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THE ONTARIO TOBACCO RESEARCH UNIT
UNITÉ DE RECHERCHE SUR LE TABAC DE L'ONTARIO

Monitoring the Ontario Tobacco Strategy

PROGRESS TOWARD OUR GOALS 2000/2001

SEVENTH ANNUAL MONITORING REPORT

Monitoring the Ontario Tobacco Strategy

Progress toward Our Goals 2000/2001

7th Annual Monitoring Report

Ontario Tobacco Research Unit

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PREFACE

This Report covers the period April 2000-March 2001 and is the seventh annual report from the Ontario Tobacco Research Unit (OTRU) to monitor the progress of the Ontario Tobacco Strategy (OTS). The Monitoring Report remains one of the major research-oriented contributions of OTRU to the OTS.

This year's Report covers the same ground as last year's, but is organized a little differently. Short-term impact and progress toward longer-term objectives — the heart of the report — are now described in Chapter 3. This follows an overview of tobacco control in Ontario and elsewhere (Chapter 1) and a more detailed description of the Strategy activities of OTS partners (Chapter 2). The discussion of implications (Chapter 4) has been retained and provides a synthesis of the earlier chapters.

Although the Report provides a reasonably comprehensive picture of tobacco control in Ontario, it is not intended to be a conclusive evaluation of individual components or of the Strategy as a whole. For this purpose, one should consult the two OTRU evaluation reports that focus on projects funded under the renewed OTS: *Evaluating the renewed OTS: Report on year 1 ending Fall 2000* and *Evaluating the renewed OTS: Report on the initial 18 months ending March 2001*. We anticipate that future versions of this annual monitoring report will include even more material from the evaluation studies, and that these will effectively be combined into a single document.

ACKNOWLEDGEMENTS

Shawn O'Connor and Bronwen Waller prepared this report, working under the guidance of OTRU's Monitoring Work Group, chaired by Tom Stephens. Rita Luk tabulated the price data in Chapter 1 and the health burden data in Chapter 3. Jackie Roberts assisted with layout and production.

Thanks are due to those persons, including staff of OTS partner agencies, who reviewed an earlier version of this Report, and Stan Shatenstein (*Tobacco News Online*), who was the source of a good deal of the background material in Chapter 1.

The Principal Investigators of OTRU have played a key role in the interpretation of the findings in this report, and are responsible for the opinions expressed herein. The Principal Investigators are:

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EXECUTIVE SUMMARY

Tobacco Control Highlights: Ontario and Beyond

Funding
Most of the new OTS initiatives implemented in January - March 2000 were continued with renewed funding for October 2000 – March 2001 (Section 1.1 and Tables B1 and B2). OTS funding levels remained unchanged at $19 million in 2000-01, or $1.65 per capita. This level was well below internationally recognized spending recommendations, which range from $5.46 to $15.05 per capita (Section 1.1).

Taxation
Despite a tax increase of $4 per carton of cigarettes at the end of the reporting period (April, 2001), cigarette prices remained below 1990 levels. This price was 20% below the average of prices in other Canadian provinces, and 43% and 37% below neighbouring New York and Michigan, respectively (Section 1.1).

Consumption
Consumption of cigarettes in Ontario in 2000 was 1968 per person age 15+. This is 12% less than the recent high of 2225 cigarettes per capita in 1996 and is about the same level as in 1991 (Section 1.5).

Activities of Strategy Partners

Cessation Focus
Over the past year the agencies providing resources and infrastructure appeared to focus much of their efforts on cessation. This contrasts with the previous year, when most of these agencies centered their activities on protection from ETS and prevention (Section 2.1.1).

Target Groups
Agencies providing resources and infrastructure continued to focus on other OTS partner agencies and youth aged 12-19. Community programming agencies tended to direct their tobacco control efforts toward the general public and youth aged 12-19. Ethnic minorities, blue-collar workers, and lower literacy populations continued to receive less attention than other groups (Section 2.1.2).

Progress toward OTS Objectives

Health Burden
There were 11,656 deaths attributable to smoking in Ontario in 1997. Whereas smoking related deaths of men decreased by 6% from 1992 to 1997, those of women *increased* by 12%. The potential years of life lost (PYLL) because of premature mortality associated with these deaths are estimated at 173,158 years. In 1997, an estimated 511,105 hospital days were used in Ontario for the treatment of smoking-related conditions (Section 3.1).

Adult Smoking
In 2000, 26% of Ontario adults age 18+ smoked daily or occasionally. Men were much more likely to smoke (31%) than women (21%) (Section 3.2.1).

Overall, there has been little change in the prevalence of smoking among Ontario adults over the last decade (Section 3.2). However, in the past five years, both current and daily smoking has decreased among women but not among men (Section 3.2.1).

In addition to men having a higher prevalence of smoking than women, men smoke more cigarettes (18.7 vs. 16.1 cigarettes/day among daily smokers), a level of consumption that has remained fairly constant for a decade (Section 3.2.2).

Overall, smoking continues to be most common in Northern Ontario and least prevalent in Toronto (Section 3.1.2).

Smoking prevalence and mean number of cigarettes smoked per day among daily smokers continues to be higher for adults with less than a high school education and for blue-collar workers than all Ontario adults combined, although the differences in 2000 were not statistically significant.

Cessation

Among current smokers in Canada, Ontario smokers were second only to those in British Columbia in seriously considering quitting within the next 30 days: 29% were considering quitting within the next 30 days. Over half of smokers (53%) were considering quitting within the next six months (Section 3.2.4).

Forty-three percent of current adult smokers had been advised by their doctor during the last 12 months to quit smoking (Section 3.2.4).

One in five Ontario smokers was aware of the Quit Smoking 2000 contest; slightly lower proportions knew of other quit programs (Section 3.2.4).

Youth Smoking

In 2000, Ontario youth aged 15-24 were slightly less likely to be smokers (27%) than their peers in the rest of Canada (30%). However, this was due entirely to the lower smoking level of young adults aged 20-24 in Ontario, as Ontario teens were just as likely to be smokers as teens elsewhere in Canada (25% in both cases, Section 3.3.1).

Between 1999 and 2000, smoking prevalence decreased significantly for young adults aged 20-24 in Ontario, from 34% to 29%. In contrast, there was no improvement among Ontario teens aged 15-19. Meanwhile, youth aged 15-19 elsewhere in Canada reduced their smoking by four percentage points. As a result, only three provinces (QC, NB, and NF) had higher teen smoking rates than did Ontario (Section 3.3.1). Evidence suggests that smoking among youth aged 15-17 has been more resistant to change than that of 18-19-year-olds (Section 3.3.1).

Sales to Minors

In 2000, 16% of tobacco retailers would sell cigarettes to underage youth, down from 38% in 1998 and 21% in 1999. Compliance in Ontario was considerably better than the national average, but not all outlet types showed improvement. Cigarettes were most available to youth in gas stations and chain convenience stores in 2000 as both types were less compliant with the law than they were the year before. In 2000, youth aged 15-17 obtained cigarettes equally from social sources (friends or parents) and retail outlets (Section 3.4), both in violation of the Ontario Tobacco Control Act, which states that no person shall supply or sell tobacco products to youth under the age of 19 years.

Exposure to ETS

Almost half of trade and farm workers were at risk of being exposed to the harmful effects of ETS at work in 2000, whereas only one in five professionals/managers and white collar workers was at risk from ETS while on the job (Section 3.5).

Smoking restrictions at work are associated with the number of cigarettes smoked per day by daily smokers: the more extensive the restriction, the less these workers smoke per day. Similarly, smokers were much less likely than non-smokers to report a complete ban on smoking at their place of work (Section 3.5).

Public Attitudes toward Tobacco Control

There is widespread support for restricting smoking in public places, and it has been fairly

constant since 1998. Approximately eight in ten adults support at least some smoking restrictions in workplaces, seven in ten adults agree with restrictions in restaurants, and four in ten support restrictions in bars (Section 3.6).

In 2000, 45% and 40% of Ontario adults were in favour of banning tobacco industry sponsorship and increasing cigarette taxes, respectively (Section 3.6). This moderate level of support has remained consistent since the mid-nineties.

Eighty-two percent of Ontario adults feel that tobacco products should be regulated as "hazardous" products (Section 3.6).

Implications for the OTS

Implications for Prevention

Overall, Ontario merchants are more likely than ever to comply with the sales-to-minors provisions of the Ontario Tobacco Control Act. Enforcement, however, needs to continue and should be intensified for those types of stores where violations are most likely to occur.

Smoking prevalence among Ontario youth aged 15-19, and especially 15-17, is not decreasing at the same rate as the rest of Canada. In 2000-01, Ontario had the cheapest cigarettes in Canada, merchant compliance was uneven, and only two OTS partners had a clear focus on prevention. Measures to address youth smoking that require heightened attention include higher tobacco prices, tighter enforcement of restrictions on tobacco sales to youth, efforts to educate retail and non-retail sources of tobacco products to minors about the need to curb youth smoking, increased time in school curricula for prevention programs, and leadership and commitment to make *existing* programs work in schools and in the community.

Implications for Cessation

Having the lowest price for cigarettes in Canada, a lack of smoking restrictions in many workplaces, and a tobacco control effort that is only modest, likely contribute to the lack of decline of smoking prevalence among adults in Ontario, as these factors have been shown to be strongly related to both prevalence and amount smoked (Stephens et al., 2001). Although large numbers of Ontario smokers express an intention to quit in the near future, only a small portion are aware of major provincial programs available to assist them in quitting, and only a minority have been advised by their doctors to quit. More visible cessation programs, and more widespread physician encouragement and advice, are called for.

Smoking continues to be more common among men, by a margin of 3:2, and men continue to smoke more each day than women. Although women have been designated a target group of the OTS for some years (their smoking prevalence has declined by six percentage points since 1995), men have not been targeted in any systematic manner. The time has come to recognize men's smoking as a challenge that requires new strategies to combat it. Smoking by blue-collar workers and low-literacy Ontarians also requires more focused attention.

There is a continued association between smoking restrictions at work, the likelihood of being a smoker, and the amount smoked daily. Also, a continuing, substantial proportion of Ontario workers still do not have meaningful restrictions on smoking in the workplace. Provincial legislation to introduce such restrictions would offer not only protection to non-smokers, but would also encourage smokers to cut down and eventually quit altogether.

Implications for Protection

Provincial legislation is needed to provide workplace protection to the 20% of white-collar workers and the 48% of blue-collar workers, among others, exposed to ETS while on the job. There is also a need for increased education

directed toward policy makers, the hospitality sector, and the general public about the failure of ventilation to provide adequate protection from ETS, and the lack of choice imposed on non-smokers when there is no provision for smoke-free public places.

Implications for Denormalization

Because the province's lawsuit against the tobacco companies in a U.S. federal court was not successful, Ontario should follow the lead of British Columbia, Quebec, and Newfoundland, as well as several private parties, and initiate proceedings within its own jurisdiction to recover health care costs due to smoking.

There has been little change since 1994 in the public's support for increasing tobacco taxes. More effort could be made to explain to the Ontario public that this is not just another tax, but a very effective means to prevent smoking and encourage cessation. The public also needs to be aware that higher taxes in Ontario will not lead to smuggling.

Public education messages about the role and responsibility of the tobacco industry in sustaining the tobacco epidemic need to be strengthened.

Implications for Monitoring, Evaluation, and Research

The most effective allocation of effort to prevention, cessation, protection, denormalization, and infrastructure development needs to be carefully assessed, with routine monitoring, in-depth evaluation, and ongoing dialogue with the Ministry of Health and Long-Term Care (MOHLTC).

A system needs to be established for collecting timely reports from Public Health Units (PHUs) on their tobacco-control activities. While the PHUs play a vital role in education, cessation services, enforcement, and the development of smoke-free public places, the current method of monitoring these activities used by the MOHLTC does not provide timely data for this annual report.

Given the limitations in existing surveys used for monitoring, particularly regarding content, sample design, and sample size and thus reliable local-level data, a survey dedicated to tobacco control issues in Ontario needs to be initiated, with reliable funding from the MOHLTC.

Implications for the OTS as a Whole

A more intensive tobacco control effort is called for, with funding increasing from current levels to amounts approaching internationally recognized standards. Increasing tobacco taxes to the Canadian average would provide more than enough new revenue for this purpose, while serving as a useful tobacco-control measure in its own right.

Major strategic opportunities remain, and critical target groups have yet to be addressed. A multi-year plan with assured funding from the Ministry is needed, as is a more visible role to complement and strengthen that of the partners whose activities are described in Chapter 2.

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CHAPTER 1. TOBACCO CONTROL HIGHLIGHTS: ONTARIO AND BEYOND

This chapter highlights tobacco control developments occurring over the reporting year April 1, 2000 – March 31, 2001 from a provincial, national, and international perspective, and describes selected tobacco industry activities in Canada. Events occurring after March 31, 2001 will be covered in next year's report, with the exception of the April 2001 tax increase on tobacco products, which is discussed in Section 1.1. Appendix A contains a list of Internet addresses of government and non-government organizations that the reader might wish to consult for additional details and more recent information.

This chapter covers the following topics:

1.1 Ontario

1.2 Provinces and Territories

1.3 National

1.4 International

1.5 Tobacco Industry

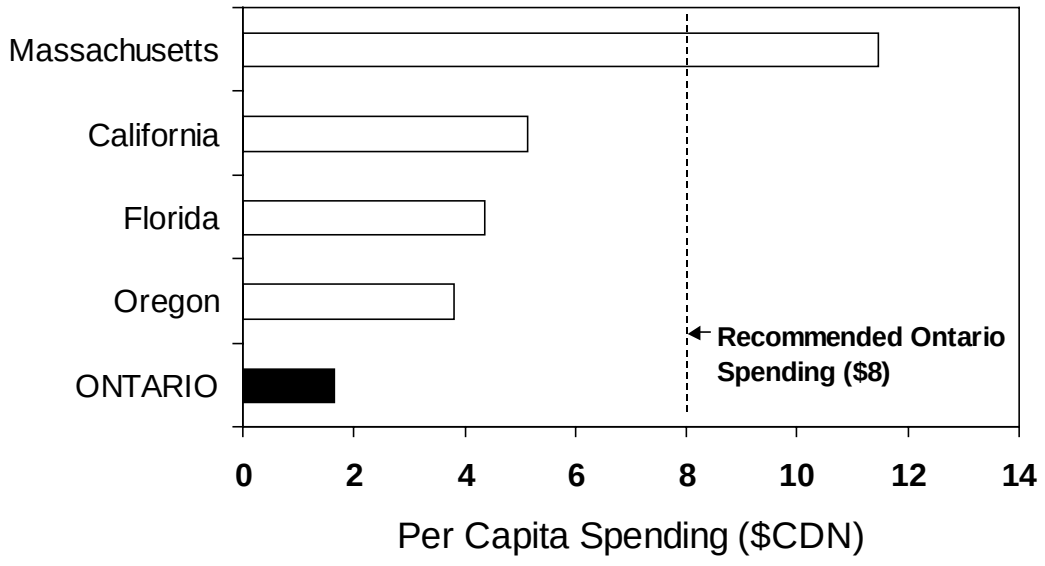
1.1 Ontario

In this chapter, we highlight a series of initiatives carried out over the past year as part of the Ontario Tobacco Strategy (OTS). These include continued funding to public health units, Strategy partners, and community organizations, a lawsuit against the tobacco industry, and tax increases on tobacco products.

1.1.1 Funding

With the renewal of the Ontario Tobacco Strategy in 1999, funding levels remained constant at $19 million or $1.65 per capita. Of this, $4 million provided continued support to OTS resource centres, $5 million was allocated to the activities of the province's 37 Public Health Units (Ontario Tobacco Research Unit, 2000b), and $10 million was allocated to new projects. Although per capita expenditures were at the highest level of provincial tobacco control spending in Canada, they were below internationally-recognized spending recommendations, which range from $5.46 (lower estimate) to $15.05 (upper estimate) per capita (Centers for Disease Control and Prevention, 1999) and that recommended by the Minister's Expert Panel (Ashley et al., 1999; 0.05 cents per cigarette sold – about 90 million, based on 1999 sales figures, or about $8.00 per capita).

Figure 1. Per Capita Spending on Tobacco Control, FY 2000 or 2001



To give some context to the $19 million spent on provincial tobacco control, Ontario recently announced a $20 million aid package to the Ontario Flue Cured Tobacco Marketing Board. Far from encouraging farmers to switch to alternative crops, this aid was to help tobacco-curing kilns reduce nitrosamine levels in tobacco.

