

T h e N a t i o n a l S t r a t e g y :

M o v i n g F o r w a r d

**The 2001 Federal Provincial
Territorial Progress Report on
Tobacco Control**

Prepared by the Advisory Committee on Population Health Working Group on Tobacco Control.
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Executive Summary

In September 1998, the Provincial/Territorial Conference of Ministers of Health asked the Provincial/Territorial Conference of Deputy Ministers of Health to develop a national tobacco control strategy. Under their direction, the Steering Committee of the National Strategy to Reduce Tobacco Use in Canada in partnership with the Advisory Committee on Population Health prepared *New Directions for Tobacco Control in Canada—A National Strategy*.

Released in 1999, the National Strategy provides a framework encouraging collaborative action by governments and non-governmental organizations to reduce the use of tobacco in Canada. The federal/provincial/territorial Ministers of Health endorsed the strategy, agreeing that sustained, comprehensive, integrated, and collaborative approaches were required for successful tobacco control. Since tobacco use is the most important cause of preventable illness, disability, and premature death in Canada, the desired result for tobacco control is to reduce the number of deaths and illnesses attributable to smoking and exposure to second-hand smoke.

This report, *The National Strategy: Moving Forward*, is the first annual progress report and identifies indicators for measuring progress and establishes baselines to track progress in achieving the National Strategy's goals of prevention, cessation, protection, and denormalization. This first report addresses advances made by the federal, provincial, and territorial governments, often working in partnership with NGOs, community groups, and voluntary health agencies, in support of the National Strategy up to May 2001 and presents data for 2000 where it is available. It is hoped that any future progress reports will include initiatives of non-governmental organizations as well.

While progress is difficult to measure on a year-to-year basis, an annual progress report can track trends over time and pinpoint deficiencies in the knowledge required to combat tobacco use. This report identifies what information is currently available; notes trend data; establishes, where possible, baseline data for previously unreported indicators; and identifies areas where data is not currently available.

The *National Strategy: Moving Forward* presents data on the prevalence of smoking in Canada, on the consumption of tobacco products, on Canada's tobacco industry, and on selected adverse health effects of tobacco use. It also provides anecdotal material on a variety of tobacco control initiatives currently taking place across the country that are indicative of progress in the National Strategy's five strategic directions.

The 2000 data from Health Canada's Canadian Tobacco Use Monitoring Survey indicate that the percentage of smokers in Canada has edged downward to 24% from 30% in 1990. However, prevalence rates among young Canadians continue to be of particular concern since the majority of new recruits to smoking come from among adolescents. Smoking rates among women are also of concern as the decrease in prevalence appears to have flattened with a downward shift of only 0.2% since 1999.

The report also identifies some serious data gaps. There is some indication that the smoking rates for aboriginal groups are much higher than those of the general population, but there is no data collection mechanism that regularly tracks smoking rates among aboriginal groups. There is also a serious lack of data from Yukon, Northwest Territories, and Nunavut. And finally, while the health risks of tobacco use are well established, data collection has focused on certain conditions, particularly lung cancer and cardiovascular diseases. Other illnesses that are known to be associated with smoking, such as asthma and middle ear infections, require more refinement in data collection.

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Introduction

Canada is recognized internationally as a leader in combating tobacco use and in regulating the sale, marketing, and labelling of tobacco products. Through a combination of legislation, public education campaigns, and public health actions, the percentage of smokers in the Canadian population is about half what it was in 1965.

However, the rate of decline in the use of tobacco has slowed over time, raising concerns about how best to move forward toward reducing tobacco use. In September 1998, the Provincial/Territorial Conference of Ministers of Health asked the Provincial/Territorial Conference of Deputy Ministers of Health to develop a national tobacco strategy. Under their direction, the Steering Committee of the National Strategy to Reduce Tobacco use in Canada in partnership with the Advisory Committee on Population Health prepared *New Directions for Tobacco Control in Canada: A National Strategy*.

Released in 1999, the National Strategy provides a framework for action to reduce the use of tobacco in Canada. The federal/provincial/territorial Ministers of Health endorsed the strategy, agreeing that sustained, comprehensive, integrated, and collaborative approaches were required for successful tobacco control.

The revised National Strategy retained three long-standing goals: prevention—keeping youth from starting to smoke; cessation—helping smokers quit; and protection—ensuring smoke-free environments. To these goals, it added a fourth: denormalization—changing Canadians' attitudes toward tobacco products and tobacco use.

The National Strategy is based on a population health framework that addresses a wide range of the known determinants of smoking. A population health framework 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. Obviously, a problem of this complexity and magnitude requires long-term, sustained, and complementary approaches in the areas of research, policy, legislation, and health promotion programs.

While the no-smoking message is meant for all Canadians, interventions directed to the general public must be balanced by interventions tailored to the needs of groups and individuals facing particular risks. Successfully controlling tobacco use and reducing the demand for tobacco products requires diversified strategies that include conducting research, developing policies, and designing effective programs. It also requires a coordinated approach with responsibility shared among all levels of government and non-government organizations. Non-governmental organizations have made substantial contributions to various aspects of tobacco control in Canada and it is anticipated that the next progress report will benefit from their input.

While it is outside the scope of this report, it should be noted that Canada is a leading supporter of international tobacco control efforts and that many Canadian non-governmental organizations, with the support of Health Canada, have participated in World Health Organization meetings to develop an International Framework Convention on Tobacco Control.

Measuring progress is a necessary adjunct to the National Strategy. Given the length of time between the implementation of an initiative and its impact, key indicators must be identified and tracked regularly over a long period of time. This report, *The National Strategy: Moving Forward*, identifies indicators for measuring progress and establishes baselines to track progress. This first report addresses advances made by the federal, provincial, and territorial governments in support of the National Strategy up to May 2001 and presents data for 2000 where it is available.

While progress is difficult to measure on a year-to-year basis, an annual progress report can track trends over time and pinpoint gaps in the knowledge required to combat tobacco use. This report identifies the information currently available; notes trend data; establishes, where possible, baseline data for previously unreported indicators; and identifies areas where data is not currently available.

This baseline report provides information in three sections. Part One presents statistics on the prevalence of smoking in Canada, on the consumption of tobacco products, on Canada's tobacco industry, and on selected adverse health effects of tobacco use. Part Two examines ways of measuring progress toward meeting the strategy's four goals. Part Three provides anecdotal material on a variety of tobacco control initiatives currently taking place across the country that are indicative of progress in the National Strategy's five strategic directions. While space limitations did not permit providing a comprehensive list of activities, the number and extent of initiatives throughout the country is itself an indication of progress in tobacco control and an indication of the commitment at all levels to moving forward with the National Strategy.

Part One: Tracking Key Indicators



Knowledge is often the most powerful change agent. But it is not sufficient to merely know the destination or even the route. The careful traveller notes milestones and landmarks to make sure that the route is followed and the destination attained. To make sure that Canada stays on track and keeps moving forward toward becoming a smoke-free society, certain key indicators must be tracked over time.

The annual progress report to the Ministers of Health will track 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). The progress report will also track selected adverse health effects of tobacco use. To complete the statistical picture of tobacco use, it will present some tobacco industry financial and sales information.

About statistics

Traditionally, tobacco use has been measured in three ways: prevalence, consumption, and tobacco sales. While each of these measures has its strengths and weaknesses, together they complement each other.

Prevalence statistics

Existing Canadian prevalence data have been collected through a variety of surveys with no long-term continuity or comparison. Unfortunately until 1999, there were no annual large-scale surveys. Figures 2 and 3 illustrate this inconsistent and sporadic data collection. Of those surveys that had been conducted, few had sample sizes large enough to provide statistically significant provincial prevalence rates. In addition, because of the time it took to ensure the quality of the data, there was usually a time lag of two or even three years between the survey and the availability of the data. A time lag of this length can complicate planning tobacco control initiatives.

As a correction to some of these deficiencies, Health Canada instituted the Canadian Tobacco Use Monitoring Survey (CTUMS) in 1999. CTUMS is a data collection vehicle that provides Health Canada and its partners with up-to-date, reliable, comparable, and continuous 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, with a full-year sample size of about 20,000 respondents. About 50% of those surveyed are between 15 and 24 years of age. At 6 months, the turn around time for CTUMS data is much shorter than previously conducted surveys.

There is still, however, a serious data gap. The most common, and economical, data collection method is the telephone survey. Because of the fewer number of households with telephones in the North, data collection in Yukon, Northwest Territories, and Nunavut is more costly. For this reason, the territories typically are not included in large surveys, thus making tobacco use data difficult to obtain for the North.

It should be remembered that current surveys also are not able to gather information on certain population groups, for example, individuals who have been institutionalized or incarcerated and those who are homeless.

When examining historical data, it is important to remember that until recently there was little consistency in the way Canadians were asked about their smoking patterns. In 1994, Health Canada hosted a workshop on formulating questions about smoking behaviours. Since the workshop's recommendations were published in *Chronic Diseases in Canada* (Summer 1994, Vol. 15, No. 3) they have served as a guide in constructing tobacco use surveys.

For all of these reasons, while existing prevalence data may not bear close scrutiny on a year-to-year basis, they still provide a useful picture of overall trends when viewed over a number of years.

Tobacco consumption statistics

The collection and analysis of consumption data present a different problem. Sometimes consumption is determined by averaging the number of cigarettes smoked by all daily smokers. Sometimes consumption statistics are determined by dividing the number of cigarettes sold by the total population, or by the smoking population. Since these are averages, large changes that can be seen in sales data are not reflected in changes in consumption. Furthermore, the former method relies on self-reporting and smokers inevitably under-report their consumption. Therefore, these numbers tend to be lower than cigarette sales reported for the same time period. There has been a difference between self-reported consumption figures and sales figures of as much as 30%. However, since under-reporting is consistent for both women and men, and among all age groups, some year-to-year comparisons can be made with a degree of confidence.

Tobacco sales statistics

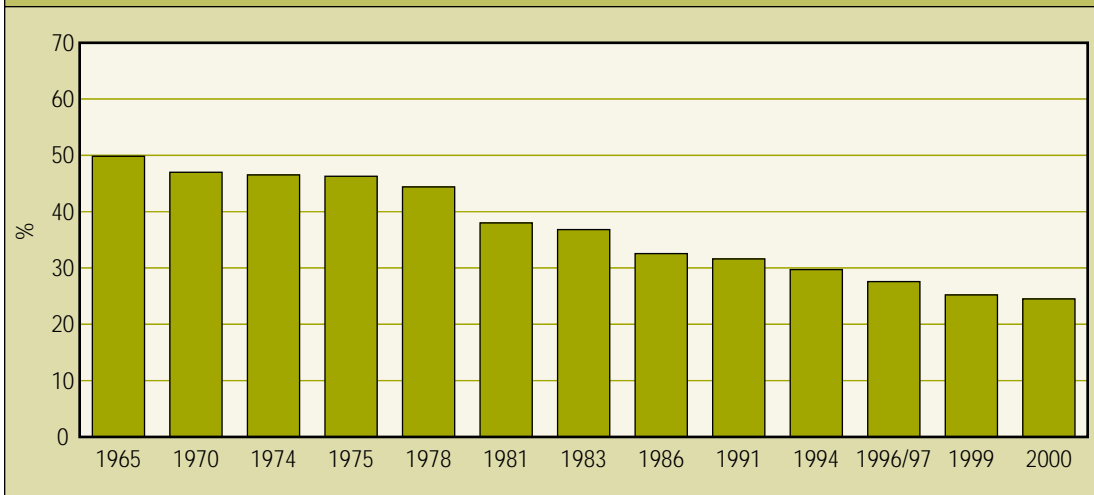
The sales figures reported are not retail sales figures but sales from the manufacturer to the wholesaler, for which excise taxes and duties have been paid. While these data are collected and reported monthly, they do not represent short-term consumer purchases. Nevertheless, in the long-term (1 year or longer), these data do represent consumer behaviour.

