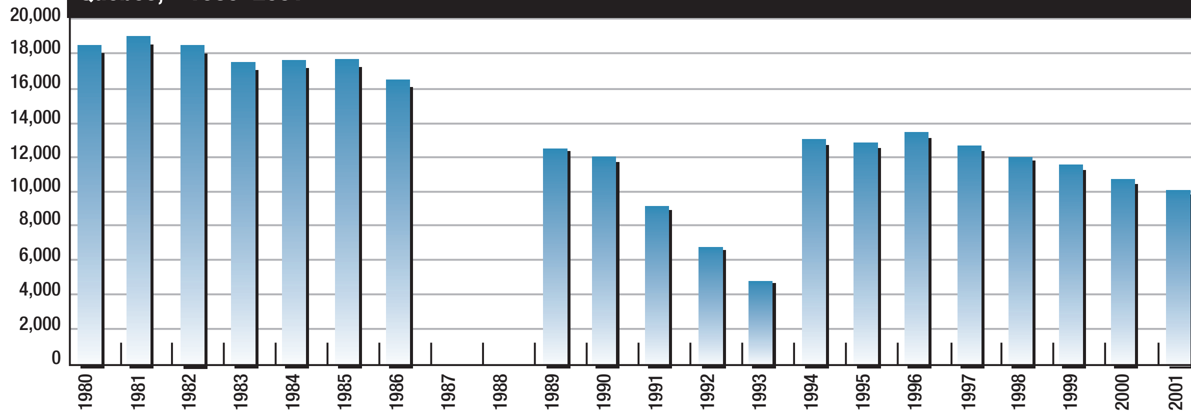
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-11 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Quebec,[a-c] 1980–2001



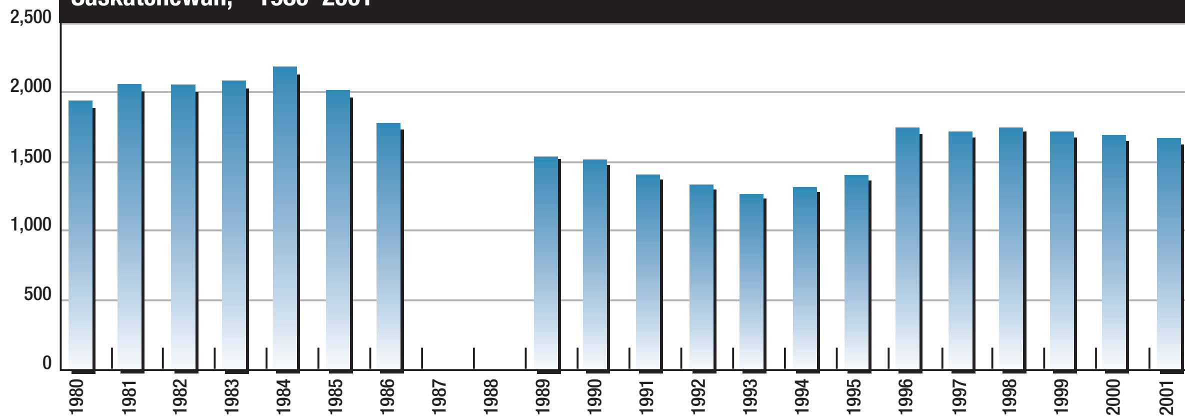
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-12 Domestic cigarette sales from the manufacturer to the wholesaler (millions of cigarettes), Saskatchewan,[a-c] 1980–2001



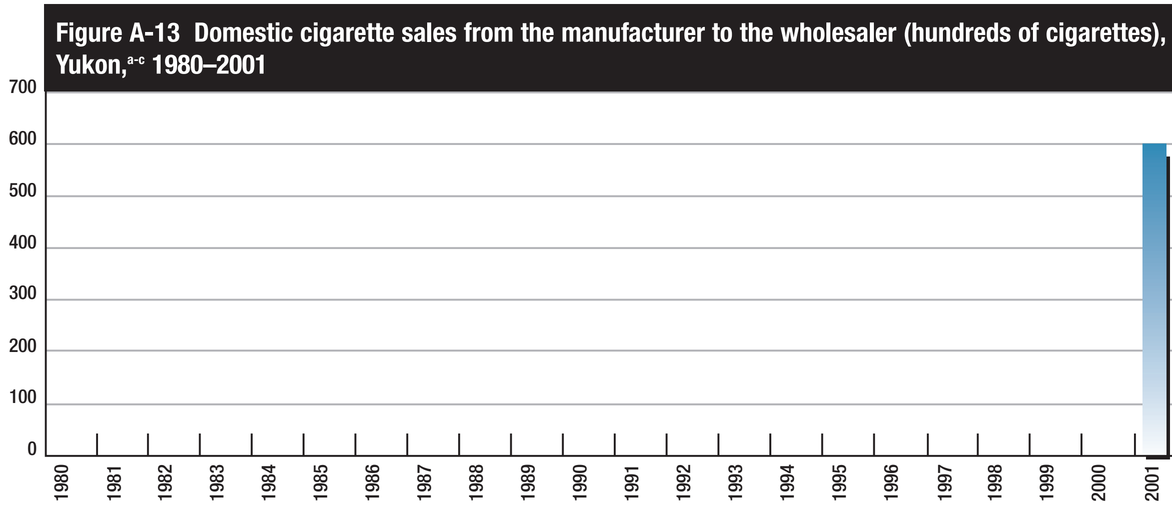
Source: Health Canada, Tobacco Control Programme, Office of Research, Surveillance and Evaluation.

a Excise taxes and duties are not paid on these sales.

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

c Industry sales by province were not reported for 1987 and 1988.