1.1.2 Renewed OTS Projects

The renewed OTS is built on a range of initiatives that utilize a variety of strategies to achieve the OTS goals of prevention, protection, and cessation. Initiatives funded over the period of the present report were approved in several batches – 15 transfer-payment projects in January 2000, 11 competitive (RFP) projects in March 2000, and eight transfer-payment and eight competitive projects for the period October 2000 – March 2001. Thirteen of the initial transfer-payment projects were province-wide in scope, and 10 of the initial competitive projects were based in local communities. Many of these initial projects received renewed funding in the fall of 2000 to take them through March 2001. (See Appendix B, Tables B1, B2). Additional information on these projects is contained in an OTRU report to the Ontario Ministry of Health and Long Term Care, *Evaluating the renewed OTS: Report on year 1 ending Fall 2000* (Ontario Tobacco Research Unit, 2001a) and *Evaluating the renewed OTS: Report on the initial 18 months ending March 2001* (Ontario Tobacco Research Unit, forthcoming).

1.1.3 Lawsuits

Under the U.S. Racketeer Influenced and Corrupt Organizations Act (RICO), Ontario filed a U.S federal court lawsuit against major North American tobacco companies on March 2, 2000 to recover $40 billion worth of smoking-related health care costs. The suit was dismissed, first on August 7, 2000 and again on appeal. (The court noted that Ontario's alleged injury was too remote to permit legal recovery and suggested that foreign suits should be filed in a country's home court.) Currently, a number of class action and individual product liability cases are before Ontario courts including those of Caputo, Ragoonanan, Spasic, and McIntyre (Rob Cunningham, personal communication, June 27, 2001).

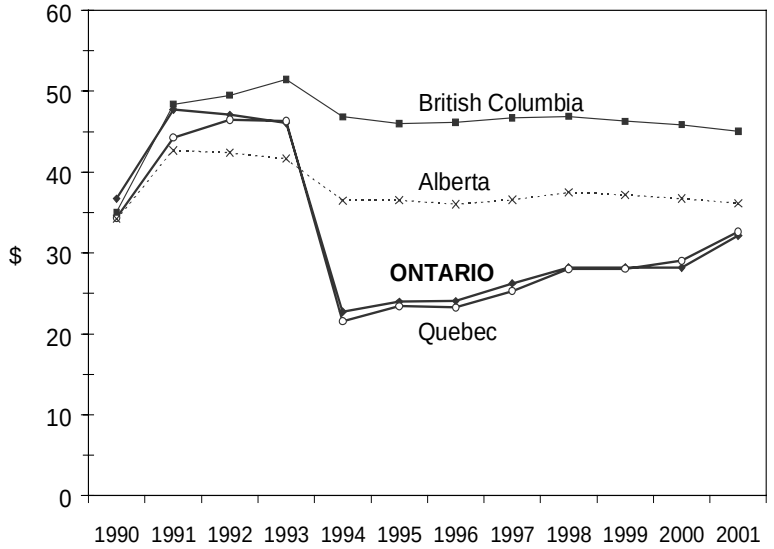
1.1.4 Price

In early 1994, the federal, New Brunswick, Nova Scotia, Ontario, PEI, and Quebec governments reduced tobacco taxes in response to the smuggling of tobacco products. A joint federal-Ontario tax increase of $4 per carton of cigarettes took effect in April 2001. Although encouraging, this raise failed to bring cigarette prices back to pre-1994 levels (Figure 2). Moreover, cigarette prices in Ontario remain 29% below cigarette prices in British Columbia, and 11% lower than those in Alberta (Figure 2).

Compared to the other provinces and all U.S. States, 2001 cigarette prices in Ontario remain the lowest (Figure 3), a finding unchanged from last year's Report. Given this ranking, Ontario would most likely be a source of cigarettes intended to be smuggled rather than a destination for contraband cigarettes.

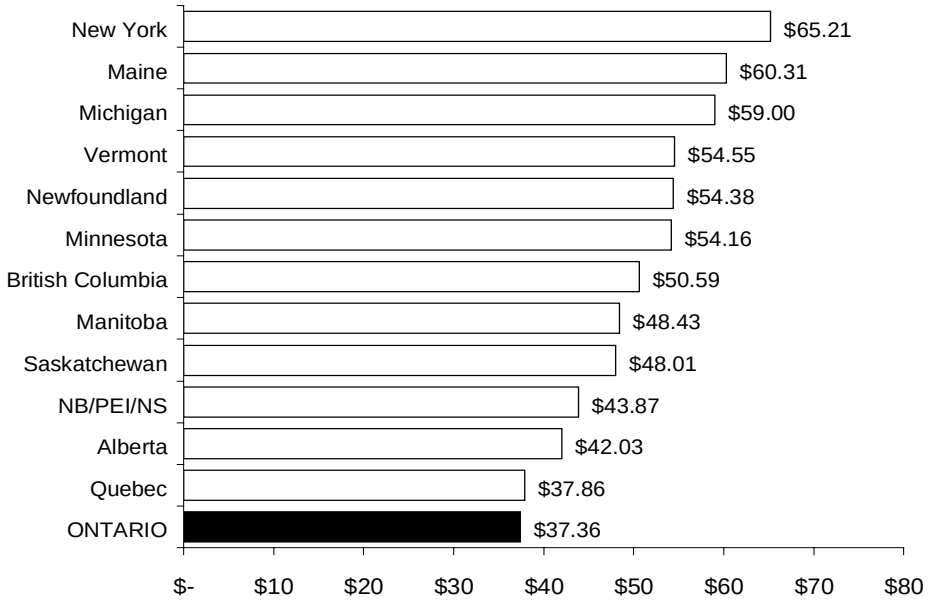
Although outside the reporting period, the November 2001 joint federal-Ontario tax increase of $3.40 per carton of cigarettes still does not bring prices in the province to pre-1994 levels nor does it change Ontario's provincial ranking.

Figure 2. Price per Carton of 200 Cigarettes in Four Provinces 1990-2001



Note: In 1993 constant dollars.
Source: Statistics Canada Price Division, custom tabulations based on city average (see Appendix C).

Figure 3. Price per Carton of Cigarettes, by Province and U.S. Border States, April 2001



Source: Smoking and Health Action Foundation, April 2001 (see Appendix C).

1.2 Other Provinces and Territories

1.2.1 Alberta

The Alberta Tobacco Reduction Alliance (ATRA), a coalition of government, non-government, and private sector organizations, continued to be the prime catalyst for tobacco control in the province. With the recent publication of *ATRA Handbook: Tobacco Basics* (www.atra.ab.ca), tobacco control advocates in the province and beyond have a readily available source of tobacco-related information about Alberta.

In early 2001, the government of Alberta set up an Interdepartmental Steering Committee to develop recommendations for a comprehensive tobacco reduction strategy. To date, Alberta remains the only province in Canada without legislation to control tobacco sales and marketing.

1.2.2 British Columbia

In 2000-01, British Columbia continued to be at the forefront of tobacco control in Canada with its integrated approach of legislation and legal action, public education, and program funding. In a recent report card (Clean Air Coalition of BC, 2001), a coalition of non-government organizations (NGOs) commended the province for "its progress in specific areas of tobacco control such as developing programming for children and youth within schools, developing media campaigns and promoting information on environmental tobacco smoke, developing legislation to disclose product ingredients, additives and smoke emissions, and attempting to recover the health care costs from tobacco companies" (p. 18).

British Columbia became the first jurisdiction in Canada to launch a lawsuit against tobacco companies in November 1998. The British Columbia Supreme Court struck down the province's *Tobacco Damages and Health Care Costs Recovery Act* in February 2000 on the basis that foreign tobacco interests could not be grouped together and treated as domestic companies (Cunningham, personal communication, June 27, 2001). In June 2000, British Columbia passed revised legislation addressing the Court's concerns, and a lawsuit against tobacco companies was refiled in January 2001.

In March 2000, citing insufficient consultation with stakeholders, the British Columbia Supreme Court struck down regulations adopted by the British Columbia Worker's Compensation Board to make workplaces smoke-free including hospitality, long-term care, and provincial correctional facilities. After comprehensive public consultations with all stakeholders, the Board approved amendments that would limit worker exposure to second-hand smoke to outdoor locations and separately ventilated smoking rooms after September 10, 2001. The recently elected provincial government, however, has put these amendments on hold.

1.2.3 Manitoba

To better understand the extent of tobacco control activities in the province, the government of Manitoba surveyed organizations involved in provincial tobacco control in August 2000 (Manitoba Health, 2001). The survey was intended to assist in planning for future activities, identify gaps, avoid duplication, increase awareness among organizations as to the activities of others, and identify successful initiatives that could be implemented elsewhere. Although Manitoba has stated its intention to sue tobacco companies for health-care costs associated with tobacco use, no movement on this front has occurred recently.

1.2.4 New Brunswick

Provincial Stakeholders Meetings with representatives from NGOs and Government were held to review drafts of an Anti-Tobacco Strategy prepared by an appointed Implementation Committee. Among the 21 objectives, eight priority objectives were selected, and action plans continue to be implemented through regular meetings of the lead organizations. Activities have included: reducing youth access to tobacco; new municipal restrictions on smoking; advocating for adequate and sustainable funding; developing social-marketing plans to support the strategy; increasing anti-tobacco education; research on attitudes and beliefs around tobacco use; planning the Eastern Canadian & New England States 2001 Tobacco Control Conference; and establishing a cessation network working group.

Ongoing enforcement of tobacco sales to minors through the *Tobacco Sales Act* compliance-testing program has led to a number of non-compliant retailers losing their licenses to sell tobacco for thirty days. The New Brunswick Coalition for a Smoke-Free Generation, affiliated with the Canadian Council for Tobacco Control, has been active over the past year in advocating smoke-free policies in several of the province's main cities and towns.

1.2.5 Newfoundland

With an initial three-year funding commitment from the provincial government in 1999, the Alliance for the Control of Tobacco (ACT), a consortium of government and non-government partners, continues its mandate to develop and implement a comprehensive tobacco reduction strategy for the province.

On the legislative front, Newfoundland has been active. Late in 2000, the government passed an Act that provided for a total ban on the use of tobacco products in food establishments and public places frequented by children and youth (to take effect January 2001). It also amended the *Tobacco Control Act* to prohibit the sale of tobacco products in pharmacies. In May of 2001, the legislature passed the *Tobacco Health Care Costs Recovery Act*, which permits the province to file a lawsuit against tobacco manufacturers.

1.2.6 Northwest Territories

An April 2001 report by the Department of Health and Social Services detailed the current status of smoking behaviour in the North, providing a baseline against which future initiatives will be evaluated (Northwest Territories, 2001). The report concludes that the Northwest Territories should employ a population health framework to implement tobacco control measures that targets specific groups and social factors, creates sustainable partnerships, and is multidisciplinary.

1.2.7 Nova Scotia

Following a consultation process initiated by the Nova Scotia Tobacco Control Unit, the provincial government announced a new Comprehensive Tobacco Control Strategy in March 2001. This strategy is comprised of taxation, legislation, youth smoking prevention, community-based programming, cessation services, media/public awareness, and monitoring and evaluation. As of May 2001, all correctional facilities in the province were tobacco-free.

1.2.8 Nunavut

The Department of Health and Social Services launched a series of mass media advertisements centred on prevention and cessation. Other initiatives include anti-tobacco workshops and discussions with municipal leaders and the RCMP to encourage tobacco control efforts.

1.2.9 Prince Edward Island

All Island schools and school property have become completely smoke-free over the past year, and comprehensive school programs centering on prevention and cessation have been updated. Last fall, the Department of Health and Social Services, in conjunction with the Prince Edward Island Tobacco Reduction Alliance, initiated a smoke-free home project that focused on protecting Island children from exposure to second-hand smoke in their homes. This initiative will be supplemented in the coming year with a smoke-free car program. A province-wide telephone quitline was launched in January 2001 and is complemented by additional cessation services including counselling and subsidies for nicotine replacement therapies ($75 per applicant).

1.2.10 Quebec

Over the past year, Quebec made preparations for a multi-billion dollar lawsuit against Canadian tobacco companies to recoup health-care costs associated with smoking-related disease. The launch of a media campaign and an increase in the number of enforcement officers investigating cigarette sales to minors have also been implemented as have new province-wide smoking restrictions in the workplace and in public buildings (e.g., restaurants must set aside 60% of their seating for non-smoking). In October, the province extended Quebec health insurance to cover nicotine replacement therapy such as prescription medicine (Zyban) and nicotine gum and patches.

1.2.11 Saskatchewan

In January 2001, an all-party Special Committee on Tobacco Control released its final report to the Saskatchewan Legislative Assembly. A series of recommendations was tabled including the development and implementation of a comprehensive tobacco reduction strategy funded in part by a dedicated excise tax on tobacco products. In reaction to the report, the government introduced legislation that prohibited the display and promotion of tobacco products in places where youth have access, prohibited the sale of cigarettes to anyone under the age of 18, increased penalties for retailers who sell tobacco products to minors, restricted cigarette vending machines to age-restricted establishments, and prohibited smoking in public places where children have access (excluding restaurants, bars, bowling centres, and bingo and billiard halls, which fall under a less restrictive requirement). Also in 2000, provincial correctional facilities became smoke-free.

1.2.12 Yukon

In the recent 2000/2001 budget, the Yukon government increased the tobacco tax by one cent per cigarette, citing the position of the World Health Organization and World Bank that tax increases are an effective tool for lowering tobacco use. In January 2001, the government, in partnership with the Kwanlin Dun First Nation, announced a youth tobacco initiative that seeks to prevent youth from starting to smoke and to help those who want to quit. The Yukon Tobacco Reduction Strategy, a community action group working on tobacco reduction in all Yukon Communities, has continued to be active in the territory.

1.3 National

Once again, Canada is being recognized internationally as a leader in the labelling of tobacco products, with the introduction of full colour graphic health warnings covering 50% of the display surface. Further information about the health effects of tobacco products, including tips for quitting and the address of an Internet web site with additional health information, are now required to be printed on the back of the inside "slide" of cigarette packages (or as leaflets inserted in the package). These labelling regulations became law on June 26, 2000, and tobacco manufacturers and importers of tobacco products were required to display the new messages within 180 days of the date the regulations became law. Information about the toxic emissions/constituents found in tobacco smoke (benzene, carbon monoxide, formaldehyde, hydrogen cyanide, nicotine, and tar) and the toxic chemicals in chew and snuff (lead, nicotine, and nitrosamines) had to be displayed on packages by June 26, 2001.

Restrictions on event sponsorship by tobacco companies continued to be phased in, with the result that the industry withdrew its support from a number of high-profile sport and cultural events. Replacement sponsors continue to come forward.

The Canadian Tobacco Use Monitoring Survey (CTUMS) provided timely, reliable, and continual data on tobacco use and related issues for the year 2000 and is expected to continue next year and beyond. This survey, in addition to the AC Nielsen retailer compliance survey (AC Nielsen, 2001), will provide the basis for evaluating the Government of Canada's promised investment of $480 million in Health Canada's Tobacco Control Strategy over the next five years. Although the allocated level of funding is considered low by internationally recognized guidelines (Centers for Disease Control and Prevention, 1999), the Government's 10-year measurable targets appear reachable with continued National Strategy funding and regulation of tobacco products.

The U.S. District Court for the Northern District of New York dismissed the Government's lawsuit against JTI-Macdonald and related companies for damages resulting from the illegal import of tobacco products on the basis that U.S. courts cannot enforce tax laws of foreign countries (Cunningham, personal communication, June, 2001). Also falling to a procedural ruling was Bill S-15, *An Act to enable and assist the Canadian tobacco industry in attaining its objective of preventing the use of tobacco products by young persons in Canada*. Specifically, because the Speaker of the House ruled that the Bill constituted a tax, it was declared null and void. Nevertheless, the Bill raised awareness of youth smoking in general and the federal government's failure in the recent past to adequately address this serious health issue.

In addition to the joint federal/provincial tobacco tax increase previously mentioned, the federal government implemented additional tax measures in April 2001. These included a revised export tax; a tax on Canadian tobacco products sold to airlines and cruise ships; a tax on Canadian tobacco products sold to domestic and foreign duty-free shops and on imported tobacco products delivered to Canadian duty-free shops; a change to the traveller's exemption to ensure that tax is levied on the previously exempted quantities of tobacco products; and an increase in the excise tax and the surtax on tobacco manufacturers' profits (Department of Finance, 2001).

1.4 International

In May 2000, the World Health Assembly unanimously adopted a resolution that formally began the process of holding multilateral negotiations on a *Framework Convention on Tobacco Control*. These negotiations centre on defining a set of rules and regulations that will address the global rise and spread of tobacco and tobacco products. The first session was held in October 2000, and negotiations are expected to be completed in 2003. Legally binding to signatory states, the Framework is expected to address issues such as tobacco advertising and promotion, agricultural diversification, smuggling, taxes, and subsidies.