Smoking prevalence in Canada

According to the 2000 CTUMS results, Canadian smoking prevalence rates have reached the lowest overall level recorded since regular monitoring of smoking began in 1965. Slightly more than 6 million Canadians 15 years of age and older were smokers in 2000. This represents a decline in the percentage of smokers from 50% in 1965 to 24% in 2000. (Figure 1)

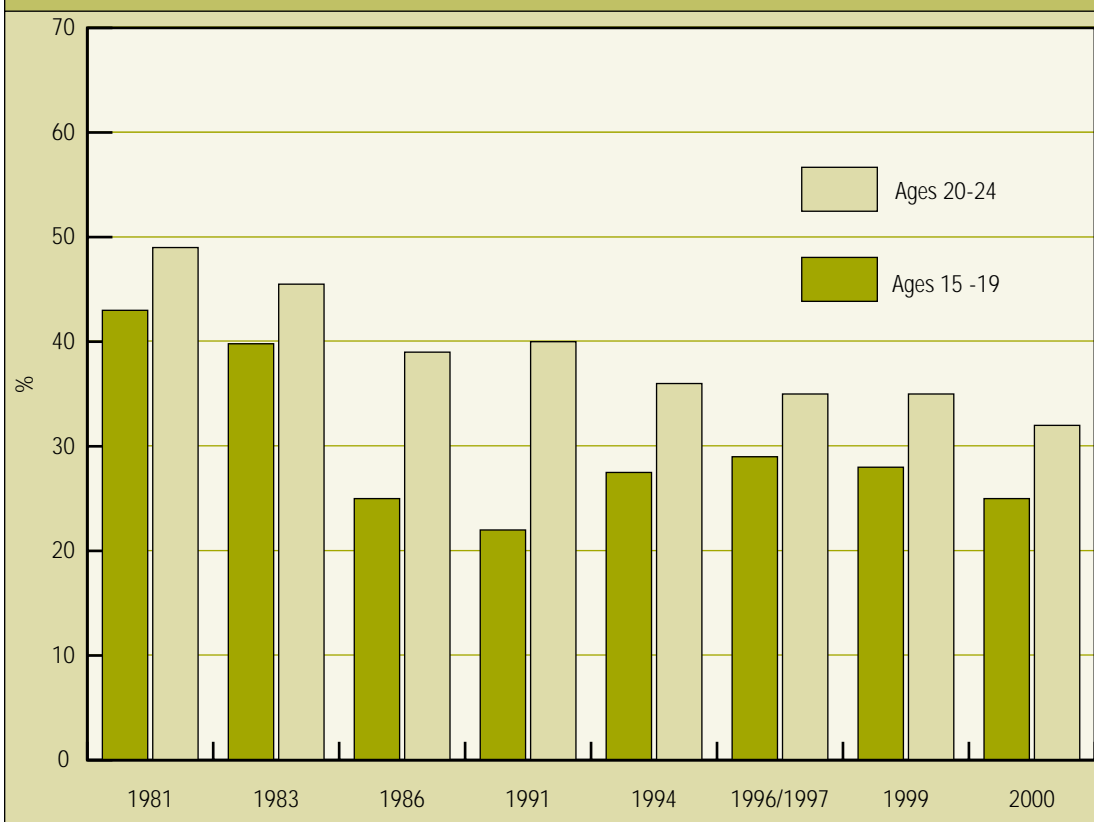
Twenty-three percent of women smoke and 26% of men. Since the prevalence rate of male smokers has always been higher, the decline among male smokers has been greater than among female smokers. In 1965, men accounted for 61% of smokers while women accounted for 38%. (Figure 3)

Figure 1 Prevalence of Canadian current smokers, aged 15 years and over, 1965–2000



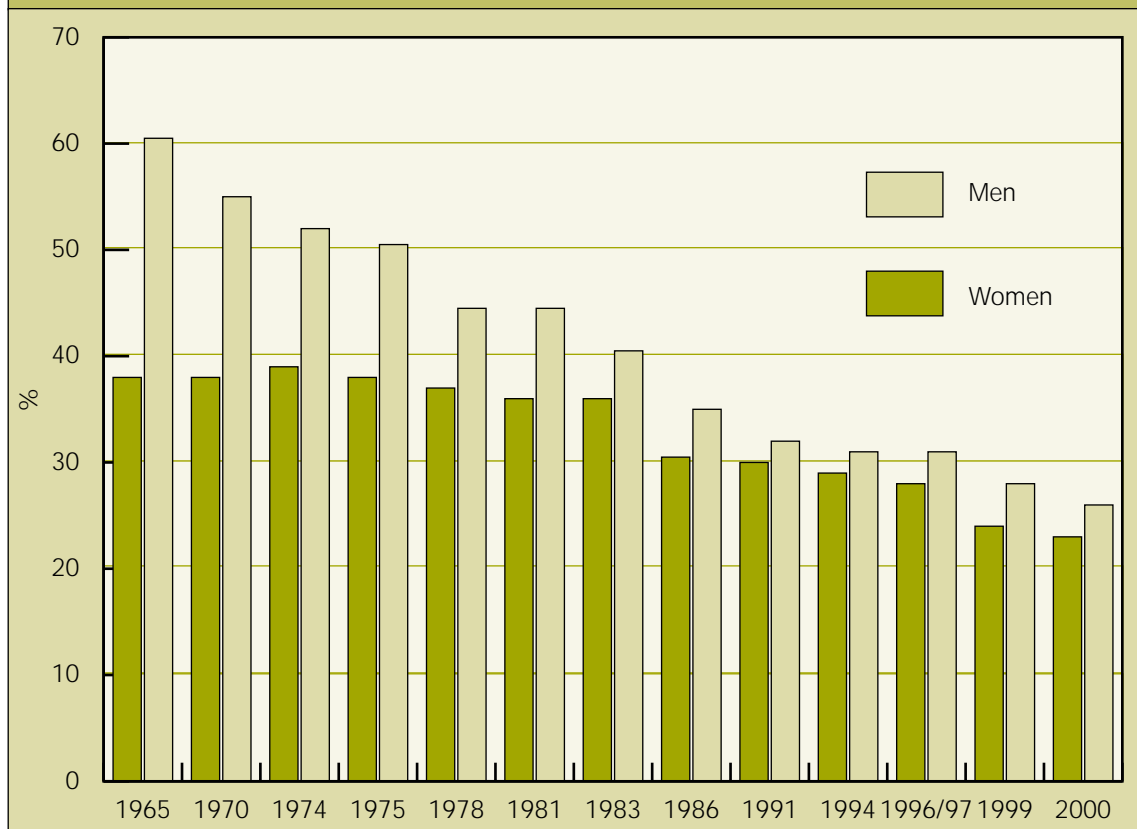
Sources: 1965-1975, 1981-1986 Labour Force Survey Supplement; 1978, Canada Health Survey; 1991, General Social Survey; 1994, Survey on Smoking in Canada; 1996/97, National Population Health Survey; 1999-2000, Canadian Tobacco Use Monitoring Survey (Annual).

Figure 2 Prevalence of Canadian current smokers, by youth age group, 1981–2000



Sources: 1981-1986 Labour Force Survey Supplement; 1991, General Social Survey; 1994, Survey on Smoking in Canada; 1996/97, National Population Health Survey; 1999-2000, Canadian Tobacco Use Monitoring Survey (Annual).

Figure 3 Prevalence of Canadian current smokers, aged 15 years and over, by sex, 1965–2000



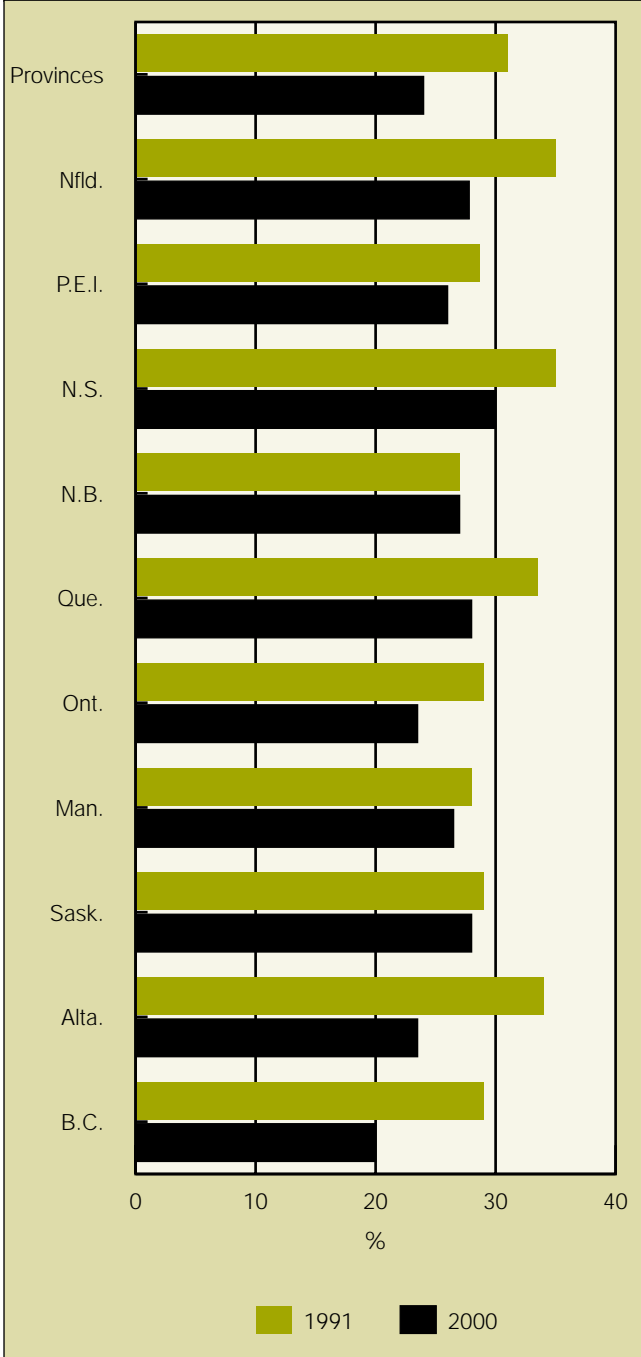
Sources: 1965-1975, 1981-1986 Labour Force Survey Supplement; 1978, Canada Health Survey; 1991, General Social Survey; 1994, Survey on Smoking in Canada; 1996/97, National Population Health Survey; 1999-2000, Canadian Tobacco Use Monitoring Survey (Annual).

While the overall smoking prevalence rates and those for men and women have exhibited a steady decline over the past 35 years, the rates for youth aged 15 to 19 years of age have not shown the same steady decline. Between 1990 and 1994 the prevalence rates of teenagers increased. However, the trend reversed in 1994 and in 2000 was 25%, down from 28% in 1999. The rate for teenage females was slightly higher at 27%, than for teenage males at 23% in 2000. The survey results indicate that more girls begin smoking at an earlier age than boys. If the 15 to 19 year age group is broken down, 25% of 15 to 17 year old girls smoked as compared to only 19% of boys. By the 18 to 19 age group, the prevalence rate reaches 31% for both genders. (Figure 2)

The prevalence rate for the 20 to 24 age group has declined from 35% in 1999 to 32% in 2000. Since the rate for women in this age group remained stable at 32%, the change is due primarily to the decline in the smoking rate for men, which went from 40% in 1999 to 33% in 2000.

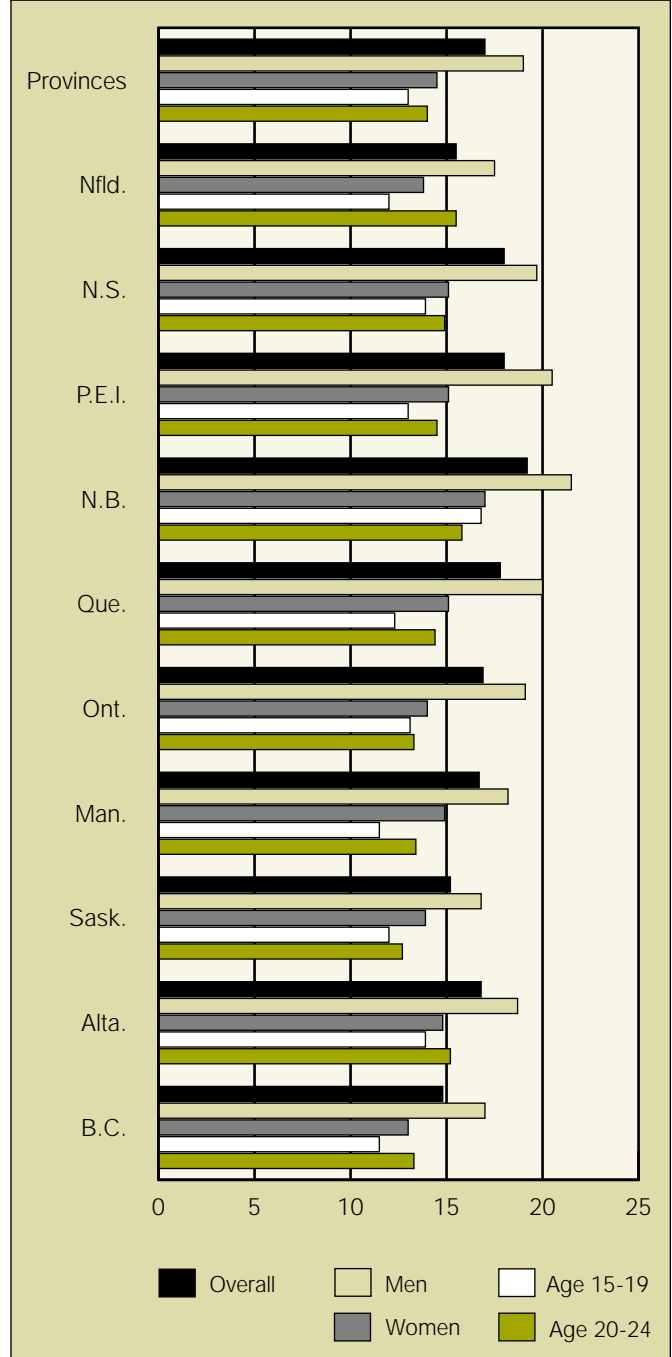
Prevalence rates vary widely between the provinces from 20% in British Columbia to 30% in Nova Scotia. For the first time in a decade, Quebec was not ranked first in overall smoking prevalence. Teen smoking rates dropped from 36% to 30% in Quebec, from 31% to 24% in Saskatchewan, and from 28% to 21.5% in Prince

Figure 4 Prevalence of Canadian current smokers, by province, 1991 and 2000



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

Figure 5 Average number of cigarettes smoked daily by Canadian daily smokers, aged 15 years and over, 2000



Source: Canadian Tobacco Use Monitoring Survey Annual, 2000.