Figure A-13 Domestic cigarette sales from the manufacturer to the wholesaler (hundreds of cigarettes), Yukon,[a–c] 1980–2001



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

a Excise taxes and duties are not paid on these sales.

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

c Sales statistics for Yukon were not separately reported before 2001.

Appendix B:

Member List—Federal Provincial Territorial Tobacco Control Liaison Committee

Andrew Hazlewood (Co-Chair)
Provincial Director General
Ministry of Health Planning
Population Health and Wellness
1515 Blanshard Street, 4th Floor
Victoria, British Columbia V8W 3C8
Telephone: (250) 952-1731 **Fax:** (250) 952-1713
E-mail: Andrew.Hazlewood@gems4.gov.bc.ca

Hélène Goulet (Co-Chair)
Director General
Tobacco Control Programme
P.L. 3507A2, Room D787
MacDonald Building
123 Slater Street
Ottawa, Ontario K1A 0K9
Telephone: (613) 941-1977 **Fax:** (613) 954-2288
E-mail: helene_goulet@hc-sc.gc.ca

Lloyd Carr (AB)
Senior Manager, Tobacco Reduction Unit
Alberta Alcohol and Drug Abuse Commission
10909 Jasper Avenue, 2nd Floor
Edmonton, Alberta T5J 3M9
Telephone: (780) 422-1350 **Fax:** (780) 422-7200
E-mail: lloyd.carr@aadac.gov.ab.ca

Laurie Woodland (BC)
Director of Tobacco Control Programs
Ministry of Health Planning
Population Health and Wellness
RBB 4-2, 1515 Blanshard Street, 4th Floor
Victoria, British Columbia V8W 3C8
Telephone: (250) 952-2847 **Fax:** (250) 952-1570
E-mail: laurie.woodland@gems6.gov.bc.ca

Andrew Loughead (MB)
Tobacco Control Policy Coordinator
Manitoba Health
Public Health, Environment Unit
4070–300 Carlton Street
Winnipeg, Manitoba R3B 3M9
Telephone: (204) 788-6731 **Fax:** (204) 948-2040
E-mail: aloughead@gov.mb.ca

Marlien McKay (NB)
Project Manager, Office of Chief Medical Officer of Health
Public Health Management Services
Department of Health and Wellness
520 King Street, 2nd Floor
P.O. Box 5100
Fredericton, New Brunswick E3B 5G8
Telephone: (506) 444-4633 **Fax:** (506) 453-8702
E-mail: marlien.mckay@gnb.ca

Bernie Squires (NL)
Lifestyle and Health Promotion Consultant
Department of Health and Community Services
Government of Newfoundland and Labrador
P.O. Box 8700
St. John's, Newfoundland and Labrador A1B 4J6
Telephone: (709) 729-1374 **Fax:** (709) 729-5824
E-mail: bsquires@mail.gov.nf.ca

Nancy Hoddinott (NS)
Coordinator, Tobacco Strategy
Nova Scotia Department of Health
1690 Hollis Street, 11th Floor
P.O. Box 488
Halifax, Nova Scotia B3J 2R8
Telephone: (902) 424-5962 **Fax:** (902) 424-0663
E-mail: hoddinnl@gov.ns.ca

Miriam Wideman (NT)
Health Promotion Consultant
Department of Health and Social Services
Government of Northwest Territories
5022–49th Street, Centre Square Tower, 7th Floor
P.O.Box 1320
Yellowknife, Northwest Territories X1A 2L9
Telephone: (867) 920-8826 **Fax:** (867) 873-0202
E-mail: Miriam_Wideman@gov.nt.ca

Erin Levy (NU)
Tobacco Reduction Specialist
Department of Health and Social Services
Government of Nunavut
Building 1107, 3rd Floor
P.O. Box 1000, Station 1000
Iqaluit, Nunavut X0A 0H0
Telephone: (867) 975-5783 **Fax:** (867) 975-5780
E-mail: elevy@gov.nu.ca

Joanne Bergen (ON)
Tobacco Strategy Manager
Ontario Ministry of Health
Tobacco Strategy Unit
5700 Yonge Street, 4th Floor
Toronto, Ontario M2M 4K5
Telephone: (416) 314-5475 **Fax:** (416) 314-5497
E-mail: joanne.bergen@moh.gov.on.ca

Lisa Shaffer (PE)
Community Development/Tobacco Reduction
Public Health and Evaluation Division
Department of Health and Social Services
11 Kent Street, P.O. Box 2000
Charlottetown, Prince Edward Island C1A 7N8
Telephone: (902) 368-6133 **Fax:** (902) 368-4969
E-mail: llshaffer@gov.pe.ca

April Barry (SK)
Director, Health Promotion Unit
Population Health Branch
Saskatchewan Health
3475 Albert Street
Regina, Saskatchewan S4S 6X6
Telephone: (306) 787-4086 **Fax:** (306) 787-3823
E-mail: abarry@health.gov.sk.ca

Ian Parker (YK)
Health Promotion Coordinator
Health and Social Services
Government of Yukon
2 Hospital Road
Whitehorse, Yukon Territory Y1A 3H8
Telephone: (867) 667-8394 **Fax:** (867) 667-8338
E-mail: ian.parker@gov.yk.ca

Havelin Anand (Health Canada)
Director, Policy and Strategic Planning
Tobacco Control Programme
Health Canada
P.L. 3506B, Room D687
MacDonald Building
123 Slater Street
Ottawa, Ontario K1A 0K9
Telephone: (613) 941-9826 **Fax:** (613) 952-5188
E-mail: havelin_anand@hc-sc.gc.ca

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