In October 2000, the European Commission's Tobacco Advertising and Sponsorship Directive of 1998 was struck down by the European Court of Justice on technical and legal grounds—the Directive was ruled to have gone beyond its stated aim of resolving imbalances among member states. However, the Court confirmed the Commission's right to protect the health of the public. An agreement on a new Directive, dealing with the manufacturing, presentation, and sale of tobacco products, was reached in February 2001 and adopted in May. This legislation included the banning of cigarettes labelled "light" and "mild" by September 30, 2003, echoing a ban already in place in Brazil and one proposed by the Minister of Health for Canada in August. With respect to the Directive, British American Tobacco has announced that it will legally challenge it.

Two U.S. Surgeon General Reports were released in 2000/2001. The first report, *Reducing Tobacco Use: A Report of the Surgeon General* (U.S. Dept. of Health and Human Services, 2000), assesses the impacts of a wide range of interventions that have been used to reduce the use of tobacco. The second report, *Women and Smoking: A Report of the Surgeon General* (U.S. Dept. of Health and Human Services, 2001), documents the impact of smoking on women's health by summarizing the patterns of tobacco use among women, factors associated with starting and continuing to smoke, the health consequences of smoking, tobacco marketing targeted at women, and cessation and prevention interventions.

In 2000-2001, numerous jurisdictions filed civil lawsuits against the tobacco industry in U.S. courts including the European Union, Belgium, Finland, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, and states in Ecuador and Colombia[1].

Government Medicare cost recovery lawsuits have been filed against the tobacco industry in Israel and in France by a local agency of the French social security health insurance system. Government lawsuits to recover costs of treating tobacco-related diseases have been filed in U.S. courts by Belize, Bolivia, Guatemala, Honduras, Nicaragua, Panama, Russia, Tajikistan, Ukraine, Venezuela, seven Brazilian states and a group of Argentinean health plans.

[1] The background material on tobacco industry lawsuits used here and in the next section (Tobacco Industry) was copied (with permission) from material written by Rob Cunningham.

1.5 Tobacco Industry

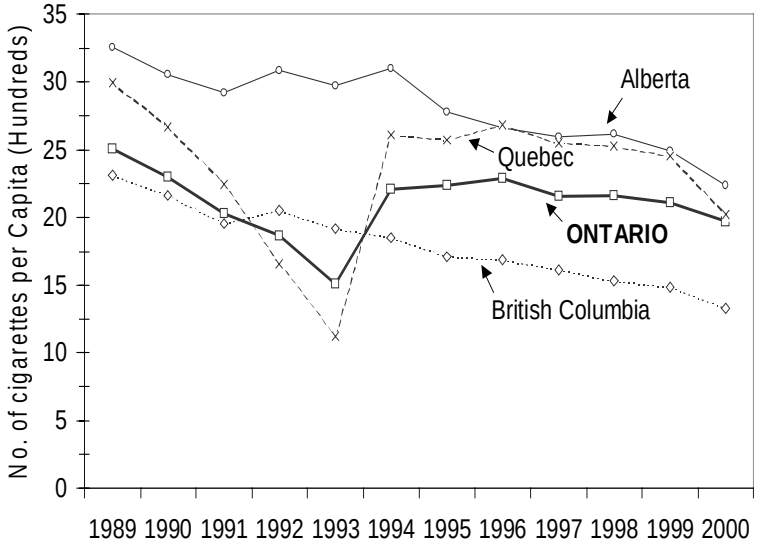
In the Senate of Canada hearings on Bill S-20 (*An Act to enable and assist the Canadian tobacco industry in attaining its objective of preventing the use of tobacco products by young persons in Canada)*, senior executives of Canada's three largest tobacco companies supported the aims of the Bill. Imperial Tobacco Canada Limited ran full-page ads in the *Toronto Star* expressing its support (*Toronto Star*, September 28, 2000). With the Fall 2000 federal election, Bill S-20 died on the Order Paper. Re-introduced as Bill S-15 following the election, both Imperial Tobacco and JTI-Macdonald publicly supported the Bill in large ads placed in several major Canadian newspapers, a move not endorsed by Rothmans, Benson & Hedges. Arguably, this difference led to the restructuring of the Canadian Tobacco Manufacturers' Council (CTMC), announced in April of 2001. Although CTMC will continue with several public programs (e.g., Operation ID and ID School Zone), it will no longer provide media and government liaison roles for the three member companies, mentioned above. Bob Bexon, Chairman of the CTMC Board of Directors and President and CEO of Imperial Tobacco Canada Ltd., indicated that "changes in the competitive and regulatory climate for Canada's major tobacco manufacturers make it increasingly imperative that each company speak directly and on its own behalf to its various audiences including government and the media, rather than through the industry association" (*Canadian NewsWire*, 2001).

Although two of the three main tobacco companies in Canada supported Bill S-15, the industry in general has actively opposed effective tobacco control interventions including higher taxation, elimination of second-hand smoke in workplaces and public places, and stronger package warnings.

The tobacco industry in Canada appears to be financially sound. Rothmans Benson & Hedges, for instance, reported profits of $16.7 million or 28 per cent in the fourth quarter ending March 31, 2001 (*Globe and Mail*, June 8, 2001). Although Imperial Tobacco's sales volume declined 5% during the past year, its profits went up 0.9 % (with sales of $538.2 million) due to an increase in company pricing (see Figure 4 below and Appendix C). Consumption of cigarettes in Ontario in 2000 was 1968 per person age 15+. This is 11.6% less than the recent high of 2225 cigarettes per capita in 1996 (Figure 4), and is about the same level as in 1991.

Despite new regulations that restrict tobacco sponsorship, the industry continued to garner favourable media coverage. Du Maurier, for instance, received press for its Arts Council funding announcements. Awarding projects on a province-by-province basis enabled du Maurier to make a series of monthly announcements and thus draw favourable press throughout the year. Moreover, tobacco industry programs, including *Operation ID*, *Operation ID – School Zone*, *Wise Decisions*, and *Courtesy of Choice*, can give the impression that the industry is a responsible corporate citizen. There is no evidence to suggest, however, that these programs are effective.

Figure 4. Per Capita (Age 15+) Legal Sales of Cigarettes and Cigarette Equivalents, Selected Provinces 1989-2000



Sources: Sales of cigarettes based on monthly shipment data provided by the major tobacco companies to Health Canada (Appendix C).

CHAPTER 2. ACTIVITIES OF STRATEGY PARTNERS

This section describes the tobacco control activities of agencies having a significant role in the Ontario Tobacco Strategy (OTS) over the period April 1, 2000 through to March 31, 2001. Appendix A contains a list of Internet addresses of government and non-government organizations that the reader might wish to consult for additional details and more recent information.

This chapter covers the following topics:

2.1 Overview of OTS Agency Tobacco Control Activities

2.1.1 Agency Focus on OTS Objectives
2.1.2 Beneficiaries of Agency Tobacco Control Activities

2.2 Agencies: Resources and Infrastructure

2.2.1 Cancer Care Ontario
2.2.2 Council for a Tobacco Free Ontario (Quit Smoking 2001)
2.2.3 National Clearinghouse for Tobacco and Health
2.2.4 Ontario Campaign for Action on Tobacco
2.2.5 Ontario Tobacco-Free Network
2.2.6 Ontario Tobacco Research Unit
2.2.7 Program Training and Consultation Centre
2.2.8 Smoking and Health Action Foundation

2.3 Agencies: Community Programming

2.3.1 Canadian Cancer Society – Ontario Division
2.3.2 Centre for Addiction and Mental Health
2.3.3 Heart and Stroke Foundation of Ontario
2.3.4 Ontario Lung Association
2.3.5 Public Health Units (PHUs)

2.1 Overview

The Ontario Tobacco Strategy is supported by several organizations. We classify these organizations along two lines: (a) agencies that provide resources and infrastructure for the OTS, and (b) agencies that deliver services and programs at the community level (e.g., non-government organizations or NGOs). The purpose of this categorization is twofold: 1) historical, as these demarcations have been used in previous monitoring reports, and 2) for simplicity's sake. They are not meant to be mutually exclusive, there is overlap and some agencies fit into both categories.

Agencies with a focus on resources and infrastructure offer support such as informational materials, referrals, advice and training to organizations and health professionals, and include Cancer Care Ontario, Council for a Tobacco Free Ontario, National Clearinghouse on Tobacco and Health, Ontario Tobacco-Free Network, Ontario Tobacco Research Unit, Program Training and Consultation Centre, and the Smoking and Health Action Foundation.

Agencies focusing on programming operate mainly at the community level, promoting awareness, education and research and include the Canadian Cancer Society – Ontario Division, Centre for Addiction and Mental Health, Heart and Stroke Foundation of Ontario, Ontario Campaign for Action on Tobacco, and the Ontario Lung Association.

The information we present in this chapter was gathered by questionnaire directly from agencies in the spring of 2001 (Ontario Tobacco Strategy Partner Agency Questionnaire; Ontario Tobacco Research Unit, 2001b). Unless otherwise specified, all descriptive figures and data are taken from the questionnaire. (Appendix C, Notes to Chapter 2 provides additional detail about the questionnaire). Where applicable, we organize information on agency activities into the following sections: a) information resources produced and distributed, b) direct services provided, c) networking and collaborative activities, d) policy change initiatives and e) intended directions for 2001 and beyond.

Agency projects funded under the renewed OTS during 2000-01 are mentioned briefly in the text and summarized in Appendix B (this appendix covers additional projects funded through community grants to local agencies other than those discussed in this report). More detailed information on OTS funded projects can be found in *Evaluating the renewed OTS: Report on year 1 ending Fall 2000* (Ontario Tobacco Research Unit, 2001a) and *Evaluating the renewed OTS: Report on the initial 18 months ending March 2001* (Ontario Tobacco Research Unit, forthcoming).

2.1.1 Agency Focus on OTS Objectives

Whereas the focus of most agencies centred on prevention and protection from ETS in the 6th Monitoring Report, over the past year the resource and infrastructure agencies appeared to be focusing more of their efforts on cessation. Community programming agencies have maintained much the same focus allocation as the previous year (Table 1). Nevertheless, progress on any one OTS objective has an impact on the others, for example, efforts allocated towards prevention and cessation reduce the need for protection from environmental tobacco smoke.

Although an agency's allocation of effort devoted to OTS objectives is informative, comparisons among agencies and conclusions in general must be made with caution because of the variations in original mandates of the organizations, funding available for tobacco control initiatives from the OTS and elsewhere, and complexities inherent in sorting the many activities of a large multifaceted organization into appropriate strategy objectives.

2.1.2 Beneficiaries of Agency Tobacco Control Activities

The beneficiaries of agencies focusing on resources and infrastructure continued to be broad with the major focus being tobacco control groups and youth aged 12-19. Agencies focusing on community programming tended to direct tobacco control efforts toward the general public and youth aged 12-19 (Table 2).

Despite their priority status in the OTS, ethnic minorities, blue-collar workers, and lower literacy populations were given lower priority than other groups, particularly with respect to community programming.

Table 1. Agency Reports of Proportion of Effort Devoted to OTS Objectives in 2000/2001

	Objectives			
Agencies	**Prevention (%)**	**Protection (%)**	**Cessation (%)**	**OTS Funded[a] (%)**
Resources & Infrastructure				
Cancer Care Ontario	33	33	33	100
Council for a Tobacco-Free Ontario[b]	2	3	95	100
National Clearinghouse for Tobacco and Health	30	34	36	17.2
Ontario Campaign for Action on Tobacco[c]	20	70	10	0
Ontario Tobacco Research Unit[d]	33	33	33	41
Program Training and Consultation Centre	5	40	55	100
Smoking and Health Action Foundation	70	15	15	34
Community Programming				
Canadian Cancer Society – Ontario Division	10	40	50	50
Heart and Stroke Foundation of Ontario	25	75	0	90
Ontario Lung Association	60	20	20	75

[a]Proportion of agency's tobacco control effort funded by the MOHLTC under the Ontario Tobacco Strategy.

[b]Although the CTFO was dissolved 31July 2000, the Quit Smoking 2000 planning team continued to plan for and implement a contest for 2001.

[c]The Ontario Campaign for Action on Tobacco (OCAT) is a network of NGO's.

[d]Although OTRU is not a resource centre of the OTS, the Unit supports the strategy directly through tobacco control research, monitoring and evaluation.

Table 2. Agency Reports of Beneficiaries of their Tobacco Control Activities in 2000/2001

Agencies	Tobacco Control Groups	General Public	Smokers	Youth Aged 12-19	Adult Women	Pregnant Women/New Mothers	Ethnic Minorities	Blue Collar	Lower Literacy	Other
Resources & Infrastructure										
Cancer Care Ontario	⌖									
National Clearinghouse on Tobacco and Health[a]	⌖		❄	❄	❄	❄	❄	❄	❄	⌖
Ontario Campaign for Action on Tobacco[b]	❄	⌖	❄	❄	⌖	❄	✌	❄		
Ontario Tobacco Research Unit[c]	⌖	✌	❄	⌖	❄	⌖	✌	✌	✌	
Program Training and Consultation Centre	⌖	✌	⌖	⌖	✌	⌖	✌	✌	⌖	
Smoking and Health Action Foundation	⌖	⌖	❄	⌖	❄	❄				
Community Programming										
Canadian Cancer Society-ON Division	❄	❄	❄	✌	✌	✌				
Heart and Stroke Foundation of Ontario		⌖	✌	⌖	✌	✌	✌	✌	✌	
Ontario Lung Association	❄	❄	❄	⌖	✌	✌		✌		❄ (COPD[d])

[a]Beneficiaries reached through services to health intermediaries.
[b]OCAT is a network of NGO's.
[c]Although OTRU is not a resource centre of the OTS, the Unit supports the strategy directly through tobacco control research, monitoring and evaluation.
[d]People with Chronic Obstructive Pulmonary Diseases, including asthma.

⌖ = major focus ❄ = important focus ✌ = modest focus

2.2 Agencies: OTS Resources and Infrastructure

2.2.1 Cancer Care Ontario

As principal advisor to the Ministry of Health and Long-Term Care with respect to cancer issues, Cancer Care Ontario (CCO) is responsible for ongoing planning of the cancer care system, including cancer surveillance, prevention, screening, research, treatment and care. CCO also strives to ensure consistency within the province for the quality of care patients receive. The CCO Prevention Unit was established in 1999 as a primary cancer prevention initiative, and because tobacco and diet-related risk factors account for approximately one half of all fatal cancers, tobacco control has become a focus of high priority. CCO has constructed the Ontario-wide Tobacco Media Network, a project that is the focal point of this overview.

Tobacco Media Network
The Media Network supports the implementation of the overall tobacco control strategy through enhancing media coverage of tobacco and tobacco control issues. Specifically, the Media Network is intended to enhance the relationship between OTS partners and the news media, provide credible and timely information to media, and promote awareness of tobacco-related issues. The Media Network currently has a membership of 98 organizations, representing participation by approximately 180 individuals.

Information Resources
The Media Network's News Tracking Database has over 10,000 entries and can be used to query newspaper clippings, television and radio features on a large variety of topics. The ongoing Video Library of Testimonials is a collaboration between the Media Network and the Program Training and Consultation Centre, the Ontario Campaign Against Tobacco, the Ontario Tobacco-Free Network, the Ontario Lung Association, and the Heart and Stroke Foundation of Ontario.

Media Network website
This password-protected website provides members of the tobacco community with access to all Network resources (Backgrounders, Help Sheets, etc.) The site also has an online directory of OTS partners and network members. Ongoing production of Backgrounders dealing with tobacco control and related issues, and Help Sheets dealing with media relations and advocacy are available on the website.

Networking and Collaborative Activities
Several networking activities have taken place over the last year. The Media Network facilitates relations between the media and OTS partners. For example, the "Meet the Media" workshops introduced guests to media professionals and gave them an opportunity to practice interviewing techniques. Speaking engagements involved collaboration with the Program Training and Consultation Centre, and included Smoke-Free Bylaw Workshops in Barrie and Timmins. CCO also collaborated with the Program Training and Consultation Centre to develop a Youth Advocacy Guide. Another event, the Ontario Winston Man Tour, is an ongoing collaboration between the Media Network and the Ontario Campaign Against Tobacco, the Ontario Tobacco-Free Network, the Ontario Lung Association, and the Canadian Cancer Society (Ontario division).

Policy Change Initiatives
Letters to the media, and letter and e-mail campaigns to policymakers have contributed to increased awareness of certain issues (smoke-free bylaws, Bill S-20, tobacco packaging, sponsorship issues). Because members of the Media Network now have better access to the

media to promote stories and a better understanding of how to conduct effective media campaigns and strategies, it is anticipated that the media will respond with increased and more accurate health oriented coverage of tobacco control issues.

Intended Directions for 2001 and Beyond
The Network continues to disseminate and/or make available resources to support member organizations in their efforts to use media effectively to further tobacco control and to counter pro-tobacco influences.