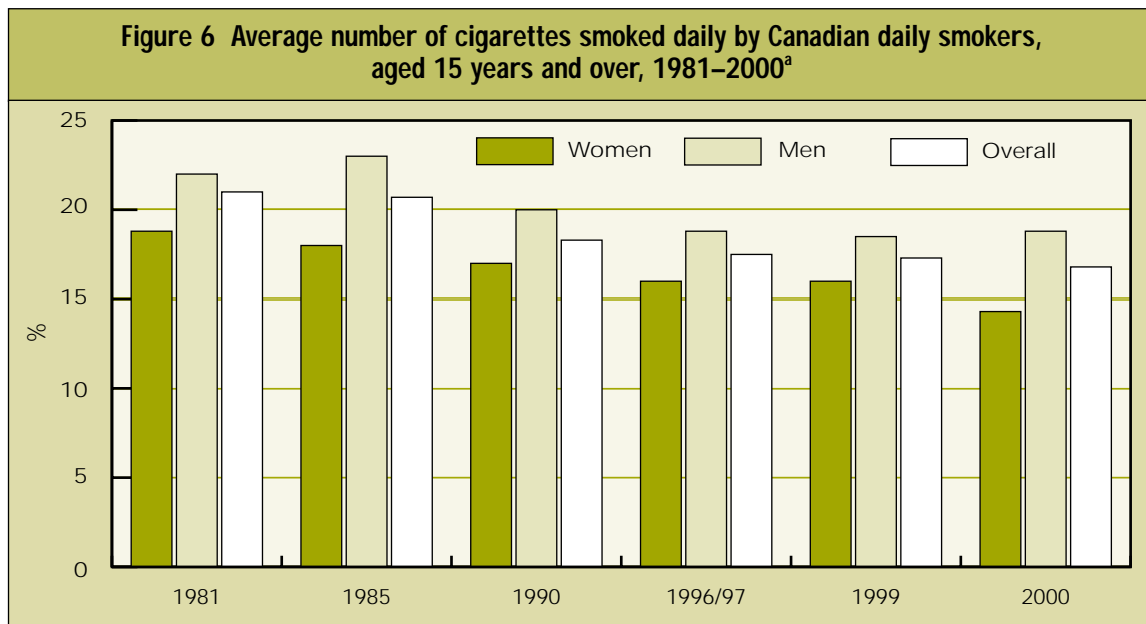
Edward Island. Along with Quebec, the greatest improvements were noted in Alberta and Newfoundland, with most provinces showing a decline. (Figure 4) Tables with more detailed provincial prevalence rates are in Appendix A.

Unfortunately, little data exist on tobacco use by aboriginal peoples. What we do know from the Aboriginal Peoples Survey, which was conducted on reserves only, and the First Nations and Inuit Regional Health Survey is that aboriginal smoking prevalence is likely more than twice the rate for Canada. In 1997, the prevalence rate among First Nations and Labrador Inuit was 62%. (See Table A-11 in Appendix A for more detailed prevalence information for the Northwest Territories.)

The Department of Health and Social Services of the Northwest Territories has published a technical report, *The Facts About Smoking in the Northwest Territories*, that is based on data from several surveys conducted in 1996 and 1999. The report's findings confirm that prevalence rates in the Northwest Territories are very high—42% of the population 18 years and older smoke and 27% of 10 to 17 year olds are current smokers. According to this report, smoking prevalence is higher among aboriginal people for every age group. For the 25 to 34 year age group, the aboriginal smoking rate (62%) is more than double that of non-aboriginals (28%).

Cigarette consumption

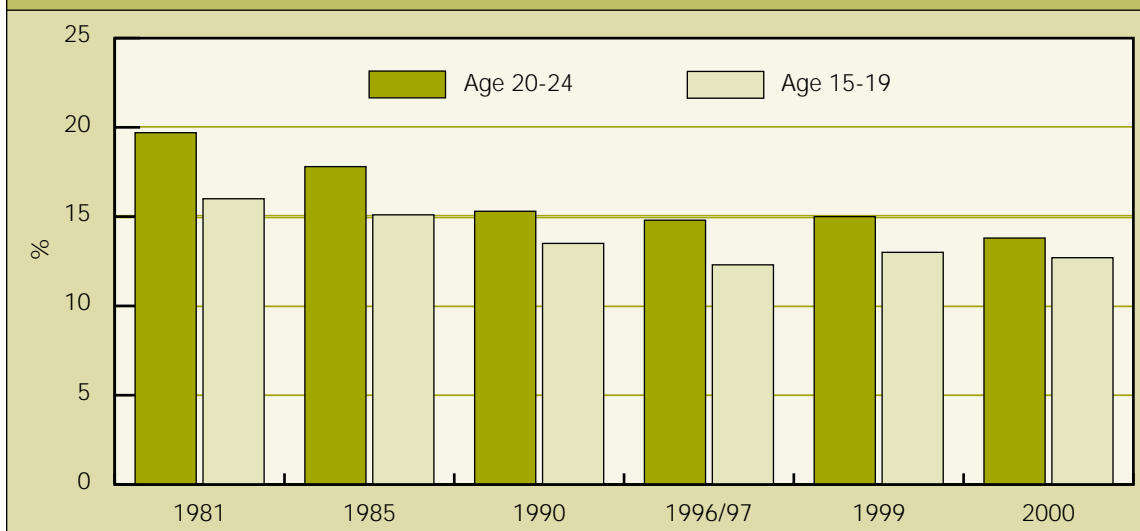
According to the 2000 CTUMS, there were approximately 6 million self-reported smokers in the 10 provinces. There were provincial differences in consumption that may be at least partially due to cigarette price differences, but that may also reflect tobacco control initiatives. The lowest average daily consumption level was reported in British Columbia and the highest in New Brunswick. Along with British



^a Provincial data only.

Sources: 1981, Labour Force Supplement; 1985 and 1990, Health Promotion Survey; 1996/97, National Population Health Survey; 1999-2000, Canadian Tobacco Use Monitoring Survey (Annual).

Figure 7 Average number of cigarettes smoked daily by Canadian youth (daily smokers), 1981–2000^a



^a Provincial data only.

Sources: 1981, Labour Force Supplement; 1985 and 1990, Health Promotion Survey; 1996/97, National Population Health Survey; 1999-2000, Canadian Tobacco Use Monitoring Survey (Annual).

Columbia, Quebec and Newfoundland had the greatest decline in consumption in 2000. The change in Quebec's cigarette consumption level reflects the drop in daily cigarette consumption by women from 18.2 in 1999 to 15.1 in 2000. (Figure 5)

In the 15 to 19 age group, the lowest rates were found in British Columbia, Saskatchewan, and Manitoba. The highest rate was in New Brunswick where the number of cigarettes smoked per day by 15 to 19 year-old smokers went from 14.6 in 1999 to 16.6 in 2000.

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 than women did. While the overall 2000 figures indicate a decline since 1999, men are smoking marginally more cigarettes per day than they reported in 1999. (Figure 6)

In 1999, consumption levels reported by young Canadians, particularly the 15 to 19 age group, increased. However, in 2000 there was a decrease for both the 15 to 19 age group and the 20 to 24 age group. (Figure 7)

Health effects of tobacco use

Although current data collection methods have been improved through the use of standardized definitions and questions, there are still gaps in tobacco-related health statistics. Nationally, it is difficult to link datasets of smoking behaviour, health risks, and health outcomes. Thus, at this time, it is difficult to monitor some of the known illnesses resulting from tobacco use, their impact on individuals and families, and on the health care system, economically or otherwise.

Table 1 Smoking-attributable mortality estimates for current and former smokers, by region and sex, Canada,^a 1991, 1994, and 1996

	1991 ^b	1994 ^c	1996 ^c
Canada^a	40 818	45 472	45 215
Men	27 646	29 991	29 229
Women	13 172	15 481	15 986
Atlantic	3 886	4 530	4 305
Men	2 761	3 059	2 865
Women	1 125	1 471	1 440
Quebec	11 693	12 591	12 329
Men	8 094	8 580	8 254
Women	3 599	4 011	4 075
Ontario	14 295	15 931	15 642
Men	9 503	10 376	9 942
Women	4 792	5 555	5 700
Prairies	5 780	6 910	7 080
Men	3 912	4 566	4 560
Women	1 868	2 344	2 520
British Columbia	5 164	5 510	5 931
Men	3 376	3 410	3 680
Women	1 788	2 100	2 251

^a Canada total does not include Nunavut, Northwest Territories, and Yukon estimates owing to unavailability of smoking prevalence data for the territories for these years.

^b Source: Makomaski Illing EM, Kaiserman MJ, Mortality Attributable to Tobacco Use in Canada and its Regions, 1991, CJPH, Volume 86, No. 4, July/August 1995.

^c Source: Makomaski Illing EM, Kaiserman MJ, Mortality Attributable to Tobacco Use in Canada and its Regions, 1994 and 1996. CDIC, Volume 20, No. 3, 1999.

To improve estimates of smoking-attributable morbidity and mortality rates, much work needs to be done in gathering information on the smoking status of people with certain health conditions. While the adverse health effects and the health risks of tobacco use are well established, data collection has focused on certain medical conditions, notably lung cancer and cardiovascular diseases. Other illnesses that are known to be associated with smoking or exposure to second-hand smoke, such as asthma and middle ear infections, require more refinement in data collection.

Since year-to-year differences in the number of tobacco-related deaths and major diseases diagnosed may be small, long-term trends are of primary interest. A further difficulty in analyzing health statistics is the long delay in the onset of diseases associated with smoking. The incidence of lung cancer recorded today is the result of smoking patterns observed 20 to 40 years ago. Furthermore, during that period, there were considerable advances made in medical technology that have reduced the mortality figures more than might otherwise have happened.

Mortality attributable to smoking

Smoking remains the number one preventable cause of death and disease in Canada with the number of mortalities remaining around 45,000 Canadians each year. Smoking far exceeded the second most prevalent preventable cause of death—accidents, which accounted for 8,600 deaths in 1996.¹

¹ Makomaski Illing EM, Kaiserman MJ, Mortality Attributable to Tobacco Use in Canada and Its Regions, 1994 and 1996. CDIC, Volume 20, No. 3, 1999.

Table 2 Estimated number of new cases and deaths from lung and oral cancer in 2001^a

	Lung cancer ICD-9 162 ^b						Oral cancer ICD-9 140-149 ^b					
	New cases			Deaths			New cases			Deaths		
	Men	Women	Overall	Men	Women	Overall	Men	Women	Overall	Men	Women	Overall
Canada	12 100	9 200	21 200	10 700	7 400	18 000	2 100	980	3 100	730	320	1 050
Nfld.	150	90		240	100		60	10		15	— ^c	
P.E.I.	65	45		55	50		10	5		5	— ^c	
N.S.	440	340		430	290		65	35		30	15	
N.B.	380	260		350	160		45	20		20	5	
Que.	3 900	2 600		3 500	2 100		540	200		220	70	
Ont.	4 100	3 300		3 500	2 500		830	410		250	130	
Man.	450	330		350	250		100	50		30	20	
Sask.	350	260		320	250		75	30		15	10	
Alta.	840	690		740	600		160	80		50	25	
B.C.	1 300	1 200		1 200	1 050		250	140		95	45	

^a Rates adjusted. Row and column totals may not match individual figures owing to rounding.