2.2.2 Council for a Tobacco-Free Ontario (Quit Smoking 2001)

Ministry of Health and Long-Term Care funding for the Council for a Tobacco-Free Ontario (CFTO) was eliminated 31 July 2000, after which members voted unanimously for dissolution in April 2001. The original planning team members from the Quit Smoking 2000 contest nevertheless planned and implemented a 2001 contest. To secure funding and prizes, and revise contest materials, the core planning group, including the program manager, volunteered their time. The successful implementation of the Quit Smoking 2001 contest is a tribute to the strength of the planning team and the local councils across Ontario.

Quit Smoking 2001
Information Resources
A variety of materials related to the contest were compiled and distributed to local councils electronically including a *Contest Implementation Guide* and media templates. Regular updates to share progress and ideas were also provided electronically.

Direct Services
A province-wide toll-free telephone line published on all contest materials was set up to field contest inquiries from the public. The Quit Smoking 2001 contest, directed at adult smokers and promoted through media, workplaces and local community events and partnerships, attracted 10,088 participants. Participants pledged to quit smoking for one month in exchange for the opportunity to win a prize. On-line contest registration was possible through the website, and about 30% of participants entered on-line. The website had over 140,000 hits this year, a threefold increase over last year. More than 95% of the Planning Committee members and local councils are willing to be part of the same contest next year, provided lead time and resources are adequate.

2.2.3 National Clearinghouse on Tobacco and Health

The National Clearinghouse on Tobacco and Health (NCTH) is a program of the Canadian Centre for Tobacco Control, funded by federal, provincial and territorial governments. As a Canadian resource centre supplying information on tobacco and health-related issues, it provides a valuable link between scientific/medical communities and the media.

Information Resources
Website
A re-design of the NCTH program website allowed for the launch of the new Virtual Library in January 2001, providing access to tobacco-related information 24 hours a day. Through interaction with funders and stakeholders, topics were identified and developed, including promotion and prevention, cessation, environmental tobacco smoke, denormalization, legislation, and taxation. During the last three fiscal quarters, a 30% and

32% increase in hits and user sessions respectively was seen for the website, compared with the same period last year.

Library
During the past year, several library activities were undertaken, including creating a new library database containing only the most pertinent materials, archiving the old database (still user-accessible), and sending media clippings to the Media Network at Cancer Care Ontario. The library continues to seek, catalogue and house an extensive collection of tobacco-related materials.

Direct Services
All Ontarians can contact the Clearinghouse through a toll-free line (1-800-267-5234) staffed 9–5, a fax line, and an email address. Assistance in locating resources within either the virtual or hard copy library collection is provided, as well as caller referral to other sources of information and distribution of publicly funded documents or journal articles.

Networking and Collaborative Activities
The feasibility of a Third National Conference on Tobacco and Health is currently being studied. Because the last conference was in the fall of 1996, the need for another such forum has been recognized. The conference would be geared toward all health intermediaries, and would involve collaboration among federal, provincial and territorial governments along with major non-government organizations.

Intended Directions for 2001 and Beyond
Phased in over the next three years, the NCTH website will offer the following categories: unique content targeted to clients such as health intermediaries and policy makers; a network database of associations, institutes, organizations and similar personnel in the field of tobacco control; references to recent scientific literature on tobacco control and how to obtain articles; a repository of hard-to-find reports; and a discussion group forum. The NCTH will be able to circulate tobacco control information to intermediaries in the new fiscal year, as well as complete further monitoring tools to assess how the NCTH reaches Ontarians and responds to requests for information.

2.2.4 Ontario Campaign for Action on Tobacco

Founded in 1992, the Ontario Campaign for Action on Tobacco (OCAT) is a coalition of agencies including the Ontario Medical Association, the Canadian Cancer Society – Ontario Division, the Ontario Lung Association, the Heart and Stroke Foundation of Ontario, the Non-Smokers' Rights Association, and Cancer Care Ontario. OCAT leads provincial and local advocacy campaigns on behalf of member agencies and advises other provincial tobacco control groups on tobacco control strategy and tactics.

Information Resources
Website
Used by health agencies, legislators, municipal and smoke-free councils as well as the general public, the OCAT website specializes in reporting major studies on the health effects of second hand smoke and the economic impacts of tobacco use. The website received over 56,000 hits between January 1 and March 31, 2001.

Tobacco Control Report Card
Released in April 2001 in collaboration with the Canadian Cancer Society – Ontario Division, the Heart and Stroke Foundation of Ontario, the Ontario Lung Association and the Ontario Medical Association, this first annual Report Card evaluated the Ontario government's efforts regarding tobacco control. Nine key areas were addressed by the Minister of Health's Expert Panel on the Renewal of the Ontario Tobacco Strategy (Ashley et al., 1999), and these were used as sections in the report card. These sections included smoke-free spaces, tobacco taxation, cost recovery

litigation, finance and infrastructure, retail controls, support for smoking cessation, marketing including packaging, labeling, information, disclosure, public education, and research, monitoring and evaluation.

News releases and other specialized memoranda have been distributed to local health agencies and smoke-free and municipal councils, and are available on the OCAT website.

Networking and Collaborative Activities
Development of the Ontario Tobacco-Free Network (OTN) was undertaken in partnership with the Heart and Stroke Foundation of Ontario, the Ontario Lung Association, and the Canadian Cancer Society – Ontario Division. OCAT assisted in hiring OTN staff, helped to formulate network tactics and strategies, participated in the OTN fall conference, managed teleconferences and advised staff. Direct funding was renewed to local councils, and positive feedback was received from local smoke-free councils.

OCAT is participating in management of the Clinical Tobacco Intervention Program, a collaborative training project of the Ontario Medical Association, Ontario Dental Association, and Ontario Pharmacists' Association (Ontario Tobacco Research Unit, 2001a).

Policy Change Initiatives
The Tobacco Control Report Card, previously mentioned, is also a vehicle for advocacy. OCAT continues to have meetings with MPPs through staff and volunteer visits, conduct public opinion polls, and organize smoke-free bylaw campaigns.

2.2.5 Ontario Tobacco-Free Network

The Ontario Tobacco-Free Network (OTN), launched in August 2000, is a provincial network of agencies comprised of the Canadian Cancer Society – Ontario Division, the Ontario Lung Association, and the Heart and Stroke Foundation of Ontario. The OTN is funded by the Ministry of Health and Long-Term Care, and is supported by the aforementioned agencies' head offices as well as the Ontario Campaign for Action on Tobacco. OTN's mandate is to support tobacco-free councils in their education and advocacy work regarding tobacco control in Ontario.

The OTN held a conference on 2 October 2000 in Toronto, with more than 30 councils in attendance. Provincial regions shared their challenges and opportunities regarding tobacco control. The need for an OTN Advisory Board became clear at the October conference, and this was formed in November 2000, consisting of representatives from partner non-government organizations, provincial regions, the Ministry of Health and Long-Term Care, the Ontario Tobacco Research Unit, and the Association of Local Public Health Agencies.

Information Resources
Website
OTN's Internet website became operational on 10 April 2001. It contains various sections including News and Updates for information on upcoming events, OTN Advisory Board notices, and a listing of all tobacco councils across the province.

Newsletter
The first edition of an OTN Newsletter was distributed in the fall of 2000, and the second in the spring of 2001. The intention is to have a quarterly publication, which will profile relevant events pertaining to tobacco control councils across Ontario.

Direct Services
OTN staff participated in training sessions, workshops, and orientation within each of their respective agencies to obtain a comprehensive

understanding of the health agencies they represent. The OTN provided the provincial theme for the 2001 National Non-Smoking Week, based on Ontario's media campaign "Tobacco: the Truth Hurts," a campaign designed to promote denormalization of the tobacco industry. OTN is continuing to provide support to the 63 smoke-free councils across Ontario. As well, it is facilitating regional teleconferences and participating in regional council meetings. This has allowed those in isolated areas of the province to keep abreast of activities. In an effort to educate MPPs about the harmful effects of tobacco, efforts are being made to have staff meet with MPPs regularly.

2.2.6 Ontario Tobacco Research Unit

The Ontario Tobacco Research Unit (OTRU) was established by a grant from the Ontario Ministry of Health and Long-Term Care to the University of Toronto's Centre for Health Promotion in 1993. Currently, its sponsoring institutions include the Centre for Addiction and Mental Health (CAMH) and the Universities of Waterloo, Toronto and Ottawa. The revised mandate is to: exercise leadership on the design and conduct of research projects; increase Ontario's capacity to conduct research, monitoring and evaluation; monitor programs and activities conducted under the auspices of the Ontario Tobacco Strategy (OTS), and provide advice and technical expertise on program evaluation; analyze and disseminate science-based information for the research and public health communities; and strengthen and broaden our provincial, national and international network of researchers, programmers and policymakers.

Information Resources

Working Papers, Current Abstracts, and Special Reports continue to be produced and distributed in print to over 300 researchers, public health officials, ministry officials, and programmers across Ontario and beyond. OTRU-NET is an electronic forum for the discussion of research issues and opportunities of interest to the tobacco control research community in Ontario. The OTS-L is an electronic subscription list of 62 subscribers, covering OTS funded projects and used by OTS partners and the Ministry of Health and Long-Term Care (MOHLTC). A website maintained by OTRU averages 756 hits per week.

Direct Services

OTRU conducts literature searches for our network of investigators deliverable by phone, email or in print, and responds to information requests by public health officials, the Ministry of Health and Long-Term Care, as well as the tobacco control community. This year, 28 major literature searches were conducted, of which 22 were for researchers and 6 for public health officials.

Monitoring and Evaluation

OTRU continues to monitor the Ontario Tobacco Strategy, and published its 6th Annual Monitoring Report in the fall of 2000. Planning for the long-term evaluation of the Strategy was the focus of one OTRU project and several reports were prepared as part of this project (e.g., Ontario Tobacco Research Unit, 2000a).

OTRU coordinated the evaluation of OTS projects for the MOHLTC, which included providing consultation to funded agencies who were responsible for evaluating their own activities. Two OTS evaluation reports were prepared for the MOHLTC during the year, the second of which was released publicly, *Evaluating the renewed OTS: Report on year 1 ending Fall 2000* (Ontario Tobacco Research Unit, 2001a).

OTRU conducts numerous research studies to aid in the ongoing monitoring and evaluation of the OTS. Over the past year, projects have included the Provincial Survey of Tobacco Use, Knowledge about Health Effects, and Attitudes Toward Tobacco Control Measures (Q2000);

Environmental Tobacco Smoke in the Home: An Ontario Survey; Survey of School Smoking Prevention and Cessation Programs; a follow-up survey on the Ban on Smoking on School Property Survey; and an analysis of the economic impact of smoking restrictions in restaurants and bars. Two additional projects centred on developing a set of standardised measures to evaluate smoking cessation programs for youth and developing certification standards for cessation counsellors.

Networking and Collaborative Activities

The Smoking and Pregnancy Workshop, held on 8 June 2000, was an opportunity for researchers, programmers and policy makers to explore issues related to smoking during pregnancy and identify practical opportunities for collaboration. OTRU-NET and OTS-L also provide substantial network and collaborative opportunities. OTRU Principal Investigators housed at the CAMH (Addiction Research Foundation site) continue to offer a graduate studies course in *Tobacco and Health: From Cells to Society*, through the Universities of Waterloo and Toronto. This year, for the first time, the course is available via videoconference, and plans are being made to offer the course to students at other institutions.

2.2.7 Program Training and Consultation Centre

The Program Training and Consultation Centre (PTCC), first funded in October 1993, provides training and consultation services to agencies involved in community-based tobacco-use reduction strategies. It is a partnership between the City of Ottawa Public Health and Long-Term Care Branch, RBJ Health Management Associates, and the Centre for Applied Health Research at the University of Waterloo, with offices in Ottawa and Kitchener. PTCC offers a mix of training and consultation services, including provincial and regional workshops, individualized in-depth consultations, follow-up and feedback to communities on program activities, and dissemination of information packages.

Information Resources

Tobacco Resource Dissemination Service

During the reporting period, this service distributed 15,889 resources (many in both English and French) targeted to communities, schools, and populations such as pregnant women and youth via health intermediaries from public and community health centres, schools and other community agencies throughout Ontario. These resources included 68 unique products to support local tobacco programming. Requests came by telephone, fax, email and through the PTCC website. Sample resources include *How Not to Smoke* and *Stop Smoking: a Program for Women* (smoking cessation geared towards low literacy groups); *Women and Smoking* (for women who smoke, to be used in conjunction with other smoking cessation resources); and *One Step at a Time: for Smokers Who Want to Quit* (adapted to a grade 5 reading level). Smoke-free home resources have been developed including brochures and window clings (e.g. *Welcome to our Smoke-Free Home*). Training kits and other intermediary resources were also developed, including a *Youth Action Guidebook* to tobacco advocacy and a resource binder entitled *Controlling ETS in Public Places.*

PTCC Website

The website promotes services provided by the PTCC and provides information resources to health intermediaries and other clients throughout Ontario.

Direct Services

This year, 640 off-site consultations were carried out, for the purpose of providing information, advice, or referral. The most common consultations were responses to resource requests, information regarding the role of the PTCC, and providing information or advice. Requests were received through the

PTCC toll-free telephone line, email, mail, and fax. Main clients for these consultations were Public Health Unit staff throughout Ontario. Twenty-six skill development and enhancement training events were also provided throughout the province, attracting 880 participants (public health, addiction services/hospitals, occupational health, etc.) for the purpose of enhancing tobacco use reduction strategies. Nineteen on-site consultations were provided. Common topics were ETS control and smoking cessation using the stages of change model. A representative from PTCC participated on the Clinical Tobacco Intervention Expert Advisory Committee during the reporting period.

Network and Collaborative Activities
In 2000-01, the PTCC completed 157 activities for networking and coordination, and identified ways in which the PTCC could facilitate action throughout Ontario. The most common topics included coordinating activities, sharing of information, and activity planning. Collaborators included the Ontario Health Promotion Resource System and the Media Network of Cancer Care Ontario. The PTCC participated in 23 working groups and committees over the year including the Ontario Tobacco Strategy Renewal Planning Group and Media Network, the Heart Health & Policy Advisory Committee, and many others.

Policy Change Initiatives
ETS control and tobacco advocacy were major topics for PTCC information resources, training and consultations. In addition, the PTCC reviewed wording of a draft by-law for a community planning to enact a smoke-free restaurant by-law. The target audience was municipal councillors, overseeing two Northern communities.

2.2.8 Smoking and Health Action Foundation

The Smoking and Health Action Foundation (SHAF), the sister agency of the Non-Smoker's Rights Association (NSRA), supports the Ontario Tobacco Strategy by playing a key role in policy research and public education to aid in the province's healthy public policy development. It supplies information on tobacco policy, environmental tobacco smoke, taxation, tobacco industry economics, package labeling, advertising and sponsorship, and other current issues relevant to tobacco concerns.

Information Resources
SHAF maintains a collection of documents in the form of fact sheets, analyses, charts and reports. Of these, many have been developed during the current fiscal year including brochures and web documents focussing on tobacco industry practices, taxation, price, smuggling, package labeling and warnings, and the Framework Convention on Tobacco Control.

Tobacco News Online
This is an e-mail service of Canadian and international daily news provided to over 400 organizations and individuals including those from health and human services, federal and provincial governments, and research institutes.

SHAF/NSRA Website
The SHAF/NSRA website, available in both English and French, is regularly updated and receives about 1500 hits per month. Recent additions are pages focussing on the health warnings on cigarette packaging.

Methods of information distribution vary. Government officials receive policy research briefs and submissions, backgrounders are sent through the Ontario Tobacco Strategy Network, taxation brochures are sent via the Ontario Campaign for Action on Tobacco, and information requests are faxed, emailed, or mailed as needed. The taxation and smuggling documentation has enabled Ontario, Quebec, and federal senior government officials to markedly increase their understanding of

smuggling and tax increase impact, arguably resulting in a significant rise in tobacco taxes over this last fiscal year.

Direct Services

During the 2000-2001 fiscal year, SHAF responded to numerous information requests from government, media, and health and research organizations and distributed material on a variety of topics including the tobacco industry (structure, litigation, and practices), tax and smuggling issues, litigation for recovery of health care costs, and package warnings. SHAF also provided speakers, presentations and panelists to participate in various tobacco-centered forums.

Networking and Collaborative Activities

Tobacco Taxes in Canada, researched and drafted mainly by SHAF, was released as a joint project by the Non-Smokers' Rights Association, the Ontario Campaign for Action on Tobacco, the Canadian Cancer Society, Physicians for a Smoke-Free Canada and the Quebec Coalition for Tobacco Control. For Cancer Care Ontario's Media Network, SHAF provided information and wrote draft materials for the Network's tobacco control fact sheets and bulletins. SHAF continues to collaborate with the Ontario Tobacco Research Unit on policy research initiatives, as well as provide consultation to the Ontario Heart and Stroke Foundation's media campaign. SHAF participates in meetings with Canadian drug companies concerning nicotine replacement therapy. Research support was provided to the Ontario government in its effort to recover tobacco-related health care costs from the tobacco industry, and to other organizations and their respective projects.