^b ICD-9 refers to the 9th revision of the International Classification of Diseases.

^c Fewer than 5 cases.

Source: Canadian Cancer Statistics 2001. Toronto: National Cancer Institute of Canada; 2001. <www.cancer.ca/stats/tables/tab6ehtm> [Cited: 14 June 2001]

In 1991, there were an estimated 41,400 deaths in Canada attributable to smoking, which represented 21% of all deaths that year. The death rate for men was more than double that for women—27,900 to 13,500.²

By 1996, the number of deaths attributable to smoking had increased by an estimated 8%, or 3,800 deaths, of which 64% were women. During this period, the number of smoking-related deaths among men remained relatively constant at about 27,500. However, smoking-related deaths among women are increasing at a faster rate than those among men. In 1985, only 9,000 such deaths had occurred among women. In 1985, the ratio of male-to-female deaths attributable to smoking was approximately 3 to 1. In 1989, this ratio had fallen to 2.5 to 1 and in 1991 it was 2 to 1. In 1996, it further declined to 1.8 to 1.

Of the 45,200 deaths attributable to smoking in the 1996 estimates, 100 deaths were estimated for children under the age of 1, of which 60% were boys. Cancers accounted for 17,700 of the total estimates, cardiovascular diseases accounted for another 17,800, and respiratory diseases accounted for the remaining 9,500 deaths. Regionally, between 1991 and 1996, smoking-related deaths increased in the Prairies by 20% and in Ontario by 8%.

² Makomaski Illing EM, Kaiserman MJ, Mortality Attributable to Tobacco Use in Canada and its Regions, 1991. CJPH, Vol. 86, No. 4, July/August 1995.

Lung cancer

Cigarette smoking is the predominant cause of lung cancer, accounting for at least 80% of all new cases in women and 90% of those in men. The risk of lung cancer rises sharply as the number of cigarettes smoked daily increases and rises even more sharply with the length of time as a smoker.³

In 1991, of all smoking-related deaths, lung cancer accounted for 31% of deaths among men and 26% of deaths among women. By 1998, an estimated 17,100 deaths due to lung cancer occurred in Canada, and there were an estimated 20,400 new cases of lung cancer diagnosed.

Lung cancer incidence and mortality rates among women have been historically much lower than among men, although both of these rates have been increasing among women over the past two decades while incidence rates for men started to decline by the mid-80s.

Table 3 Estimated age-standardized mortality rates for lung and oral cancer, 2001

	Rate per 100 000			
	Lung cancer ICD-9 162 ^a		Oral cancer ICD-9 140-149 ^a	
	Men	Women	Men	Women
Canada ^b	69	37	5	2
Nfld.	89	28	5	— ^c
P.E.I.	75	52	6	1
N.S.	87	44	6	2
N.B.	89	32	4	— ^c
Que.	95	41	6	1
Ont.	58	33	4	2
Man.	59	34	5	2
Sask.	55	35	3	1
Alta.	57	37	4	2
B.C.	56	37	4	2

^a ICD-9 refers to the 9th revision of the International Classification of Diseases.

^b Estimates are adjusted to eliminate the influence of variation in population composition between provinces. Rates are adjusted to the age distribution of the 1991 Canadian population. Canada totals include provincial and territorial estimates.

^c Numbers are too small to report.

Source: Canadian Cancer Statistics 2001. Toronto: National Cancer Institute of Canada; 2001.

<www.cancer.ca/stats/tables/tab6e.htm> [Cited: 14 June 2001]

Regionally, in 1995 lung cancer incidence and mortality rates in Northwest Territories were higher than those reported in the provinces. The disparity was particularly pronounced for women. There were also statistically significant variabilities in lung cancer incidence and mortality rates across provinces. Rates were particularly high for men in Quebec and for women in British Columbia.

³ Lung Cancer in Canada—Cancer updates, Health Canada Cancer Bureau, June 1998

Lung cancer estimates for 2001

Because of the delay in the onset of lung cancer, the decrease in smoking prevalence that has occurred since the 1960s will be reflected in reduced lung cancer incidence and death rates in coming years. However, the increase in smoking prevalence among youth in the 1990s is a cause for concern, as this will eventually lead to increases in future lung cancer incidence and mortality rates.

Table 4 Estimated age-standardized incidence rates for lung and oral cancer, 2001 ^a				
Rate per 100 000				
	Lung cancer ICD-9 162 ^b		Oral cancer ICD-9 140-149 ^b	
	Men	Women	Men	Women
Canada	77	47	13	5
Nfld.	53	26	21	4
P.E.I.	92	53	7	1
N.S.	86	55	12	5
N.B.	95	50	10	4
Que.	105	53	13	4
Ont.	68	44	13	6
Man.	75	47	16	6
Sask.	60	38	12	4
Alta.	64	44	11	5
B.C.	58	46	11	5

^a Estimates are adjusted to eliminate the influence of variation in population composition between provinces. Rates are adjusted to the age distribution of the 1991 Canadian population. Canada totals include provincial and territorial estimates.

^b ICD-9 refers to the 9th revision of the International Classification of Diseases.

Source: Canadian Cancer Statistics 2001. Toronto: National Cancer Institute of Canada; 2001.

<www.cancer.ca/stats/tables/tab6e.htm> [Cited: 14 June 2001]

Cardiovascular disease

While cardiovascular diseases are the leading cause of death in Canada, collecting data on risk factors such as smoking has not been integrated into the major databases such as the Discharge Abstract Database produced by the Canadian Institute for Health Information. Therefore, at this time, it is not possible to conduct an analysis by smoking status. Data on incidence of and death from heart diseases can be estimated.

Other health problems

Of health problems reported among those 15 years and older, regular smokers are most likely to report emphysema and stomach ulcers, while former smokers are most likely to report hypertension, heart trouble, and diabetes.

Table 5 Age-standardized mortality rates, all cardiovascular disease, Canada, ^a 1995						
Rate per 100 000						
	Ischemic heart disease		Stroke		Oral cardiovascular disease	
	Men	Women	Men	Women	Men	Women
Canada	155	120	41	55	58	62
Nfld.	201	147	52	65	69	80
P.E.I.	181	141	57	45	74	69
N.S.	167	118	35	57	74	78
N.B.	151	110	45	53	83	82
Que.	163	125	39	49	59	59
Ont.	160	128	42	57	51	56
Man.	165	131	49	60	68	69
Sask.	148	99	39	52	72	68
Alta.	139	109	38	56	63	76
B.C.	128	94	42	57	55	64

^a Estimates are adjusted to eliminate the influence of variation in population composition between provinces; Rates are adjusted to the age distribution of the 1991 Canadian population; Canada totals include territorial estimates.

Source: Statistics Canada, 1995. <www.statcan.ca/english/freepub/82-573-GIE/nphs.htm> [Cited 14 June 2001]

Table 6 Age-standardized mortality rates, ^a by selected cause, 1993–1997					
Rate per 100 000					
	1993	1994	1995	1996	1997
All causes	695	685	680	671	661
Men	902	886	881	864	848
Women	540	536	532	529	524
Diabetes	17	17	18	17	17
Men	19	20	21	21	21
Women	15	15	15	14	15
Heart disease	193	187	184	181	173
Men	259	250	246	241	232
Women	142	140	138	135	130
Respiratory disease	61	60	60	60	60
Men	89	88	87	86	86
Women	44	43	44	44	45
Cancer	52	51	49	50	48
Men	78	76	74	73	70
Women	32	32	32	34	33

^a Estimates are adjusted to eliminate the influence of variation in population composition between provinces; includes territorial estimates.

Source: Statistics Canada, 1995. <www.statcan.ca/English/freepub/82-573-GIE/nphs.htm> [Cited 14 June 2001]

Data regarding severe asthma, severe pneumonia, bronchitis, or middle ear infections for both children and adults can be obtained from hospitalization records. However, although these conditions are known to be associated with smoking and second-hand smoke, these risk factors are not included in patients' charts. Therefore, it is not possible to conduct analyses of these conditions as they relate to tobacco use from the Discharge Abstract Database.

Table 7 Prevalence of selected health problems by type of smoker, aged 15 years and over, Canada,^a 1991

	Overall	Regular smokers	Occasional smokers	Former smokers	Non-smokers
Any health problem	63	62	59	69	60
Hypertension	16	14	11	19	15
Heart disease	7	6	5	11	6
Diabetes	4	3	—	5	3
Asthma	6	6	4	6	6
Emphysema	8	12	6	9	6
Stomach ulcer	5	7	5	5	3

^a Does not include Nunavut, Northwest Territories, and Yukon, owing to unavailability of smoking prevalence data for the territories in 1991.

Source: Statistics Canada, General Social Survey, Tabulation, 1991.

Tobacco industry statistics

Prevalence and consumption rates create only a partial picture of tobacco use and smoking patterns in Canada. A complete picture must include information about the activities of the tobacco industry. While the focus of this report is on the National Strategy and progress made over the last year, it is interesting to juxtapose this progress on the financial activity of the industry. The statistics presented here are the most current available. (Figures 8–11)

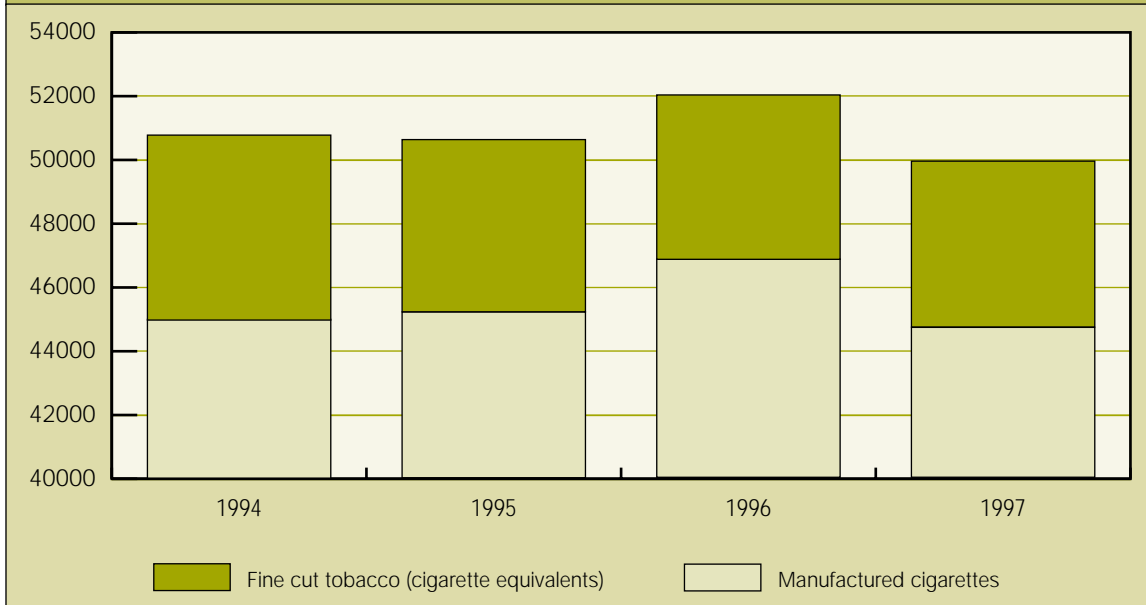
While cigarettes are the major cigarette product consumed, about 9% of Canadians who smoke (about 540,000) consume other tobacco products in addition to cigarettes. An additional 7%, or 425,000, use only non-cigarette tobacco products. Men consume 88% of all non-cigarette tobacco products. After cigarettes, cigars and cigarillos are the most commonly used form of tobacco. Pipe smoking has declined significantly over the past 10 years. Young males are the predominant users of smokeless tobacco.

Table 8 Canadian tobacco industry: Sales and tax revenues and profits (millions of dollars), 1988-1996

	Industry		Government Income taxes		
	Operating revenue	Net profit	Federal	Provincial	Total
1988	4 189	415	48	20	68
1989	4 006	328	45	17	62
1990	4 210	250	91	37	128
1991	4 954	369	125	71	197
1992	5 527	364	126	59	186
1993	5 549	548	123	61	185
1994	5 530	535	190	94	285
1995	5 634	723	180	85	265
1996	5 776	934	220	106	327

Source: Statistics Canada, STC (61-219P).