Policy Change Initiatives

The research and materials produced by SHAF for the national *Tobacco OR Kids* campaign's Black Box project set the benchmark for Health Canada's announcement of its proposed world precedent setting package warning system. SHAF staff then collaborated closely with Health Canada to make these warnings possible over the past year, and research is showing the warnings hold promise in motivating smokers to quit. A considerable amount of time was spent this year providing government officials and health partners, among others, with information regarding taxation and smuggling issues. This advocacy role resulted in an increase in tobacco taxes this spring. As well, SHAF is involved in tobacco industry denormalization including making the public aware of the industry's targeting of youth, attempts to undermine scientific research on the dangers of environmental tobacco smoke, and other 'unethical' behaviour.

Intended Directions for 2001 and Beyond

SHAF will be producing a video and accompanying brochure on denormalization of the tobacco industry in the coming year to promote understanding of industry behaviour, youth targeting, and the importance of denormalization strategies. SHAF, and its parent organization, the NSRA, is also focussed on changing the industry's behaviour through scrutiny, regulation and accurate research. SHAF is also planning to produce an educational brochure on the *light and mild* issue, termed 'deceptive product engineering' on the part of the tobacco industry. Research and information will be channeled toward lobbying efforts for a revised *Smoking in the Workplace Act* as well as a revised *Tobacco Control Act*. The website will continue to be an important resource, among many other endeavours undertaken by this organization.

2.3 Agencies: Community Programming

2.3.1 Canadian Cancer Society: Ontario Division

As a national community-based organization of volunteers, the mission of the Canadian Cancer Society (CCS) is to eradicate cancer and enhance the quality of life for people living with the disease. In collaboration with the National Cancer Institute of Canada, the CCS works toward these goals through public policy, advocacy, research, education, and patient services. The Ontario Division is a major partner in the Ontario Campaign for Action on Tobacco. At the community level, volunteers deliver both the advocacy and public education components, either alone or as part of a coalition of agencies.

Information Resources

The Canadian Cancer Society–Ontario Division has 26 tobacco-related information products for raising awareness of the impact of tobacco use and encouraging prevention and cessation. Twenty-two of these products are available in French. Three are targeted to youth, one to women, and the remainder to adults. Between April 2000 and March 2001, 667,185 information items were distributed through the CCS Cancer Information Service, Public Health Units and the Heart Health Networks.

CCS has contributed to the development of teen-focussed smoking prevention and cessation materials.

Direct Services Provided

Smoker's Helpline

This toll-free smoking cessation service (1-877-513-5333) was launched in April 2000, and over the last reporting year has received 7,769 calls, with an average of 31 calls per day. Advancements seen over the last year include expansion of staffing, promotion through January's National No Smoking Week, and the introduction of an experimental phase of proactive counseling.

CCS Cancer Information Service

This service provides information and referral. Outreach was provided to children and youth through school displays, information packages and presentations. Similarly, outreach to adults was through public displays and presentations.

Networking and Collaborative Activities

Development of the Ontario Tobacco-Free Network was undertaken in partnership with the Heart and Stroke Foundation of Ontario, the Ontario Lung Association, and the Ontario Campaign for Action on Tobacco. CCS collaborates with the Heart and Stroke Foundation of Ontario and the Ontario Lung Association to develop local council networks in the province. CCS units are encouraged to work with and through local community agencies, tobacco coalitions, schools, and local media to disseminate information about the harmful effects of tobacco.

Policy Change Initiatives

CCS continues to play an active role in OCAT and in the development and implementation of the Ontario Tobacco Strategy. Staff and volunteers participated in letter-writing campaigns to support various anti-tobacco legislation and by-law changes. The Advocacy Kit that was provided to local CCS units to support efforts related to local by-law changes continues to be used.

Intended Directions for 2001 and Beyond

Over the next year the CCS will continue to: focus its Ontario Tobacco Strategy effort on smoking cessation strategies, evaluate its existing resources and collaborations, and advocate for more effective anti-smoking legislation at all three levels of government.

2.3.2 Centre for Addiction and Mental Health

The Centre for Addiction and Mental Health (CAMH) is a public hospital providing direct patient care for people with mental health and addiction problems. The Centre is also a research facility, an education and training institute and a community based organization providing health promotion and prevention services across the province. The Centre works to advance understanding of mental health and addiction issues and to translate knowledge into practical resources and tools that can be used in programs in the broader community. The Centre conducts research on all aspects of tobacco use, from basic laboratory work to research on programs and policies. This research, conducted by scientific and program staff with expertise in the tobacco area, provides information to programmers and policy-makers across Ontario. CAMH (ARF site) houses the Ontario Tobacco Research Unit (OTRU, described in Section 2.2.6) and, in partnership with the Universities of Waterloo, Ottawa, and Toronto, is a key sponsor of OTRU.

Information Resources

CAMH's Information Centre and Marketing department circulated 78,578 English and 7,450 French copies of the Centre's pamphlets entitled *Facts about Tobacco*, *Do you Know - Tobacco* and *About Smoking* to the general population and to health professionals. Tobacco-related material is available through the extensive on-site public library. The CAMH Monitor, an annual survey of the Ontario adult population, and the Ontario Student Drug Use Survey, conducted on a biannual basis to survey drug use by students in Ontario schools, produce important data on tobacco use and attitudes toward tobacco control.

Direct Services

Treatment Services for Smokers

Services for people wishing to quit or reduce smoking include support groups, pharmaco-therapy and specialized programs for those dually diagnosed with mental health or other addiction problems. During the last year, several specialized services were made available, including a Spanish single intervention session offered at the Donwood, a group program at the Queen Street site for those with major mental illness, and smoking intervention services at the Clark site geared toward schizophrenic patients receiving medication.

Training of Professionals

In 2000-01, the Nicotine Dependence Service of the Centre provided residency training for physicians in smoking cessation treatment. Additionally, CAMH local offices helped to coordinate professional development for physicians and other health care workers through the Clinical Tobacco Intervention training offered jointly by the Ontario Medical Association, the Ontario Pharmacists' Association, the Ontario Dental Association, the Program Training and Consultation Centre and the Ontario Campaign for Action on Tobacco. Specifically, this training reached 327 physicians, dentists and pharmacists and 86 addiction workers, nurses and public health staff during the past year.

Info-CAMH

This toll-free line of drug, alcohol and mental health information provides two taped messages in both English and French regarding tobacco issues*: Tobacco - the Most Addictive Drug?* and *Smoking, Why to Quit and Ways to Do It*.

Clinical and Research Debates and Seminars (CARDS)

In a November 2000 CARDS presentation, a guest speaker from the Unites States (Brion Fox) spoke about U.S. clinical practice guidelines for treating tobacco use and dependence.

Consultation and Support

CAMH provided support and consultation to 71 coalitions across Ontario focussing on

prevention and reduction of drug, alcohol and tobacco problems. The Centre provided support on issues, such as no-smoking bylaw development, community awareness (Not to Kids, Breathing Spaces, Tobacco or Kids) and quit or reduce smoking programs (Provincial Quit Smoking Campaign), to 23 tobacco councils or committees.

Networking and Collaborative Activities

ACTION Program

Developed in 1996 for youth in grades 6-9 in collaboration with the Ontario Physical Health Education Association and the Program Training and Consultation Centre and revised and updated over the last year, ACTION is a health promotion program focussing on alcohol, tobacco, and cannabis. The expected release date for the newly revised program is the fall of 2001.

Opening Doors Program

The target group for this personal and social skills improvement harm-reduction program is "at-risk" students in grade 9 and their parents. Over the last year, the program was delivered to 55 Ontario schools, 46 English and 9 French.

Educating Students about Drug Use and Abuse

This program has been expanded from grades 1-8 to include students in grades 9 and 10. The province-wide curriculum on drug use and abuse has its strongest emphasis on tobacco in grade four. This section of the CAMH website has tallied 34,000 visits.

The Centre also consulted on the development of Lungs are for Life, an Ontario Lung Association production geared toward students in kindergarten to grade 8.

2.3.3 Heart and Stroke Foundation of Ontario

The Heart and Stroke Foundation of Ontario (HSFO) is a community-based volunteer organization whose mission is to reduce the risk of premature death and disability from heart disease and stroke by raising funds for health promotion and research. The Foundation was a founding member of the Ontario Campaign for Action on Tobacco and continues to be a major funding partner.

Information Resources

HSFO has distributed 18 tobacco-related fact sheets and pamphlets throughout Ontario for use by health professionals and the general public. During the previous year, approximately 143,000 copies of these materials were disseminated through HSFO area offices, a toll-free line (1-800-473-4636), Heart Health networks, the HSFO national website, and special events.

Mass Media Campaign

The media campaign was a $3 million public education initiative. The goal of this campaign was to make tobacco use less socially acceptable over time. Agencies adopting this approach are the Ontario Lung Association, the Canadian Cancer Society – Ontario Division, the Non-Smokers' Rights Association, the Ontario Campaign for Action on Tobacco, and Cancer Care Ontario. The campaign was disseminated through radio, television and newspaper ads that ran for two 16-week periods: April – July 2000, and mid-December 2000 to the end of March 2001.

Networking and Collaborative Activities

HSFO is part of the new Ontario Tobacco-Free Network, collaborating with the Ontario Lung Association, Canadian Cancer Society – Ontario Division, and the Ontario Campaign for Action on Tobacco. The network has led to improved support and communication with local smoke free councils across Ontario.

Policy Change Initiatives
As a member of the Ontario Campaign for Action on Tobacco, HSFO was involved in many advocacy initiatives at the municipal level to create smoke-free public places over the reporting period. HSFO volunteers also made visits to MPP and local government offices to increase awareness of the hazards of tobacco use. Numerous government officials have acted on these concerns by helping to formulate tougher tobacco controls in their communities.

2.3.4 Ontario Lung Association

First established in 1900 to stop the spread of tuberculosis, the Canadian Lung Association now provides community services and supports medical research to improve respiratory health. The Ontario Lung Association (OLA) is a division of the Canadian Lung Association, and has a provincial office and 33 community offices throughout Ontario. The Lung Association has played a key role in encouraging smoking cessation since the early 1960s.

Information Resources
Lungs are for Life
The Lungs are for Life School Program is designed to help teachers and health educators address respiratory health and smoking prevention with students from kindergarten through to high school. There are easy to use lesson plans and an array of teaching activities and classroom resources. The content meets the expectations of the Ontario Health and Physical Education Curriculum as well as the Ontario public health guidelines. Modules are in both English and French, and intended coverage is all of Ontario schools and public health units. Requests for this free program are placed by internet, fax, mail or phone, and shipping is done by mail. Promotional items for Lungs are for Life include an information pamphlet for schools and other educational channels, as well as a display for conferences and workshops. Lungs are for Life is online, and can be accessed through the OLA website. Revisions of the program have continued through the period October 2000-March 2001, with funding under the renewed OTS, to ensure compatibility with Ontario's new physical and health education curriculum and Ministry guidelines (Ontario Tobacco Research Unit, 2001a).

Get on Track
Get on Track is a smoking cessation program offering advice on readiness to quit, how to go about quitting and how to stay quit. Information and self-help manuals for *Get on Track* are available through the Lung Health Information Line.

Direct Services
Lungs are for Life Workshops
These workshops are geared toward local Lung Associations and selected school board staff, covering all 33 Ontario offices and Ontario school boards.

The OLA has a Lung Health Information Line (1-800-972-2636), available toll-free across Ontario, providing information about the Lung Association programs such as *Get on Track*, described above.

Networking and Collaborative Activities
The OLA has been active in preparing several networking opportunities including the Winston Man Tour for selected schools in Ontario, collaborating as a partner of the Ontario Tobacco-Free Network along with the Heart and Stroke Foundation of Ontario, the Canadian Cancer Society – Ontario Division and the Ontario Campaign for Action on Tobacco, as well as preparing to participate in the Ontario Tobacco-Free Network annual conference (held 18-19 June 2001). Policy Change Initiatives
The OLA has contributed to the planning and execution of visits to MPP offices for information distribution over the last year.

Intended Directions for 2001 and Beyond
Remaining modules (kindergarten to grade 3) of the Lungs are for Life program will continue to be revised over the next two years. Development of the website and a study focusing on student behaviours, knowledge and attitudes are also planned.

2.3.5 Public Health Units (PHUs)

Under the *Health Protection and Promotion Act* (Ministry of Health, 1990), boards of health are required to provide or ensure the provision of minimum levels of public health programs and services set by the Ministry of Health and Long-Term Care's *Mandatory Health Programs and Services Guidelines* (Ontario Ministry of Health, 1997). Tobacco-free living is a major area of focus in these guidelines, and tobacco-related content is mainly under the "Chronic Disease Prevention" section, with minor references under "Sexual Health" and "Reproductive Health."

The goal of Chronic Disease Prevention is to reduce the early deaths and illnesses associated with preventable chronic diseases. With respect to tobacco use this includes: the reduction of daily smoking among youth 12-19, reduction of sales to minors by tobacco vendors, and an increase in the proportion of smoke-free homes, workplaces and other public sites. In working toward these goals, PHUs promote tobacco-free living through school and community smoking cessation programs, publicize the risks of second hand smoke, and encourage smoke-free by-law development.

PHUs are also required to enforce the Tobacco Control Act (Ontario Legislative Assembly, 1994). This includes vendor inspection and compliance checks, inspection of secondary schools for their observance of applicable sections of the Act, ensuring the continual use of community media to increase and facilitate awareness of the Act, and ensuring that sufficient public health staff are trained to perform inspection and enforcement duties.

With respect to tobacco, the goal of the Sexual and Reproductive Health section under the *Mandatory Health Programs and Services Guidelines* is to promote tobacco-free living as a vehicle to promote healthy pregnancies, as well as the health of children and youth.

All Public Health Units in Ontario deserve credit for much effort toward community programming and promotion of tobacco control by-laws. Tobacco-control activities of PHUs, including education, provision of direct services, enforcement of the TCA, and support for municipal smoking restrictions, are monitored by the MOHLTC by means of an annual questionnaire. OTRU is seeking to find ways to achieve timely access to the questionnaire results in order that they may be included in future editions of the Monitoring Report.

CHAPTER 3. PROGRESS TOWARD OTS OBJECTIVES

This chapter provides a description of some short-term impacts and longer-term outcomes related to the Ontario Tobacco Strategy. The reader should not assume a causal relation between reported outcomes and tobacco control activities—a more complex research design would be required to achieve this goal. Nevertheless, this Monitoring Report does provide a description of tobacco-related knowledge, attitudes, and behaviours within Ontario, which should lead to an increased awareness of progress and opportunities for enhancing the Ontario Tobacco Strategy. Additional statistical and methodological considerations, as well as data sources, are described in Appendix C.

This chapter covers the following topics:

3.1 Health Burden of Smoking

3.2 Adult Smoking

3.2.1 Prevalence
3.2.2 Level of Use
3.2.3 Selected Target Groups
3.2.4 Smoking Cessation

3.3 Youth Smoking

3.3.1 Prevalence
3.3.2 Level of Use
3.3.3 Smoking and School

3.4 Sales to Minors

3.5 Exposure to Environmental Tobacco Smoke (ETS)

3.6 Public Attitudes toward Tobacco Control

3.6.1 Support for Restrictions
3.6.2 Attitudes toward the Tobacco Industry and its Products

3.1 Health Burden of Smoking

There were 11,656 deaths attributable to smoking in Ontario in 1997, an estimate similar to that reported for 1992 (11, 649) by Xie et al. (1996). Deaths caused by smoking as a percentage of total deaths in Ontario, however, declined slightly from 16% in 1992 to 15% in 1997 and the smoking-related mortality rate per 100,000 in the population dropped from 110 in 1992 to 104 in 1997 (Appendix D).

Of the 11,656 deaths attributable to smoking in 1997, males accounted for 7,492 and females accounted for 4,164, including 47 infant and fetal deaths linked with maternal smoking (Table 3). Whereas smoking related deaths among men declined by 6% from 1992 to 1997, those of women *increased* by 12% (data not shown). As a result, the ratio of male to female deaths attributable to smoking has fallen from 2.1 in 1992 to 1.8 in 1997.

The potential years of life lost (PYLL) because of premature mortality associated with these deaths are estimated at 173,158 years (Table 3). In 1997, an estimated 511,105 hospital days were used in Ontario in the treatment of smoking-related conditions. The overall number of deaths and hospital days attributable to smoking remains high, accounting for more than one in seven deaths, and 6% of all hospital days in Ontario.

Table 3. Deaths and Potential Years of Life Lost (PYLL) due to Tobacco Use, Ontario 1997

	Males			Females			Total		
Ages	Deaths	PYLL	Hosp days	Deaths	PYLL	Hosp days	Deaths	PYLL	Hosp days
0-19	29	2,130	12,028	22	1,751	10,053	51	3,881	22,081
20-44	177	7,031	17,657	86	3,861	16,830	263	10,892	34,487
45-64	1,853	42,824	102,991	800	22,324	53,094	2,652	65,147	156,085
65+	5,434	55,497	176,662	3,256	37,741	121,789	8,690	93,238	298,451
All Ages	7,492	107,482	309,339	4,164	65,676	201,766	11,656	173,158	511,105

Source: Single and Luk (forthcoming).

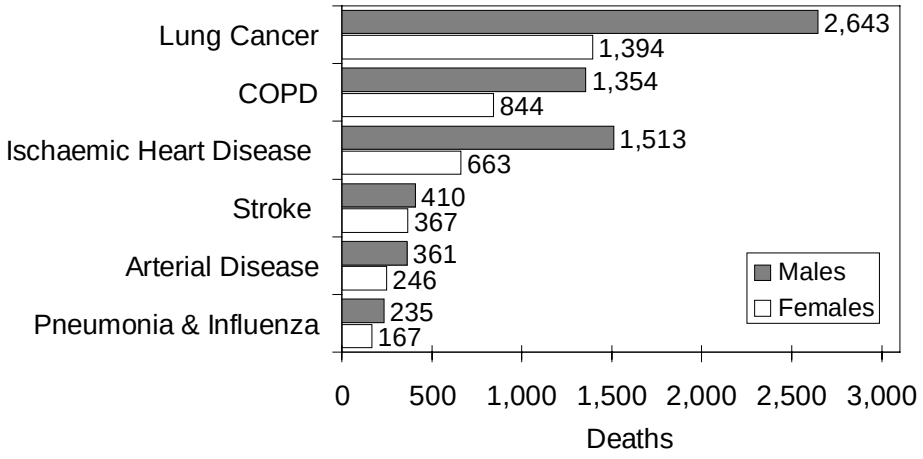
3.1 Health Burden of Smoking (cont'd)

The leading causes of smoking-related death in 1997 were the same as in 1992, namely lung cancer, ischemic heart disease, chronic obstructive pulmonary disease (COPD), and stroke and arterial disease (Figure 5). Of note is that the number of smoking-attributable deaths due to heart disease has declined since 1992, particularly among males, whereas deaths due to COPD have increased more than those due to other causes, and COPD has just surpassed Ischaemic Heart Disease as a leading cause of smoking-attributable death when both sexes are considered (Figure 5 and Appendix D).

A recent survey looking at knowledge of the health effects of smoking shows that, whereas a strong majority of Ontarians believe that smoking causes lung cancer and chronic bronchitis (83% and 71%, respectively), only 56% believe it causes heart attacks (Q2000 study).

There is conclusive scientific evidence that second-hand smoke causes serious health problems, including heart disease, stroke and lung cancer in adults and asthma and lower respiratory illness in children. In Canada, it is estimated that exposure to second-hand smoke causes between 1100 and 7800 deaths per year, at least one-third of them in Ontario. Based on U.S. estimates, the actual figure is likely closer to the highest estimate. The low estimate of 1100 is based on workplace exposure and excludes deaths due to several tobacco-related diseases such as stroke and COPD. (Ontario Tobacco Research Unit, 2001c).

Figure 5. Deaths Attributable to Tobacco Use, by Sex and Cause, Ontario 1997

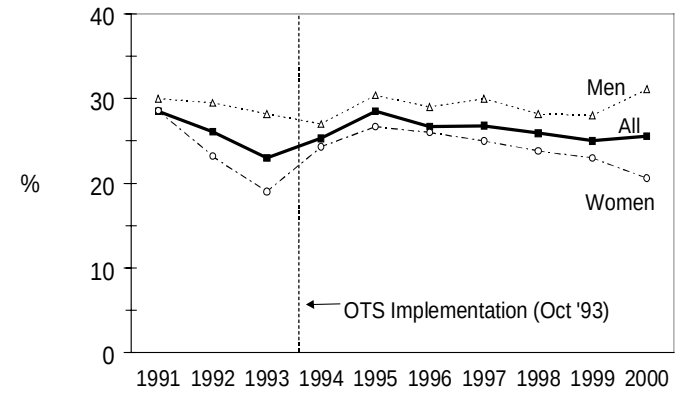


Note: Order based on male and female deaths combined. COPD = Chronic Obstructive Pulmonary Disease.
Source: Single and Luk (forthcoming).

3.2 Adult Smoking

3.2.1 Prevalence

Figure 6. Current Cigarette Smoking, by Sex, Age 18+, Ontario 1991-2000



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Men	30	30	28	27	30	29	30	28	28	31
All Adults	29	26	23	25	29	27	27	26	25	26
Women	29	23	19	24	27	26	25	24	23	21

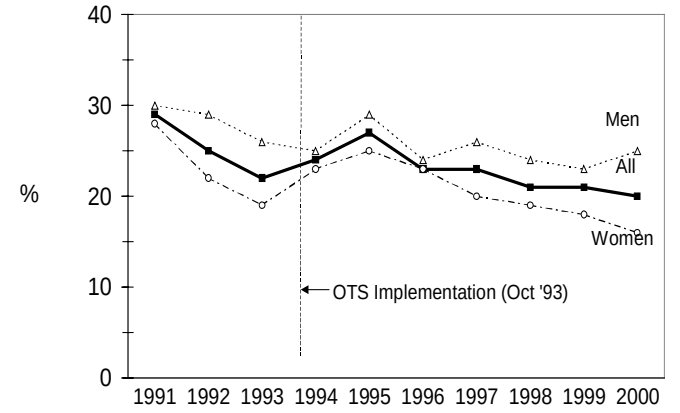
Source: CAMH Monitor, Centre for Addiction and Mental Health.

- Overall, there has been little change in the prevalence of cigarette smoking among Ontario adults over the last decade (an overall decrease from 29% to 26%).

- In 2000, one quarter (26%) of Ontario adults smoked daily or occasionally.

- In 2000, there was a significant difference in smoking prevalence between men and women (31% and 21% respectively), as prevalence increased for men over 1999 levels, but decreased for women. Current smoking decreased among women in the past five years, but not among men.

Figure 7. Daily Cigarette Smoking, by Sex, Age 18+, Ontario 1991-2000



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Men	30	29	26	25	29	24	26	24	23	25
All Adults	29	25	22	24	27	23	23	21	21	20
Women	28	22	19	23	25	23	20	19	18	16

Source: CAMH Monitor, Centre for Addiction and Mental Health.

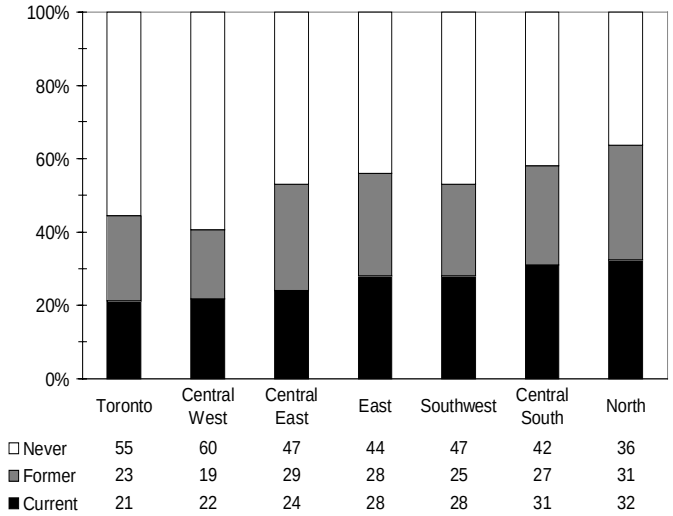
- Overall, there appears to be a downward trend in the prevalence of daily cigarette smoking among Ontario adults over the last decade. One fifth (20%) of Ontario adults now smoke daily.

- The prevalence of daily smoking among men and women in 2000 is significantly different, with the prevalence for men rising to 25% and the prevalence for women falling to 16%. This pattern is similar to that of current smoking (Figure 6).

- Among *current smokers*, men were significantly more likely than women to smoke daily in 1999 (84% vs. 78%). In 2000, the difference in prevalence of daily smoking between male and female smokers was not observed (80% and 78%, respectively).

3.2.1 Prevalence (cont'd)

Figure 8. Smoking Status, by Health Planning Region, Age 18+, Ontario 2000



Source: CAMH Monitor, Centre for Addiction and Mental Health.

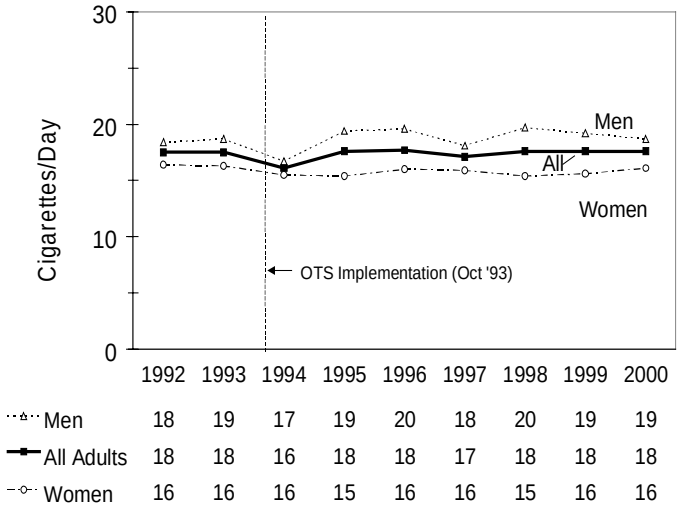
- The North Planning Region has the highest prevalence of current smokers (32%), whereas Toronto and Central West have the lowest (21% and 22% respectively).

- Nearly two-thirds of North Region residents (63%) were current or former smokers, underscoring the risk of a very high health burden from smoking in this region.

- The mean number of cigarettes smoked per day among daily smokers ranged from 19.4 for the Southwest Planning Region to 14.9 for the Toronto Region (difference not significant, data not shown).

3.2.2 Level of Use

Figure 9. Mean Number of Cigarettes Smoked Daily, by Sex, Daily Smokers Age 18+, Ontario 1992-2000



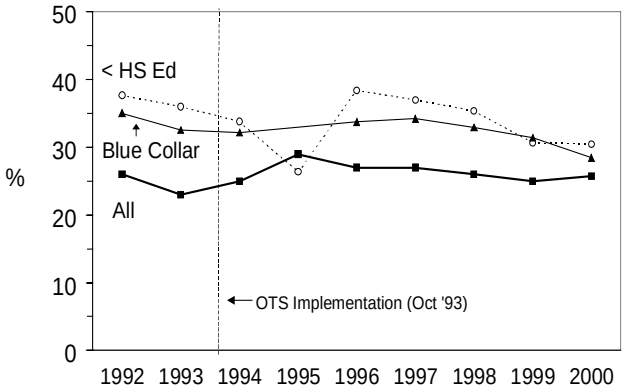
Source: CAMH Monitor, Centre for Addiction and Mental Health.

- Among daily smokers, the mean number of cigarettes smoked per day stayed relatively constant from 1992 to 2000, with the level over each of the past three years averaging 17.6 cigarettes.

- Men who smoked daily consumed an average of 18.7 cigarettes per day, whereas women who smoked daily consumed an average of 16.1 cigarettes.

3.2.3 Selected Target Groups

Figure 10. Current Smoking, by Selected Priority Groups, Age 18+, Ontario 1992-2000



	1992	1993	1994	1995	1996	1997	1998	1999	2000
< HS Ed	38	36	34	26	38	37	35	31	30
Blue Collar	35	33	32	--	34	34	33	31	28
All Adults	26	23	25	29	27	27	26	25	26

Note: < HS Ed = Less than High School Education.
Source: CAMH Monitor, Centre for Addiction and Mental Health.

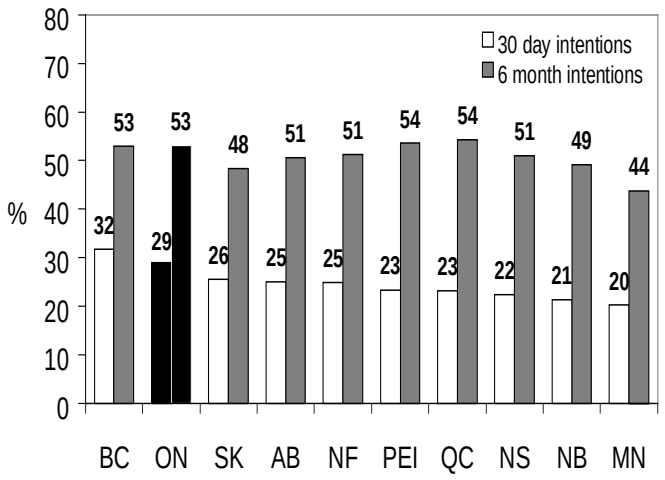
- Although the difference in the prevalence of smoking between all Ontario adults and those with less than high school education and blue-collar workers is not statistically significant in 2000 (26% vs. 30% and 28%, respectively), it has been consistent over the years with a few exceptions.

- Since 1997, there has been a continued decline in the prevalence of smoking among blue-collar workers despite an absence of OTS program activity directed toward this group.

- In 2000, the mean number of cigarettes smoked per day was 21.8 for those daily smokers with less than high school education, and 18.8 for those with blue-collar occupations (data not shown), compared to 17.6 cigarettes per day for all adults (Figure 9).

3.2.4 Smoking Cessation

Figure 11. Intentions to Quit Smoking within next 30 Days, 6 Months, by Province, Age 15+, Canada 2000



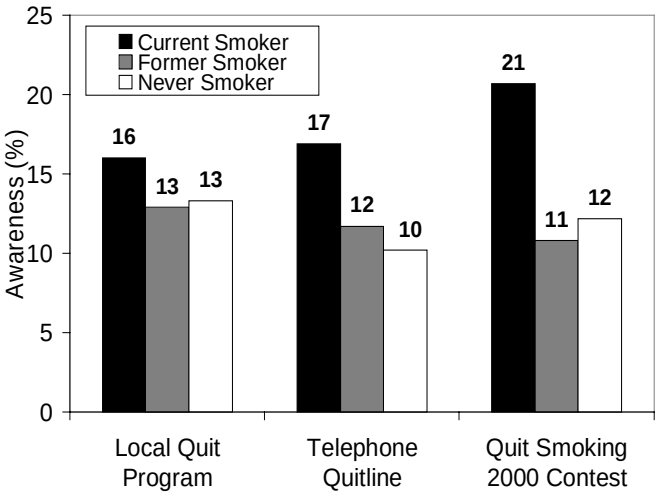
Note: Ordered by prevalence of highest 30-day quit plans.
Source: CTUMS, Health Canada.

- Over half (53%) of Ontario smokers are seriously considering quitting within the next six months.

- Among current smokers in Canada, Ontario ranked second highest (behind British Columbia) in the proportion of people seriously considering quitting within the next 30 days.

- Forty-three percent of current adult smokers had been advised by their doctor during the last 12 months to quit smoking (CAMH Monitor, data not shown).

Figure 12. Awareness of Smoking Cessation Programs, by Smoking Status, Age 18+, Ontario 2000



Source: CAMH Monitor, Centre for Addiction and Mental Health.

- The vast majority of smokers were not aware of province-wide quit smoking programs.

- In 2000, more smokers were aware of the Quit Smoking 2000 Contest (21%) than the telephone quitline (17%) and local quit programs (16%).

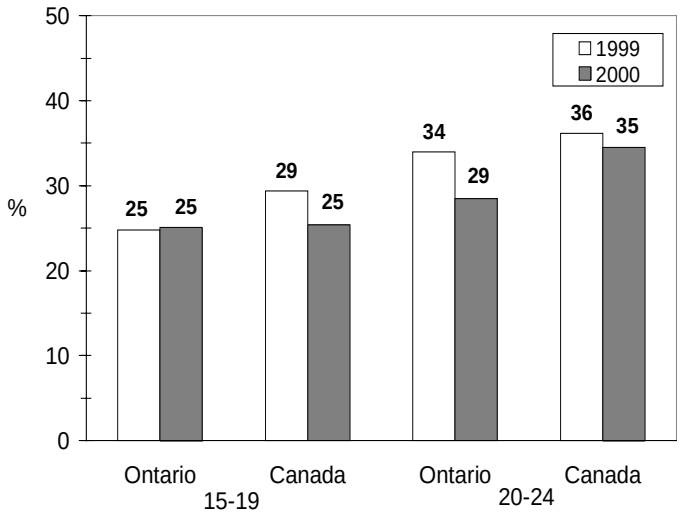
- Significantly more smokers were aware of the telephone quitline than never smokers (17% vs. 10%).