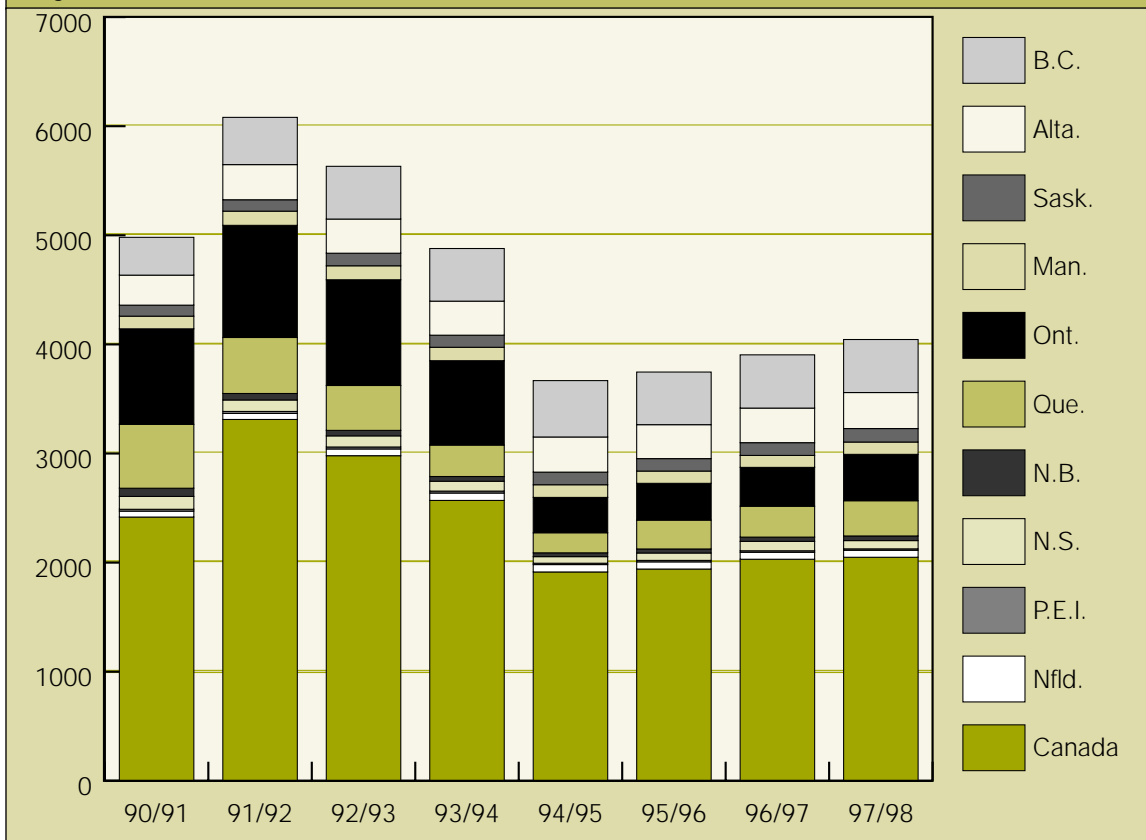
Figure 8 Sales of cigarettes and cigarette tobacco in Canada (millions of cigarettes or cigarette equivalents)^a



^a Industry statistics.

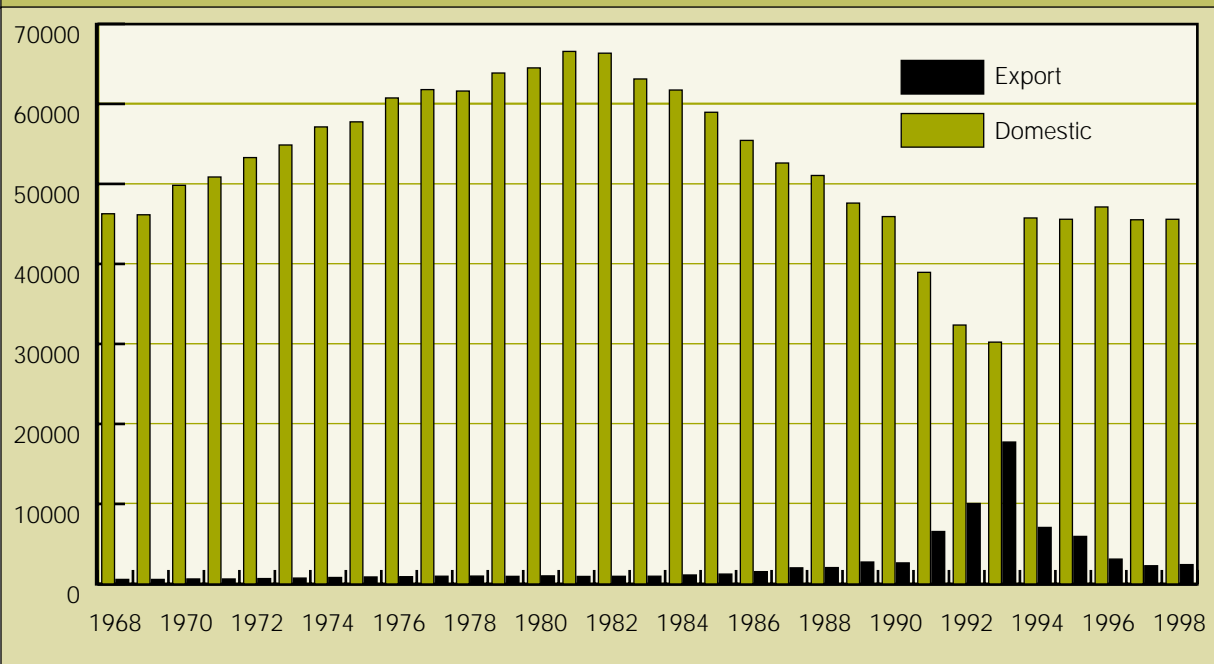
Source: Statistics Canada, *Canadian Corporate Taxation Statistics*. Cat. No. 61-219p. 1988-97.

Figure 9 Provincial and federal tax revenues from tobacco sales in Canada (millions of dollars)



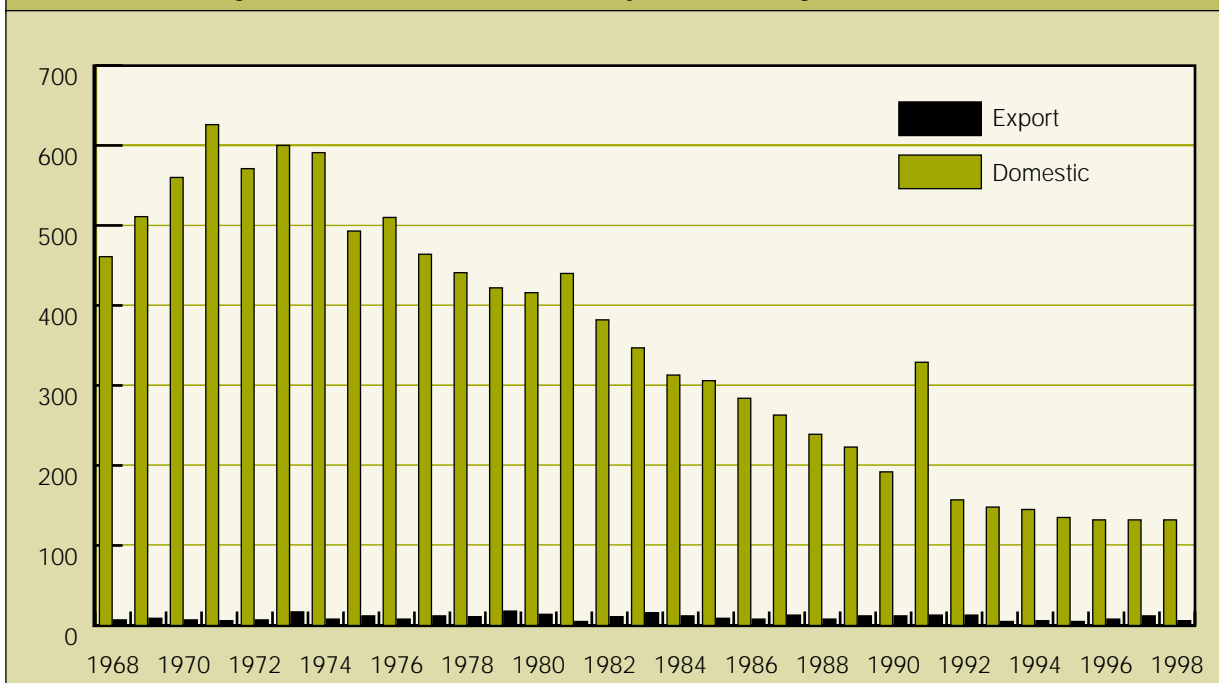
Source: Provincial revenue ministries.

Figure 10 Canadian tobacco industry: number of cigarettes sold (millions)



Source: Statistics Canada. *Production and distribution of tobacco products*. Cat. No. 32-022, monthly. 1995.

Figure 11 Canadian tobacco industry: number of cigars sold (millions)



Source: *Production and distribution of tobacco products*. Cat. No. 32-022, monthly. 1995.

Part Two: Moving Toward a Smoke-Free Society

Even though the deaths of 45,000 Canadians each year can be attributed to the use of tobacco products, the reality of a smoke-free society will be a challenge to achieve. Because the nicotine in tobacco is addictive, even when smokers are aware of the health hazards of tobacco use they have difficulty quitting. Since the adverse health consequences of smoking can take 20 to 30 years to develop, individuals, particularly teens and young adults, do not feel the gravity of the threat to their health. These are just a few aspects of the complexity and magnitude of ending the use of tobacco products.

The National Strategy recognizes that change must occur in small, but continuous and increasingly meaningful increments. Its four goals encourage governments, non-governmental organizations, individuals, and communities to break the problem down into identifiable and manageable segments. The four goals that have been identified to help achieve a smoke-free society are: Prevention, Cessation, Protection, and Denormalization.

Part One of this progress report presented a number of measures of progress in achieving those goals, as in statistics on the reduction in the number of Canadians who smoke, for example. Part Two concentrates on measuring key activities that contribute to reaching those goals.

Table 9 Provincial retailer compliance monitoring in Canada,^a 2000

	Provincial reports ^b			ACNielsen report ^c		
	Administrative checks (N)	Compliance rate (%)	Enforcement checks (N)	Compliance rate (%)	Retailers surveyed (N)	Compliance rate (%)
Nfld.	381	82.3	168	93.0	197	87.8
P.E.I.	0	N/A	598	90.5	82	86.0
N.S.	1 005	60.4	18	68.8	377	70.9
N.B.	1 389	84.8	286	94.6	218	72.7
Que.	4 530	64.8	1 839	76.5	1 177	47
Ont.	10 188 ^d	76	N/A	N/A	877	83.7
Man.	0	N/A	1 291	87.7	338	78.9
Sask.	1 346	88.6	532	88.7	320	81.4
Alta.	2 831	76.8	339	86.0	760	67.3
B.C.	10 847	90.9	3 420	91.5	678	75.3

^a Numbers for Nunavut, Northwest Territories, and Yukon are not included because they are too low for statistical purposes.

^b Source: Federal/provincial reports to the Tobacco Control Programme, Health Canada.

^c Source: Report of Findings: 2000—Final, Measurement of Retailer Compliance with Respect to the Tobacco Act and Provincial Tobacco Sales-to-Minors Legislation, December 2000, ACNielsen.

^d Includes number of enforcement checks.

Prevention

The goal is to prevent tobacco use among young people. Restricting sales of tobacco products to minors is a key activity used to achieve this goal. To this end, Health Canada works with its provincial partners to enforce retailer compliance with Canadian tobacco sales-to-minors legislation.

As part of their enforcement activities, provincial inspectors visit retailers to verify and enforce compliance. Two types of inspections are performed, Administrative Checks and Enforcement Checks. In an Administrative Check, a young person under the direct supervision of a tobacco enforcement officer attempts to purchase tobacco products. The same process is repeated in an Enforcement Check to assess a retailer's compliance after having received a warning.

In addition to the compliance information submitted to Health Canada by the provinces, Health Canada has obtained retailer compliance information every year since 1995 through surveys conducted by AC Nielsen. The 2000 survey, which questioned 5,024 retailers nationally, found a national compliance rate of 70%. When viewed province by province, the variation in compliance rates ranged from 47% in Quebec to 88% in Newfoundland.