- Significantly more smokers were aware of the Quit Smoking 2000 Contest than either former or never smokers (21% vs. 11% and 12%, respectively).

3.3 Youth Smoking

3.3.1 Prevalence

Figure 13. Current Smoking, among Young People Aged 15-19, 20-24, Ontario and Canada 1999-2000

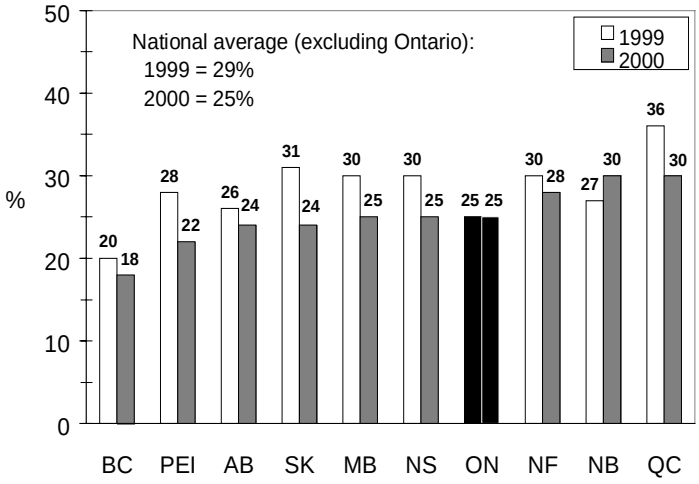


Note: Estimates for Canada exclude Ontario. Ordered by 2000 smoking prevalence.
Source: CTUMS, Health Canada.

- Between 1999 and 2000, smoking prevalence significantly decreased for young adults aged 20-24 in Ontario (34% to 29%), but remained constant for Ontario youth aged 15-19. In contrast, youth aged 15-19 elsewhere in Canada reduced their smoking by four percentage points (Figures 13 and 14).

- In 2000, the smoking prevalence of youth aged 15-24 was lower in Ontario than in the rest of Canada (27% vs. 30%; combined group data not shown).

Figure 14. Current Smoking, by Province, Age 15-19, Canada 1999-2000



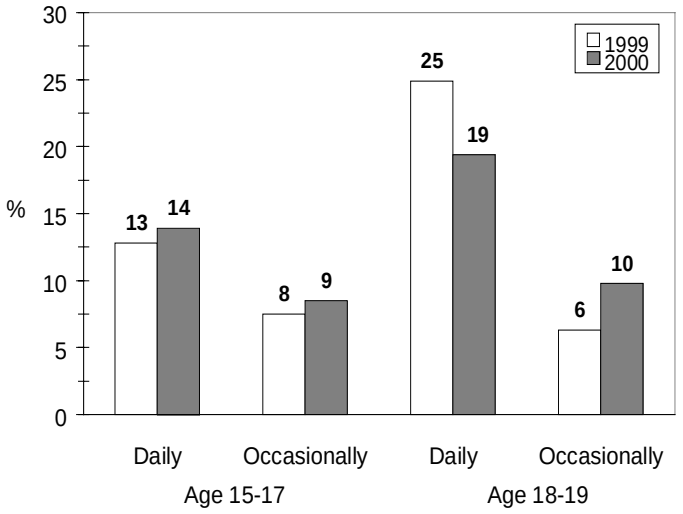
Note: Ordered by 2000 smoking prevalence.
Source: CTUMS, Health Canada.

- From 1999 to 2000, the current smoking prevalence of youth aged 15-19 decreased in all provinces except Ontario, where it stayed the same, and New Brunswick, where it increased.

- In 2000, the prevalence of smoking in Ontario was the third highest in all of Canada, tied with Nova Scotia and Manitoba. British Columbia, Prince Edward Island, Alberta, and Saskatchewan all had lower rates of smoking. Only Quebec, New Brunswick, and Newfoundland had higher rates. This stands in contrast to 1999, when compared to Ontario, the prevalence of smoking was higher in all provinces except British Columbia.

3.3.1 Prevalence (cont'd)

Figure 15. Smoking Status of Youth, by Age Group, Ontario 1999-2000



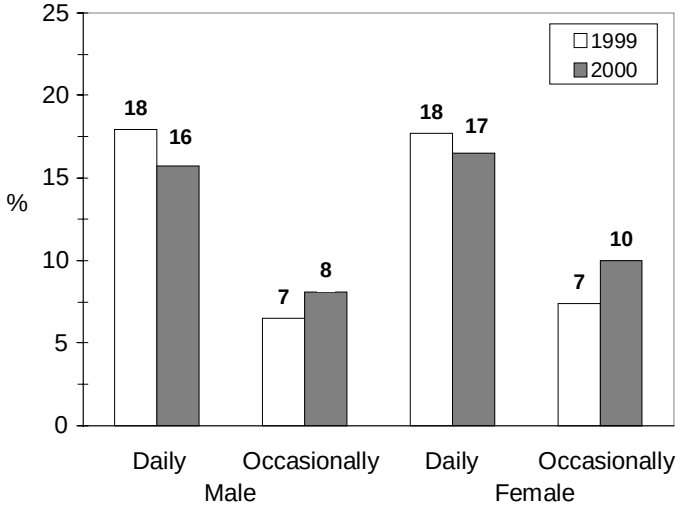
Source: CTUMS, Health Canada.

- The prevalence of daily smoking among 18-19 year olds decreased between 1999 and 2000 from 25% to 19%, whereas the prevalence of occasional smoking increased from 6% to 9%. This finding might reflect a shift from daily to occasional smoking among 18-19 year olds.

- Smoking prevalence among 15-17 year olds increased slightly from 1999 to 2000, but this change was not significant. In 2000, 13.9% of 15-17 year olds smoked daily, while 8.5% smoked occasionally.

- Daily smokers aged 15-17 smoked an average of 11.2 cigarettes per day in 2000, and daily smokers aged 18-19 years smoked an average of 15.0 cigarettes per day (data not shown).

Figure 16. Smoking Status of Youth, by Sex, Age 15-19, Ontario 1999-2000



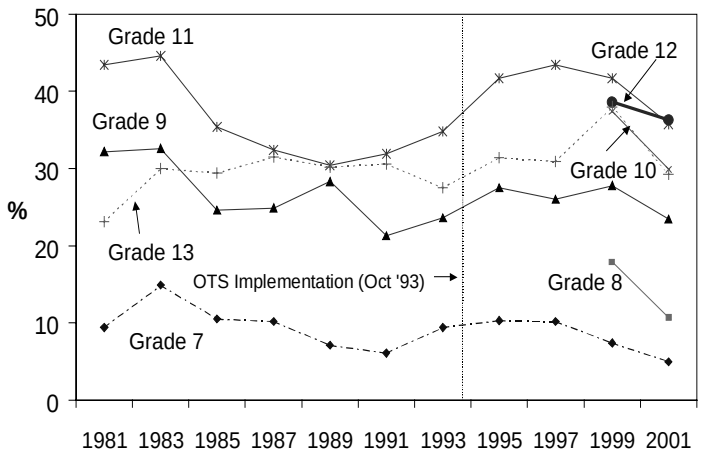
Source: CTUMS, Health Canada.

- From 1999 to 2000, daily smoking among youth remained relatively constant (18% and 16% for males and 18% and 17% for females). Although the prevalence of occasional smoking among males and females appeared to increase from 1999 to 2000, this difference was not significant for either sex.

- Male youth who were daily smokers consumed an average of 13.8 cigarettes per day in 2000; female daily smokers consumed 12.4 cigarettes on average (data not shown).

3.3.1 Prevalence (cont'd)

Figure 17. Students Smoking More than One Cigarette in the Past Year, by Grade, Ontario 1981-

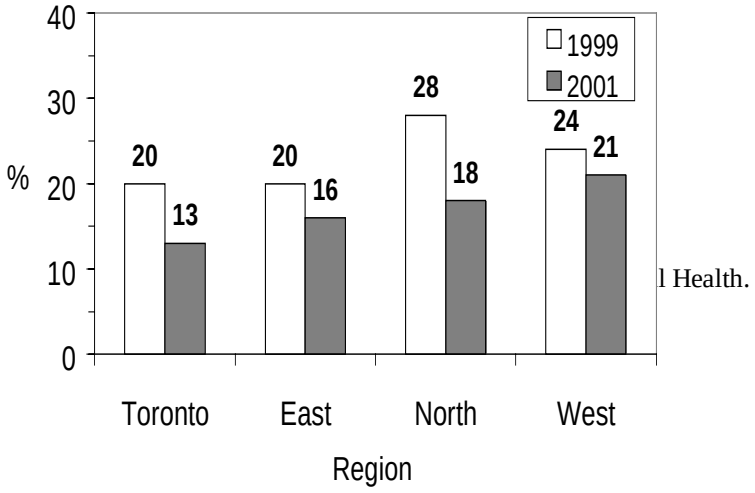


2001

- In 2001, the prevalence of smoking more than one cigarette in the past year was lower in all Grades compared to 1999, and significantly lower for students in Grades 8 and 10.

- Overall, the prevalence of Ontario students smoking more than one cigarette in the past year was significantly lower in 2001 than in 1999 (24% vs. 29%, data not shown).

Figure 18. Daily Smoking among Students, by Region, Ontario 1999-2001



l Health.

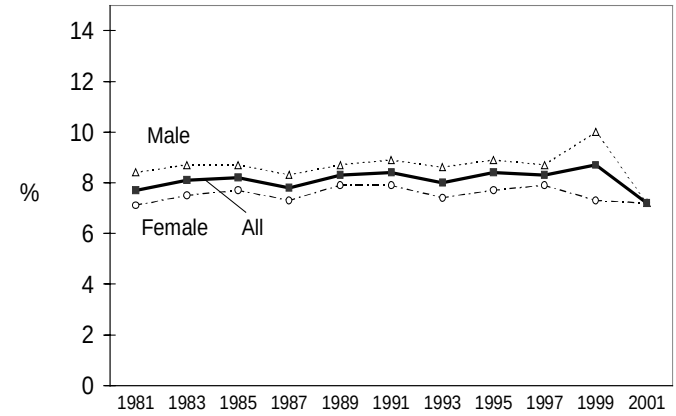
Note: Ordered by 2001 prevalence.
Source: OSDUS, Centre for Addiction and Mental Health.

- Although not statistically significant, Figure 18 suggests that the prevalence of student daily smoking in each of the four regions decreased from 1999 to 2001.

In 1999, daily smoking prevalence was highest in the Northern region. In 2001, daily smoking prevalence was highest in the West and lowest in Toronto.

3.3.2 Level of Use

Figure 19. Mean Number of Cigarettes Smoked Daily, by Sex, Daily Smokers, Ontario Students 1981-2001



	1981	1983	1985	1987	1989	1991	1993	1995	1997	1999	2001
Males	8.4	8.7	8.7	8.3	8.7	8.9	8.6	8.9	8.7	10	7.2
Females	7.1	7.5	7.7	7.3	7.9	7.9	7.4	7.7	7.9	7.3	7.2
All	7.7	8.1	8.2	7.8	8.3	8.4	8.0	8.4	8.3	8.7	7.2

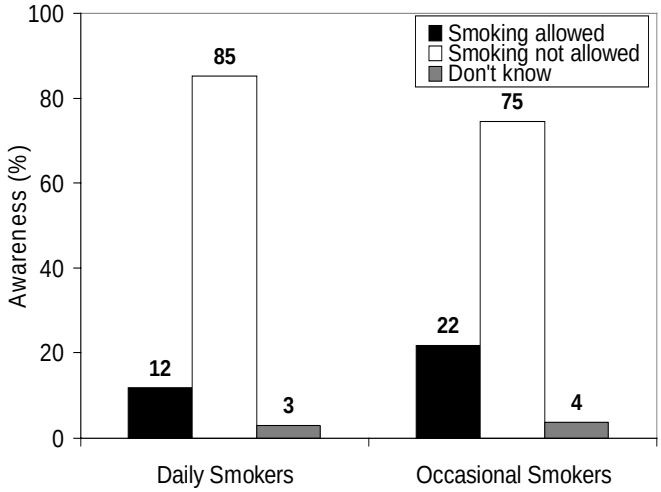
Source: OSDUS, Centre for Addiction and Mental Health.

- The mean number of cigarettes smoked per day by students in Ontario has remained relatively constant over the last two decades.

- In 2001, the mean number of cigarettes smoked daily was 7.2 for both male and female daily smokers.

3.3.3 Smoking and School

Figure 20. Student Awareness of Rules about Smoking on School Property, Ontario Students 2001



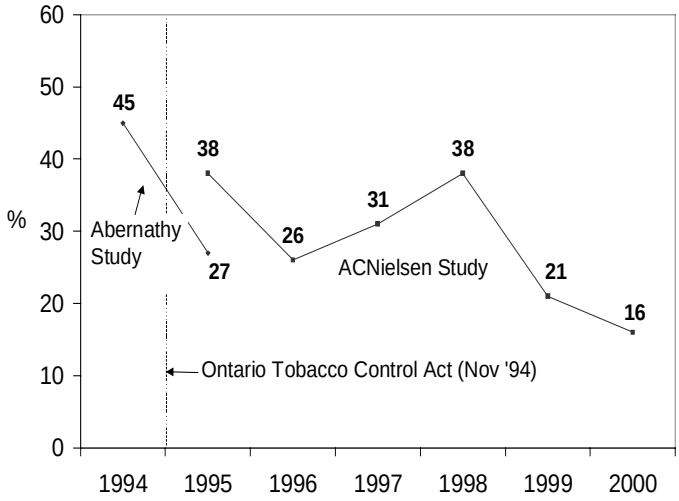
Source: OSDUS, Centre for Addiction and Mental Health.

- A large majority of students in the province who are current smokers know that smoking is not allowed on school property (83%, data not shown).

- Of high school students who smoke regularly, 86% agree that students get into trouble for breaking school smoking rules (Waterloo Smoking Prevention Project 2001, data not shown).

3.4 Sales to Minors

Figure 21. Sales to Minors, Vendor Non-Compliance (all sites), Ontario 1994-2000

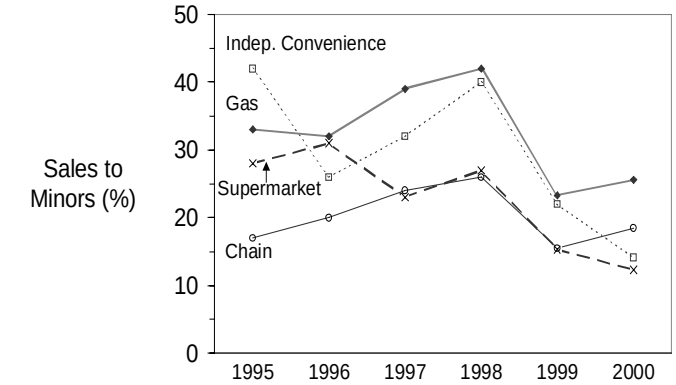


Source: Abernathy 1994, 1996; AC Nielson 1995-2000.

- From a high in 1998 (38%), sales to minors by retailers have steadily decreased (21% in 1999 and 16% in 2000). Non-compliance was lower in Ontario compared to the national rate (16% vs. 30%, data not shown). As indicated by the 16% noncompliance rate, tobacco products are still accessible to youth in the province.

- In 2000, youth aged 15-17 obtained cigarettes equally from social sources (friends or parents) and retail sources (49% and 48%, respectively; CTUMS 2000, data not shown).

Figure 22. Sales to Minors, Non-Compliance, by Type of Vendor, Ontario 1995-2000



	1995	1996	1997	1998	1999	2000
Indep. Convenience	42	26	32	40	22	14
Gas Stations	33	32	39	42	23	26
Supermarkets	28	31	23	27	15	12
Chain Convenience	17	20	24	26	16	19

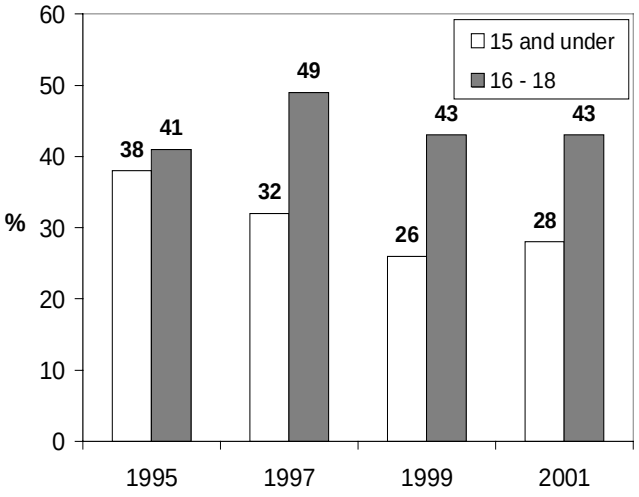
Source: AC Nielson 1995-2000.