Health Canada and its provincial partners use the findings of these surveys to design more effective information, education, and awareness programs to ensure retailer compliance. While neither measure provides a true picture of retailer compliance, as data is compiled year after year, patterns will emerge and each province will be able to track its success in enforcing compliance with its sales-to-minors legislation and to take appropriate action where needed.

Cessation

The goal is to persuade and help smokers to stop using tobacco products. To design effective cessation programs, we need to understand the process of quitting, what motivated successful quitters, and what reasons would compel smokers to quit. Analysis of the type of information presented in Tables 10 and 11 will help in planning material to convince smokers to quit.

Table 10 Percent of long-term Canadian^a quitters 15 years and older, by reason for quitting smoking, 2000

	Overall	Male	Female
Concern future health	35	38	32
Current health problem	12	12	11
Change lifestyle	14	14	15
Cost	8	8 ^b	8 ^b
Pregnancy	8	3 ^b	14
Smoking-related illness	4 ^b	4 ^b	4 ^b
Concern for family health	8	8 ^b	8 ^b
Family/ friend pressure	4 ^b	3 ^b	5 ^b
Advice from doctor	3 ^b	4 ^b	3 ^b
Other	20	20	20

^a Does not include Nunavut, Northwest Territories and Yukon estimates due to the unavailability of quitting smoking data for the territories for 2000.

^b Moderate sampling variability, interpret with caution.

Source: Statistics Canada, Canadian Tobacco Use Monitoring Survey Annual, 2000.

What motivated successful quitters

In 1999, according to the Canadian Tobacco Use Monitoring Survey, nearly 6.4 million Canadians were former smokers. Six million of these had not smoked for at least a year, while an additional 387,000 had quit smoking within the year that they were surveyed.

Health concerns played a prominent role in motivating people to quit smoking. When successful quitters were asked what prompted them to quit, the largest percentage, regardless of age or sex, cited concern about their future health. Another 10% of successful quitters cited current personal health problems as their reasons for quitting. An additional 10% cited lifestyle changes, which could also be related to a concern for better health.

Men and women were basically motivated by the same reasons. Only two notable male-female differences appeared in the 1999 survey. Not surprisingly, women were more likely to quit because of a pregnancy or the presence of a baby than men, although 2% of successful male quitters quit because of a partner's pregnancy or the presence of a baby in the household. Men were more likely (10%) than women (4%) to quit smoking because of the smoking-related illness or death of a friend or relative.

What it takes to quit

When current smokers were asked, "What would it take for you to quit smoking?" the most frequently cited reason was "More willpower". This was true for current smokers of all ages, although more women (35%) mention it than men (27%). However, 20% of smokers said that they did not know what it would take to quit. This may indicate that they had not given much thought to quitting.

While 11% of smokers stated that illness would motivate them to quit, the same percentage stated that nothing would get them to quit. Older smokers, 45 and older, were more likely to say this than smokers aged 15 to 44. Only 3% of those surveyed stated that a program aide or cigarette alternative would motivate them to quit.

**Table 11 What it would take to quit smoking:
Opinions of Canadian^a current smokers 15 years and older, 1999**

	Overall (%)	Men	Women
More willpower	30.7	26.8	35.1
Don't know	20.3	23.0	17.3
Other	18.4	18.8	18.0
Illness	10.9	10.2 ^b	11.7 ^b
Nothing	10.8	12.3 ^b	9.1 ^b
Family death	6.3 ^b	6.4 ^b	6.2 ^b
Lifestyle change	5.4 ^b	5.7 ^b	5.2 ^b
Cost	3.2 ^b	4.3 ^b	— ^c
Program/ cigarette substitute	3.0 ^b	— ^c	— ^c
Family or friend pressure	2.9 ^b	— ^c	— ^c
Pregnant	2.1 ^b	— ^c	4.0 ^b
More restrictions	— ^c	— ^c	— ^c

^a Does not include Nunavut, Northwest Territories, and Yukon estimates owing to the unavailability of quitting smoking data for the territories for 2000.

^b Moderate sampling variability; interpret with caution.

^c High sampling variability, data suppressed.

Source: Statistics Canada, Canadian Tobacco Use Monitoring Survey, Annual, 2000.

Protection

The goal is to protect Canadians by eliminating exposure to second hand smoke.

In 1995, Health Canada commissioned a survey of schools, licensed daycares and daycare agencies, health care institutions, and commercial settings to determine what, if any, smoking policies existed. The survey included all provinces and both Yukon and Northwest Territories.

Both elementary and secondary schools were surveyed and almost all (97%) had smoking policies. Of these, 83% provided protection from second-hand smoke inside school buildings. However, only 66% of school policies completely banned smoking inside and outside on school property. While only a complete ban of tobacco use on school property effectively supports non-smoking as the norm, only 10% of schools that restrict smoking indicated that they intended to strengthen their existing policies.

Almost all licensed daycare centres surveyed (93%) had smoking policies. Half of these banned smoking both indoors and outdoors. The majority (79%) of smoking policies included enforcement procedures.

By comparison, just 62% of daycare agencies regulated smoking in the home daycares they licensed. Of those with smoking regulations, half permitted smoking indoors, one quarter did not specify any penalties for violations, and only 12% of agencies without policies were considering implementing a smoking policy. These differences in smoking policies between licensed daycare centres and daycare agencies supervising home daycares clearly demonstrate the impact of legislation and licensing requirements in protecting children in daycare settings from second-hand smoke.

The 1995 survey included telephone interviews with 100 large Canadian businesses. Large businesses were defined as those typically having over \$100 million in annual sales. This part of the survey covered commercial areas where the public would most likely be at risk of exposure to second-hand smoke.

In 1995, the laws controlling smoking in public places specified weaker measures for restaurants and mall food courts than for other commercial settings. Almost 60% of bus terminals and about 35% of retail stores with smoking policies had restrictions to protect staff and customers from second-hand smoke, while no shopping malls and only about 15% of restaurants and hotels had similar policies. As more and more municipalities adopt smoke-free bylaws that include restaurants and indoor public spaces, this survey will need to be updated.

The last component of the 1995 survey covered 2,396 hospitals, extended and chronic care units, residential care facilities, rehabilitation centres, and psychiatric care facilities. Of those institutions that had smoking policies, only 3% consistently established non-smoking as the norm by totally banning smoking indoors and outdoors. Moreover, very little cessation support was provided to patients and residents who smoked.

Over the past five years a growing number of public places have been declared smoke-free. The results of this study are becoming outdated and more current information should be obtained to assess progress in protecting people from second-hand smoke.

Some provincial data on workplace smoking restrictions

According to the latest information from the Ontario Tobacco Research Unit, in Ontario 70% of the people who work outside their home reported that there was a complete ban on smoking at their workplace while the remaining population reported either a partial ban or no restrictions. According to recent estimates there are 1,265,609 smokers in Ontario workplaces. Workplace restrictions on smoking can be broken down by occupation sector:

- 85% of professional and managerial occupations reported a complete ban on smoking;
- 69% of clerical, sales, and service occupations reported a total ban; and
- 50% of trades and farming occupations reported a complete ban.

Denormalization

The goal is to make tobacco use socially unacceptable. This is done through educating Canadians about the marketing strategies and tactics of the tobacco industry and the health effects of tobacco use so that they will realize the hazardous, addictive nature of tobacco and will consider its use socially unacceptable.

Efforts in the United States, notably in California, Massachusetts, and Florida have demonstrated that comprehensive public health programs can bring about significant changes. Their success at denormalization of the tobacco industry has been encouraging. In Canada, British Columbia has taken a new, harder hitting approach. And, in January 1999, an Experts Round Table on the Denormalization of Tobacco and the Tobacco Industry provided input into the design of a new national advertising campaign. Data from the Wave 1, February-June 1999 Canadian Tobacco Use Monitoring Survey indicate that there already is a high level of public support for government sponsored anti-tobacco advertising, including advertising intended to raise awareness of tobacco industry practices.

Part Three: Progress in Strategic Directions



The National Strategy identified five strategic directions that provide the basis for planning, implementing, and evaluating collaborative action. They help identify the most appropriate types of interventions or actions for achieving prevention, cessation, protection, and denormalization goals. Most effective tobacco control interventions and actions address more than one goal. Establishing smoke free environments, for example, protects people from second-hand smoke (protection), but it also helps smokers who are trying to quit (cessation) and conveys to youth that non-smoking is socially acceptable behaviour (prevention). Because of these overlapping impacts, it is easier to group initiatives by strategic direction. The anecdotal material presented here is indicative of progress in the National Strategy's five strategic directions.

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; and
- Building and Supporting Capacity for Action.

While the sheer number of initiatives taking place around the country is in itself an indication of progress, it is not possible to present statistical measures for individual initiatives. In most cases, the impact will not be measurable for some time nor is it possible to definitively link a change in statistics with an individual initiative. But more importantly, it is the aggregate impact of individual local control strategies that will eventually become statistically measurable.

The items described in this section provide a snapshot of what is happening in Canada in tobacco control and the selection of items will differ from year to year as the picture changes. These items were chosen because they highlight where progress has been made and because some preliminary outcomes can be shown. Space limitations do not permit presenting a comprehensive list.

Policy and Legislation

The intent of the Policy and Legislation Strategic Direction is to ensure coordination of tobacco policy across sectors and to ensure implementation of organizational policies and legislation across sectors that support reducing tobacco use.

The efforts highlighted this year that relate to policy and legislation include establishing smoke-free environments, implementing tax increases, developing policies and recommendations, and strengthening provincial tobacco control strategies.

Establishing smoke-free environments

Governments were first to institute smoke-free workplaces and, in fact, the Northwest Territories' Smoke-Free Workplace Policy predates the federal government's by 6 months. While governments at many levels continue to develop smoke-free policies, more and more private sector environments are following their example and protecting their employees from second-hand smoke.

In **British Columbia**, over 50% of municipalities, accounting for more than 90% of British Columbians, have smoke free bylaws. In addition, the *Occupational Health and Safety Regulation on Second-Hand Smoke*, effective April 1998, requires that all employers protect workers from exposure to second-hand smoke. Although initially exempted, hospitality, residential, and correctional facilities are required to protect employees from exposure to second-hand smoke as of September 2001.

Alberta's *Protection from Second-Hand Smoke in Public Buildings Act* came into effect in January 1999, providing workplace protection from second-hand smoke for approximately 20,000 Alberta public sector employees. To date, seven Alberta municipalities have passed smoke-free bylaws and many others are considering similar bylaws.

In 1997, **New Brunswick's** municipalities were given the authority to enact bylaws restricting second-hand smoke. The Smoke-Free Environments Task Force (established by the Canadian Cancer Society, New Brunswick Division and the Heart and Stroke Foundation of New Brunswick) has worked to encourage and support municipalities to enact smoke-free bylaws. After a few years of minimal progress, the Task Force asked the former Department of Health and Community Services to conduct public opinion polls in selected municipalities to demonstrate to their municipal councils the level of public support for smoke-free measures. The Task Force has used this information in presentations to municipal leaders and to mobilize local community action groups. Since 1997, seven municipalities have enacted bylaws restricting smoking in a variety of public places and a number of municipalities are in the process of doing so.

Cape Breton Regional Municipality in **Nova Scotia** recently passed a non-smoking bylaw requiring that all publicly accessed buildings be completely smoke free by 2003. As of May 1, 2001, all jails and correctional centres run by the Nova Scotia Department of Justice are smoke-free.

In **Newfoundland**, amendments have been made to the *Smoke-Free Environment Act* that will ban smoking in places frequented by children and in all restaurants by 2002. The *Newfoundland Tobacco Control Act* has been amended to ban the sale of tobacco in pharmacies.

Implementing tax increases

Higher prices are a recognized deterrent to tobacco use, therefore, the National Strategy places a priority on a long-term joint federal-provincial-territorial strategy for increasing taxation of tobacco products across Canada.

On April 5, 2001, the federal government announced a series of tobacco tax measures designed to support the government's health objectives. These included a tax increase of \$4 per cigarette carton in **Ontario, Quebec, New Brunswick, Nova**

Scotia and Prince Edward Island. Also included was a new tobacco tax structure designed to reduce the incentive to smuggle Canadian-produced tobacco products back into Canada. Federal departments and agencies will receive an additional \$55 million to monitor and assess the impact of these tax measures on tobacco smuggling.

In 2000, **Yukon** placed a bill before its legislature to increase tax on all tobacco products by 12%.

Developing policies and recommendations

The National Strategy encourages the alignment of policies across departments and ministries to maximize the effectiveness of policies in reducing tobacco use and in supporting initiatives.

In the North, **Yukon** is researching and developing a strategy for reducing tobacco use while **Northwest Territories** has made the development of a Territorial Tobacco Strategy an integral component of its two-year old Health Promotion Strategy. This Territorial Tobacco Strategy will reflect those areas of the National Strategy that are particularly pertinent to the Northwest Territories.

On December 9, 1999, **Saskatchewan's** Legislative Assembly established a Special Committee on Tobacco Control. In February 2001, the Committee tabled its final report with recommendations for prevention, cessation, protection, and denormalization interventions and activities.

Strengthening tobacco control strategies

Since 1999, **Ontario's** renewed Tobacco Strategy has benefited from an allocation of \$10 million a year over and above the \$9 million previously allocated.

Quebec increased its budget for tobacco control by an additional \$10 million for fiscal year 2001-02. Previously, it had spent between \$8 million and \$10 million dollars annually. It has also allocated \$3 million to control tobacco smuggling. As of October 2000, Quebec began providing public financing for Nicotine Replacement Therapy and for the use of the cessation support pharmaceutical, Zyban.

Alberta has funded the Alberta Tobacco Reduction Alliance, which implements the Alberta Tobacco Reduction Plan. Funding for the 2001-02 fiscal year increased to \$2 million.

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

The intent of this Strategic Direction is to make available and accessible information, services, and programs about tobacco and tobacco related issues, which address prevention, cessation, protection, and denormalization.

Efforts to inform Canadians about the hazards of tobacco use and other tobacco-related issues moved forward this year through the most diverse mediums, from personal face-to-face contact to the anonymity of the Internet. Many activities were directed specifically to the needs of young people.

From household to household

In **Northwest Territories**, there is a community where 75% of the homes are smoke-free and smokers smoke outside—even at -60°C. With support from the NWT/Nunavut Branch of the Canadian Public Health Association (CPHA), the Community Health Representative, and the nurse, leaders in this community promoted smoke-free homes and the CHR and nurse went from house to house educating and encouraging residents. The NWT/Nunavut Branch of the CPHA is following this model to promote smoke-free homes in other communities.

Via telephone

In March 2001, the Canadian Cancer Society completed a two-year pilot project funded by the **British Columbia** Ministry of Health. The QuitLine provided in-depth counselling, cessation planning, and callbacks. During a 13-month period, 384 calls were referred to the QuitLine resulting in 71 individuals enrolling in a QuitLine counselling program with 46 completing the initial one-hour planning session. The pilot project evaluation reported a cessation rate of just fewer than 30% with nearly half of QuitLine clients decreasing their consumption of cigarettes by up to 50%. In April 2001, British Columbia launched the expanded BC Smokers' Helpline, which was modeled after the Ontario Smokers' Helpline developed by the Canadian Cancer Society, Ontario Division. The BC Smokers' Helpline provides more immediate telephone cessation counselling and fields a higher number of calls than the pilot project did. Four staff members of the Canadian Cancer Society, British Columbia and Yukon Division deliver this funded service.

Through television advertising

The Heart and Stroke Foundation of **Ontario** ran a successful Mass Media (television) Campaign that generated, according to a post-campaign survey, dialogue on the effects of tobacco use and second-hand smoke in 31% of Ontario households—a rare occurrence for advertising. Seventy-eight percent of those surveyed recalled seeing the TV ads; 65% said that the ads made them think about second-hand smoke and the impact of smoking on loved ones; and 76% thought that the ads were credible. In addition, the target population showed a 9% positive shift in attitudes, especially regarding second-hand smoke.

In **Nova Scotia**, a successful television ad campaign on environmental smoke has raised awareness of the serious health effects of second-hand smoke.

On the Internet

Health Canada's Tobacco Control Programme launched an interactive self-diagnosis and self-help smoking cessation feature on its Web site. It offers information and support to Canadians who are trying to quit smoking. Individuals can find personalized information on how to overcome obstacles, build motivation, and gain skills on their journey to becoming smoke-free. A preliminary evaluation indicated that the site received 150,000 hits in one week of February 2001. It is currently the most frequently visited feature at www.hc-sc.gc.ca/hppb/tobacco/index.html.

The **Alberta** Tobacco Reduction Alliance developed an extensive inventory of information and resources for its Web site, www.tobaccotruth.com.

The **Nova Scotia** Tobacco Control Unit Web site, www.gov.ns.ca/quitnow offers helpful information on the health effects of smoking and second-hand smoke, and has a special youth section.

Reaching out to youth

British Columbia held a *Kids Against Tobacco Summit* – the first youth summit on tobacco of this magnitude in Canada – from February 22 to 24, 2001.

Accompanied by 20 chaperones, 80 B.C. youths, including the province's Youth Tobacco Attack Team, met with representatives from **Nunavut, Newfoundland, Yukon**, and the federal Youth Advisory Committee on Tobacco. Participants returned to their communities with new skills, knowledge, and resources to initiate anti-tobacco activities. The summit was so successful that a second one is planned for March 2002.

BC Tobaccofacts, a comprehensive school-based tobacco education program, provides teachers with lesson plans and activities to incorporate information about tobacco into their curriculum. The subjects include tobacco science, tobacco industry marketing practices, and health effects of tobacco. Material for kindergarten through grade 7 has been distributed to all public, independent, and band schools. Material for grades 8 through 12 will be distributed by October 2001. In the 2000-2001 school year, 2,000 copies of the grades 4 and 5 resources were distributed and 28 regional orientation sessions were completed.

During the 1999-2000 school year, the **Prince Edward Island** Tobacco Reduction Alliance, which includes the province's Department of Health and Social Services, focused efforts on comprehensive school health. All school boards (which represents virtually all schools in the province) implemented policies establishing no-tobacco use on school grounds. As part of an effort to create supportive no-tobacco use environments, students were trained to lead prevention activities and to assist with cessation initiatives in their schools.

The University of Prince Edward Island School of Nursing in conjunction with the University of Waterloo conducted a survey in the province's high schools in May 1999 and in June 2000. The survey results are encouraging. Smoking levels dropped in grade 10 from 20% in 1999 to 19.4 % in 2000. The smoking levels for grade 11 students dropped from 25.5% to 23.4%. Rates increased slightly for grade 12 students from 27.6% in 1999 to 28.1% in 2000.

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 to reduce addiction and disease.

This first progress report highlights two new regulations, the impact of the new health warning and information messages printed on cigarette packs, and provincial activity related to the recovery of health care costs.

Regulations

As of June 26, 2000, two new regulations, the *Tobacco Products Information Regulations* and the *Tobacco Reporting Regulations*, require stronger tobacco labelling and reporting measures.

As a result of a constitutional challenge, British Columbia is working with **Health Canada** and the industry to implement a “standstill agreement” on the reporting requirements of the *Tobacco Testing and Disclosure Regulation*. Currently, while the industry is still required to report on ingredients, additives, and smoke constituents for the most popular cigarette brands sold in the province, the reporting requirements are being waived for loose tobacco and for cigarette brands with less than 1% market share in British Columbia. All reports received to date are posted on a Web site available to the public.

Health warnings

Since the new Health Warning and Information Messages and the **Health Canada** www.infotobacco.com Web site address began appearing on cigarette packages, there has been a remarkable increase in visitors to the Web site. Between August 2000 and February 2001, visits to Health Canada’s tobacco control Web site increased from around 162,000 hits per month to over 700,000 hits per month.

Recovery of health care costs

In February 2000, **British Columbia’s** *Tobacco Damages and Health Care Costs Recovery Act* was struck down in a constitutional challenge by the tobacco industry. Subsequently, the British Columbia legislature amended the act and re-launched its lawsuit in January 2001.

In **Quebec** a Working Group is examining the feasibility of a government lawsuit against tobacco companies for recovery of health care costs.

In April 2001, the **Newfoundland** legislature introduced an *Act to Provide for the Recovery of Tobacco Related Health Care Costs*. A Select Committee received submissions between April 30 and May 8, 2001 and is preparing a report.

Research, Evaluation, and Monitoring

This Strategic Direction is intended to increase knowledge of tobacco and tobacco use, the tobacco industry, effective interventions for tobacco control, and health and socio-economic impacts of tobacco use.

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

In **Alberta** a joint two-year research project is currently underway involving the Alberta Tobacco Reduction Alliance, the Alberta Cancer Board, and the Centre for Health Promotion Studies of the University of Alberta. Research on change in

youth tobacco use, specifically the change from nonsmoker to experimenter to regular smoker will provide benchmarks for a provincial youth monitoring system.

In **Nova Scotia**, Cancer Care Nova Scotia commissioned GPI Associates to produce a report on the “Costs of Tobacco Use in Nova Scotia”.

Pilot projects

The Environmental Health Unit of **Manitoba's** Public Health Branch recently initiated a small pilot project in which a facilitator works with teenagers who want to quit smoking. The project is conducted in a high school and offers participants the information, support, and motivation that they need to quit smoking. Evaluation of this pilot project may lead to its expansion.

New Brunswick's Addiction Services does not have a formal mandate to provide services to individuals with nicotine addiction. However, the province's schools recognize that students who want to quit smoking need support. The Department of Health and Wellness funded a pilot project in which one region's Addiction Services prevention workers helped develop peer led prevention, education, and cessation programs in two middle schools. This regional effort has evolved into a provincial pilot project supported by a stakeholder Advisory Committee. Every Addiction Services region in the province will partner with a school to deliver an education and cessation program. The effectiveness of various models used in the provincial pilot will be evaluated by a research project that hopes to draw on various research funding opportunities.

Evaluation

As part of developing a tobacco reduction strategy, **Nunavut** is evaluating projects and initiatives that were undertaken in 2000.

The **Ontario** Tobacco Strategy dedicated 10% of its funding to evaluation. The Ontario Tobacco Research Unit (OTRU), an independent research agency funded by the Ministry of Health and Long-Term Care, coordinated the evaluation, producing a report on the renewed strategy's Year 1 projects. Through planning and implementing its coordinating function, OTRU has developed and refined strategies, mechanisms, and instruments for the timely and efficient monitoring and reporting of performance levels. A notable achievement of last year's \$10 million renewed Tobacco Strategy is that funded projects substantially achieved all or most of their objectives by the end of their funding periods.

Monitoring

The 2000 Alberta Tobacco Reduction Alliance “Survey of Albertans Regarding Tobacco Use” showed an increase from 44% in 1998 to 62% in 2000, in the number of respondents who ban smoking in their homes. The number who reported smoking daily dropped from 30% to 24%. In 1998, 69% of respondents reported not smoking at all while in 2000, 75% reported not smoking. The number of Albertans surveyed who were aware of the health effects of tobacco use rose from 49% to 64%. The first survey was conducted in 1998.

A **Newfoundland** survey conducted between July and September 2000 showed strong support for smoke-free places. Eighty-one percent of adults support making

all workplaces smoke-free; 70% think that government should ensure that customers and staff are protected from second-hand smoke; and 96% of adults support limiting children's exposure to second-hand smoke.

Building and Supporting Capacity for Action

The Building and Supporting Capacity for Action Strategic Direction is intended to increase the ability of individuals, health intermediaries, and communities at the national, provincial, territorial and local levels to take 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. The items highlighted this year represent the broadest range of activities.

Northwest Territories has trained a cadre of 37 people to offer the Cancer Society's Fresh Start Program in their communities and a few cessation sessions have already been conducted. Major media campaigns encompassing press, TV, and radio included student-produced material. Through a contract with the Northwest Territories/Nunavat Branch of the Canadian Public Health Association, young people are producing relevant material and evaluating youth cessation programs. A program will be chosen and adapted.

Kick the Nic, a teen smoking cessation program launched in **British Columbia** in September 1999, supports teens committed to quitting. It helps them become tobacco-free, creates a positive learning experience, and gives them skills that they can use to make positive changes throughout their lives. British Columbia has trained approximately 50 Master Trainers who train facilitators. Among the almost 250 facilitators are prevention workers, teachers, public health nurses, and social workers who deliver the program in schools, alternate schools, and community and friendship centres. British Columbia has run Kick the Nic in about 75 communities since its launch and has distributed some 11,000 participant handbooks.

Newfoundland pilot-tested Kick the Nic in 12 schools with almost 100 teens completing the program. An evaluation was completed in May 2001 and the province has purchased resources for an additional 20 programs. **Northwest Territories** and **Saskatchewan** are negotiating with British Columbia to adapt the program for their use, and **Ontario** has pilot-tested Kick the Nic in three communities. Over 150 students in **Prince Edward Island** have completed the Kick the Nic program.

In **Alberta**, the *Municipal Government Act* allows municipalities to enact bylaws that restrict smoking. The Alberta Tobacco Reduction Alliance in cooperation with Action on Smoking and Health have supported and facilitated a media campaign, workshops, print and Web site resources, and advocacy activities. These have increased Albertans' awareness of the health effects of tobacco use. As a result, many Alberta communities have petitioned their local governments to enact no-smoking bylaws and a number of municipalities have done so.

Health Canada, and the ministries of health of **Saskatchewan** and **Manitoba** collaborated to present *The National Strategy and You Workshop*, which was attended by 60 people representing Saskatchewan and Manitoba provincial health departments, health authorities, and interest and advocacy groups. Participants identified priorities and follow-up activities for both provinces. In Saskatchewan, the Action for Tobacco Advocacy Workshops have given participants a detailed description of how to mobilize a community to influence government, regardless of the issue or level of government.

A **Health Canada** regional office sponsored a unique pilot project in **Saskatchewan** that led to the formation of a coalition of retailers, health districts, enforcement agencies, and school boards. The coalition developed a comprehensive program for retailer education and monitoring to prevent tobacco sales to young people in Moose Jaw.

The **Manitoba** Ministry of Health is developing a provincial tobacco control strategy that will largely mirror the federal strategy's goals of prevention, cessation, protection, and denormalization. NGOs and government have worked together to define provincial objectives. Confirmation of the provincial strategy is expected in 2001.

An independent evaluation by the **Ontario** Tobacco Research Unit (OTRU) concluded that, by the end of the first year, the groundwork was laid and the infrastructure was in place for an effective, multi-faceted tobacco-control program in Ontario. Local tobacco-free councils were involved in implementing the Quit Smoking 2000 contest that attracted 12,469 registrants. The contest was held in conjunction with a community education project, which helped develop resource materials, action kits, and information packs that helped communities build tobacco control capabilities and raise the profile of tobacco issues in their communities.

Teen Tobacco Team (T.T.T.) was formed in November in **Newfoundland** with 10 youth between the ages of 14 and 20 representing all parts of the province. The team meets three times a year and has participated in several anti-tobacco initiatives including developing and designing a Smoking Sucks media campaign, launching a Web site, and organizing a letter writing campaign.

In June 2000, a Best Practices Conference was held in **Nova Scotia** with representatives from the World Health Organization, the Atlanta Center for Disease Control, the Massachusetts Tobacco Control Program, and British Columbia. Over 25 key stakeholders attended and over the next few months they developed a Provincial Tobacco Strategy. The strategy encourages partnerships and focuses on taxation, legislation, youth smoking prevention, community-based programs, cessation, public awareness, monitoring, and evaluation.

The Prince Edward Island Tobacco Reduction Alliance (PETR), with combined community and government resources has designed and implemented an extensive cessation program that includes counselling and financial assistance for Nicotine Replacement Therapy (NRT). In the first five months of operation, over 600 Islanders requested cessation counselling and over 300 received NRT support. Collaboration and financial contributions have come from provincial and federal government, private corporations, as well as the PEI Pharmaceutical Association.

First Nations, Inuit and Métis

The revised National Strategy recognizes that there is no single effective approach suitable for all Canadians. Interventions and activities should address the specific needs of communities. Furthermore, lasting change is most likely to occur if those affected participate in planning it.

The 1997 First Nations and Inuit Regional Health Surveys reported smoking rates of 62% for First Nations and 72% for Inuit peoples. According to these surveys the average age for taking up smoking is also younger for these populations than for the general population. In addition to considering what may be higher risk factors, tobacco control efforts in these communities must also consider 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. This year's progress report highlights the following activities.

Northwest Territories sponsored a unique research project on Dene Tobacco Extenders. When Dene go out to the bush for long periods of time they add local plants to their tobacco to extend their supply. Research was conducted in two stages to determine which plants are used and how they are processed. A toxicology analysis of both dried and fresh plants and the smoke they produce has been conducted and a report is being prepared. The research takes into consideration the cultural context that influences Dene youth's decision about tobacco use.

In the spring and summer of 2000, departmental staff from **Nunavut** met with regional staff and members of Pauktuutit, the National Inuit Women's Association, to discuss a tobacco control strategy. These meetings have given a sense of direction, at least for the immediate future, to how Nunavut will develop its Tobacco Reduction Program.

In January 2001, **British Columbia** launched "Honouring Our Health, an Aboriginal Tobacco Strategy for British Columbia". It is the first of its kind in Canada. It is a community-based strategy, an integral component of the provincial Tobacco Strategy, and aboriginal people designed it for aboriginal people. It was inaugurated with an Honour Your Health Challenge in which participants from aboriginal communities across British Columbia were encouraged to quit smoking, to reduce the number of cigarettes they smoked, or to make their homes smoke-free for one month. A celebration of their efforts was held in March 2001.

The Aboriginal Tobacco Strategy's strategic priorities include: 1) mobilizing aboriginal leadership, 2) joining the larger vision of cultural re-vitalization, 3) generating community enthusiasm and enlisting volunteers, 4) strengthening relationships with health authorities, 5) developing community capacity, 6) integrating with existing health and social initiatives, 7) blending best practices (mainstream interventions to reduce misuse of commercial tobacco) with best traditions (respecting traditional uses of tobacco in aboriginal communities), and 8) evaluating progress.

An Aboriginal Working Group made up of aboriginal representatives from across the province ensures that the Aboriginal Tobacco Strategy continues to be informed by and embraced by aboriginal communities.

Conclusion: Moving Forward



The data and information presented in this first progress report on the National Strategy to Reduce Tobacco Use demonstrate that over the past 35 years Canada has significantly reduced the percentage of the population that uses tobacco. However, because of the population growth over that same period of time, the absolute number of smokers has not declined significantly. While the 2000 data from Health Canada's Canadian Tobacco Use Monitoring Survey indicate that the percentage of smokers in the ten provinces has continued to edge downward, there are a number of areas of concern. The decline in smoking rates among women appears to have flattened with only a marginal downward shift since 1999. And prevalence rates among young Canadians continue to be of particular concern since the majority of new recruits to smoking come from among adolescents.

Prevalence rates among youth actually increased in the mid to late 1990s and only now are beginning to show slight decreases. We need greater insight into what motivates young people to start smoking and what measures may help deter them from taking up smoking. Obviously, they are a target group that requires an approach tailored to their needs, lifestyle, and stage of life. It is difficult enough for adults to acknowledge the reality of the adverse health consequences of smoking when their onset is often delayed by decades. It is that much more difficult for teenagers whose concerns are quite different from those of most adults and who often have difficulty visualizing their lives five years from now.

Currently, data on youth smoking is reported for two age groups: 15 to 19 year olds and 20 to 24 year olds. But we know that a certain number of children as young as 10 or 12 years old take up smoking. More information is required on the circumstances and motivation of very young smokers.

There are other serious data gaps. There are indications that prevalence rates among First Nations and Inuit are much higher than among the general population, but there is no regular data collection mechanism to track tobacco use among these peoples. As aboriginal communities address the non-traditional use of tobacco, their initiatives will need to be evaluated so that successful efforts can be effectively reinforced and enlarged. There is also a serious lack of data from Yukon, Northwest Territories, and Nunavut. A strategy must be developed to ensure routine data collection for the territories.

Current surveys are also not able to gather information on certain population groups such as individuals who are institutionalized and those who are homeless.

To improve the estimates of smoking-attributable morbidity and mortality rates, there is much work yet to be done in gathering information on the smoking status of people with certain health problems. And, while the health risks of tobacco use are well established, data collection has focused on certain conditions, particularly lung cancer. Other illnesses that are known to be associated with smoking or exposure to second-hand smoke, such as asthma and middle ear infections, require more refinement in data collection.

There have been several innovative data collection activities to date, but they should be repeated so that trends and patterns can be monitored. For example, the survey of schools, daycares, health care institutions, and commercial settings gave us a good picture of those organizations' smoking policies. However, the results are becoming outdated and more current information is required to monitor progress in eliminating exposure to second-hand smoke.

The federal, provincial, and territorial governments are already working to address some of the issues and data deficiencies addressed in this report. This past year Yukon, Northwest Territories, and Manitoba have taken steps toward developing or implementing tobacco control strategies. In April 2001, the Honourable Allan Rock announced a renewed federal strategy for tobacco control that includes \$480 million in funding. Among the many initiatives for the coming year will be a specially designed "North of 60" tobacco use survey.

While progress toward the National Strategy's goals may be difficult to measure on a year-to-year basis, over time we expect that trends will become discernable. Annual progress reports that can track trends and pinpoint deficiencies in the knowledge we need to combat tobacco use will play a vital role in maintaining the momentum toward our shared goal of a society where as few Canadians as possible are addicted to tobacco products.

Appendix A: Smoking Prevalence Statistics by Province



Table A-1 Prevalence of current smokers aged 15 years and older in British Columbia, 1986–2000

	1986	1991	1994	1999	2000
Men	29	31	28	21	22
Women	23	27	23	19	18
Age 15–24				25	23
Overall	26	29	25	20	20

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Statistics Canada, Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-2 Prevalence of current smokers aged 15 years and older in Alberta, 1986–2000

	1986	1991	1994	1999	2000
Men	36	36	34	27	24
Women	32	33	26	25	21
Age 15–24				33	27
Overall	34	34	30	26	23

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Statistics Canada, Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-3 Prevalence of current smokers aged 15 years and older in Saskatchewan, 1986–2000

	1986	1991	1994	1999	2000
Men	35	29	35	27	29
Women	28	29	24	24	27
Age 15–24				32	30
Overall	31	29	30	26	28

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Statistics Canada, Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-4 Prevalence of current smokers aged 15 years and older in Manitoba, 1986–2000

	1986	1991	1994	1999	2000
Men	35	25	36	27	29
Women	30	31	27	19	23
Age 15–24				31	31
Overall	32	28	31	23	26

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; Survey on Smoking in Canada, Cycle 1, 1994; Statistics Canada, Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-5 Prevalence of current smokers aged 15 years and older in Ontario, 1986–2000

	1986	1991	1994	1999	2000
Men	31	31	28	26	25
Women	29	28	27	21	21
Age 15–24				29	27
Overall	30	29	28	23	23

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Statistics Canada, Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-6 Prevalence of current smokers aged 15 years and older in Quebec, 1986–2000

	1986	1991	1994	1999	2000
Men	42	33	37	32	28
Women	36	33	38	29	28
Age 15–24				38	34
Overall	38	33	38	30	28

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Statistics Canada, Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-7 Prevalence of current smokers aged 15 years and older in New Brunswick, 1986–2000

	1986	1991	1994	1999	2000
Men	37	28	38	31	27
Women	31	26	32	23	26
Age 15–24				32	33
Overall	34	27	35	26	27

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-8 Prevalence of current smokers aged 15 years and older in Nova Scotia, 1986–2000

	1986	1991	1994	1999	2000
Men	38	41	26	31	31
Women	33	30	33	27	29
Age 15–24				33	31
Overall	35	35	29	29	30

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-9 Prevalence of current smokers aged 15 years and older in Prince Edward Island, 1986-2000

	1986	1991	1994	1999	2000
Men	33	36	49	28	29
Women	23	23	29	23	26
Age 15–24				33	34
Overall	27	29	39	26	28

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-10 Prevalence of current smokers aged 15 years and older in Newfoundland, 1986–2000

	1986	1991	1994	1999	2000
Men	35	40	29	32	29
Women	30	29	25	25	26
Age 15–24				33	34
Overall	32	35	27	28	28

Sources: Smoking Behaviour of Canadians (supplements to the Labour Force Surveys); non-proxy; General Social Survey, 1991; Survey on Smoking in Canada, Cycle 1, 1994; Canadian Tobacco Use Monitoring Survey, Annual, 1999 and 2000.

Table A-11 Prevalence of smokers in the Northwest Territories

	1999
Men	42.4
Women	39.7
Age 15–24	40.3
Age 25–39	44.9
Age 40–59	39.9
Age 60+	30.7
Aboriginal	54.2
Non-Aboriginal	30.1
Overall	42

Source: Northwest Territories Ministry of Health and Social Services.

Table A-12 Prevalence of current smokers aged 15 and older in the Yukon, 1994

	1994
Men	43.6
Women	39.2
Age 15–24	42.3
Overall	41.5

Source: National Population Health Survey, 1994. Smoking data from the 1998 NPHS and the 2000 CCHS are not yet available.