- The positive gains in compliance with sales-to-minors legislation observed across gas stations and chain convenience stores from 1998 to 1999 did not carry forward to 2000. Independent convenience stores, however, continued their recent trend toward better compliance, in line with supermarkets, which had the best record.

- Although there appeared to be some convergence in the non-compliance rate between the different types of vendors in 1999, this pattern did not continue in 2000.

3.4 Sales to Minors (cont'd)

Figure 23. Underage Students Asked for ID when Purchasing Cigarettes, by Age, Ontario Students 1995-2001



Source: OSDUS, Centre for Addiction and Mental Health.

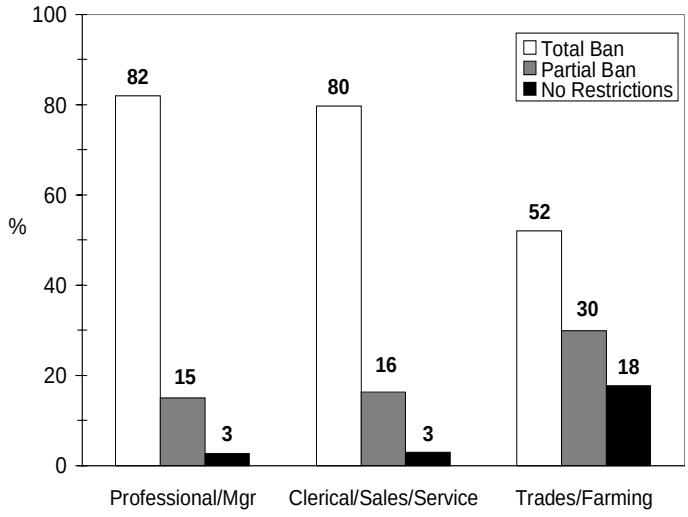
- In 2001, students aged 16-18 were more likely to be asked for ID when purchasing cigarettes during the past four weeks than those aged 15 and under (43% vs. 28%), a finding consistent with previous years. In recent years, there have been no significant changes in the percentage of students asked for ID.

- In a recent AC Nielson survey (2001), retailers who asked for ID were significantly less likely to sell cigarettes to underage youth compared to retailers who did not ask (9% vs. 76%).

- A survey of Ontario secondary schools found that more than half of educators (54%) stated that the accessibility of tobacco products to youth is an obstacle to success of tobacco control programs in the schools (Brown, 2000).

3.5 Exposure to Environmental Tobacco Smoke

Figure 24. Smoking Restrictions at Work, by Occupation, Age 18+, Ontario 2000



Source: CAMH Monitor, Centre for Addiction and Mental Health.

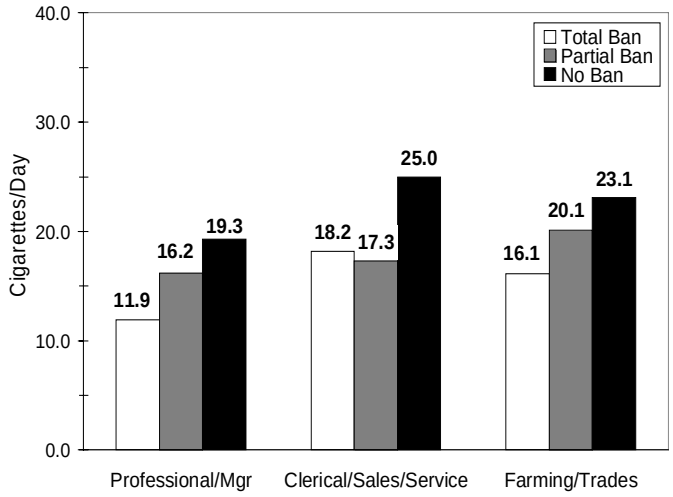
- The majority of Ontario workers were employed in environments with a total ban on smoking (73%), fewer worked with only a partial ban in place (19%), and a minority (but still a substantial number) had no restrictions at all (7%; aggregate data not shown).

- Just under half of trade and farm workers were at risk of being exposed to environmental tobacco smoke while at work.

- Trade and farm workers were less likely to have smoking restrictions at work compared to other workers.

3.5 Exposure to Environmental Tobacco Smoke (cont'd)

Figure 25. Mean Number of Cigarettes Smoked Daily, by Smoking Restrictions at Work and Occupation, Age 18+, Daily Smokers, Ontario 2000



Source: CAMH Monitor, Centre for Addiction and Mental Health.

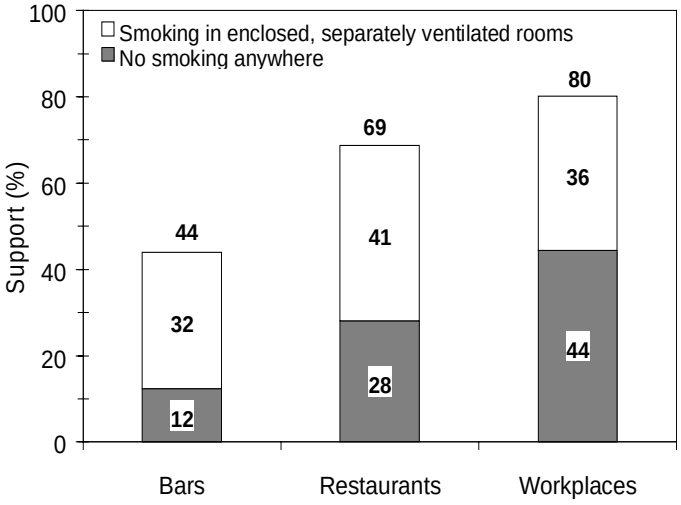
- Daily smokers working in environments having no smoking restrictions smoked significantly more cigarettes per day than those smokers in workplaces having total restrictions (23.0 vs. 15.2, data not shown).

- Smokers were significantly less likely than non-smokers to report that their workplace had a complete ban on smoking (61% vs. 76% respectively, data not shown).

3.6 Public Attitudes toward Tobacco Control

3.6.1 Support for Restrictions

Figure 26. Support for Smoking Restrictions, Age 18+, Ontario 2000



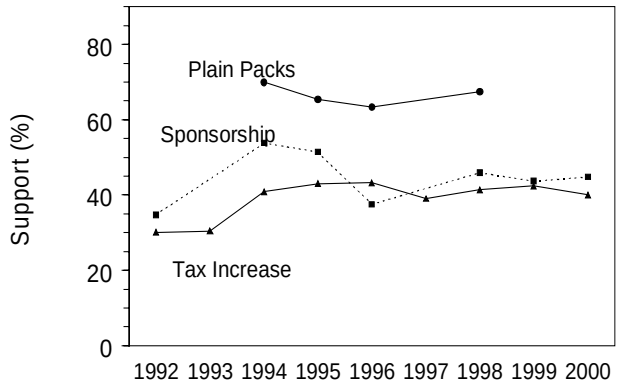
Source: CAMH Monitor, Centre for Addiction and Mental Health.

- Approximately four in ten adults in Ontario support some sort of smoking restrictions in bars, seven in ten adults support restrictions in restaurants, and eight in ten support restrictions in workplaces. These levels of support have remained relatively constant since 1998 (Ontario Tobacco Research Unit, 1999).

- Smoking status appears to be a strong predictor of support for restrictions: 19% of never smokers felt smoking should be completely banned in bars and taverns, compared with 9% of former smokers and 4% of current smokers; 39% of never smokers felt smoking should be completely banned in restaurants compared with 26% of former smokers and 9% of current smokers; and 55% of never smokers felt smoking should be completely banned in the workplace, compared with 45% of former smokers and 24% of current smokers (data not shown).

3.6.1 Support for Restrictions (cont'd)

Figure 27. Support for Tobacco Control Policies, Age 18+, Ontario 1992-2000



	1992	1993	1994	1995	1996	1997	1998	1999	2000
Ban Sponsorship	35	--	54	51	38	--	46	44	45
Plain Packs	--	--	70	65	63	--	67	--	--
Tax Increase	30	30	41	43	43	39	41	42	40

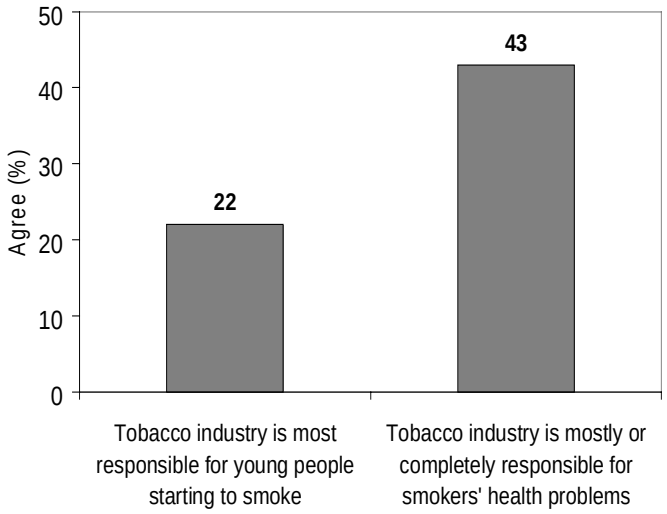
Source: CAMH Monitor, Centre for Addiction and Mental Health.

- Since the mid-nineties, there has been a consistent and moderate amount of support for banning tobacco industry sponsorship and increasing cigarette taxes.

- Support for banning sponsorship varies depending on whether one is a current, former, or never smoker (28%, 48%, and 53%, respectively; current smoker support significantly lower than former and never). Likewise, support significantly varies for tax increases among these groups (11%, 40%, and 56%, respectively).

3.6.2 Attitudes toward the Tobacco Industry and its Products

Figure 28. Views about Tobacco Industry Responsibility, Age 18+, Ontario 2000



Source: Q2000 Study, Ontario Tobacco Research Unit; Ashley, Cohen, & Osterlund, 2001.

- 22% of Ontario adults agree that the tobacco industry is most responsible for young people starting to smoke. The view that the tobacco industry is responsible for smokers' health problems is widely shared, with 43% of Ontario adults in agreement.

- When questioned as to opinions regarding the tobacco industry's practices, 75% of Ontarians felt the industry either rarely or never tells the truth about the health effects of smoking (data not shown).

- Eighty-two percent of Ontarians felt that tobacco products should be regulated as "hazardous" products (Q2000 study; Ashley et al., data not shown).

CHAPTER 4: IMPLICATIONS FOR THE RENEWED OTS

What do the findings reported in Chapters 1 to 3 mean for the future of the Ontario Tobacco Strategy?

This discussion is based on the evidence presented earlier and is organized around the three OTS goals of prevention of smoking, encouragement of cessation, and protection of non-smokers. It deals as well with the "denormalization" of smoking; ongoing monitoring, evaluation, and research of the strategy; and overall strategic considerations.

This chapter is not intended to be a primer on "best practices" in tobacco control, but rather is an interpretation of the findings in the first three Chapters – the temporal trends and other patterns in the data, possible linkages and explanations, and some selected action implications in the interests of tobacco control.

Relevant sections in earlier chapters are referenced.

This chapter covers the following topics:

4.1 Implications for Prevention

4.2 Implications for Cessation

4.3 Implications for Protection

4.4 Implications for Denormalization

4.5 Implications for Monitoring, Evaluation, and Research

4.6 Implications for the OTS as a Whole

4.1 Implications for Prevention

The prevalence of smoking among youth aged 15-19 has remained relatively constant in the province from 1999 to 2000, with approximately 25% of youth reporting smoking in each year (Section 3.3.1). Although it may appear that the tobacco epidemic among the province's youth is being contained, some other jurisdictions have had greater success in curbing youth smoking, as evidenced by the greater reductions in youth prevalence rates from 1999 to 2000 in all other provinces except New Brunswick (Section 3.3.1), and by recent findings from the U.S., which show a 33% decline in the number of youth who became daily smokers over the period 1997 to 1999 (U.S. Dept. of Health and Human Services, 2001).

Several factors have very likely contributed to this unchanged prevalence of youth smoking in the province. In 2000-01, Ontario had the cheapest cigarettes in Canada (Section 1.1), compliance with sales-to-minors restrictions actually declined at gas stations and chain convenience stores (although compliance did increase overall), and social sources (i.e., family and friends) provided cigarettes when merchants did not (Section 3.4). Only eight in ten students were aware that smoking was banned on school property (Section 3.3.3), and only two OTS partners had a clear focus on prevention (Section 2.2.1).

It may be that Ontario's success in curbing youth smoking has reached the limits of what can be accomplished with the type of program and policy initiatives that have been part of the OTS to date. To reach the more resistant youth smokers, Ontario needs to act aggressively. What is required is the type of comprehensive and well-funded program and policy initiatives seen in some U.S. States. Critical measures needed are higher tobacco prices, restricted access to tobacco from retailers and other sources, more time in school curricula for proven prevention programs, leadership and commitment to make existing programs work in school and in the community, and a better example provided by adults who currently smoke at home or in other settings frequented by young people. Complete smoking bans in workplaces popular with youth and young adults, including restaurants and bars, are also important components of a comprehensive prevention program.

4.2 Implications for Cessation

With 11,656 deaths attributable to smoking in Ontario in 1997, it is obvious that the tobacco epidemic in the province takes a high personal, social, financial, and health-care toll. The 12% increase in smoking-attributable deaths between 1992 and 1997 on the part of Ontario women is especially discouraging (Section 3.1). Given that the prevalence of current cigarette smoking among Ontario adults is over 25% and has changed little over the past decade (Section 3.2.1), costs are expected to continue to burden Ontarians and the government for the foreseeable future. Because nearly two-thirds of Northern Ontario residents are current or former smokers, the health burden in this region is expected to be particularly high.

Although large numbers of Ontario smokers express an intention to quit in the near future, only a small percentage of them are aware of major provincial programs available to assist them in quitting, and only a minority have been advised by their doctors to quit (Section 3.2.4).

Ontario needs a comprehensive tobacco cessation plan that includes a standard assessment and referral system, as well as standard methods for measuring success. More Ontario smokers need

to know that cessation produces immediate and long-term benefits, and there are many available programs that can increase the odds they will quit. They also need to know where to find these programs.

Smoking continues to be more common among men, by a margin of 3:2, and men continue to smoke more each day than women (Section 3.2.1). Although women have been designated a target group of the OTS for some years (and their smoking prevalence has declined by six percentage points since 1995), men have not been targeted in any systematic manner, and their smoking is not declining. Men's smoking is a challenge that requires new strategies to address and combat it. Smoking by blue-collar workers and low-literacy Ontarians also requires more focused attention.

4.3 Implications for Protection

Support for smoking bans and smoking restrictions (with separately ventilated rooms) in bars, restaurants, and workplaces has remained relatively constant since 1998 (Section 3.6.1), despite public discussion of this issue. This suggests the need for increased public education on the harmful effects of ETS, the failure of ventilation to provide adequate protection from ETS (Repace, 2000), and the importance of restrictions in preventing initiation and relapse and encouraging cessation of smoking. Physicians and other health professionals have an important role to play in this effort.

For their part, Public Health Units need sufficient resources to promote smoke-free bylaws including increased funding to prepare a smoke-free bylaw, advertise relevant meetings, engage in intensive proprietor education once a bylaw is passed, undertake pre-implementation advertising, and ensure the kind of enforcement that 100% smoke-free restaurant and bar bylaws require.

A municipality-by-municipality approach to smoke-free bylaw implementation has inherent deficits. Such an approach can lead to an absence of a level playing field of smoke-free rules for the hospitality industry, which results in different levels of worker protection and proprietor requirements in many adjoining municipalities. It also results in wasteful and expensive duplication as municipality after municipality embarks on campaign after campaign with different available levels of expertise, information, advertising and implementation funding, and enforcement resources.

Provincial action would be much more cost effective in providing protection for the large number of workers, especially those in blue-collar jobs, exposed to ETS while at work (Section 3.5). Support for just such a position comes from the Association of Municipalities of Ontario. At their August 2000 annual convention, the Association passed a resolution asking the provincial government to take over responsibility for protecting the health of Ontarians in public places and workplaces through the enactment of a provincial smoking policy. Provincial action should take the form of an updated *Smoking in the Workplace Act* or revised regulations under the *Occupational Safety and Health Act.*

4.4 Implications for Denormalization

The tobacco industry in Canada continues to be in good financial health (Section 1.5), and adults in Ontario continue to hold moderate views about this industry (Section 3.6.2.). For

instance, only a fifth of the population believes that the industry is most responsible for young people starting to smoke. Although three quarters of adults felt the industry either rarely or never tells the truth about the health effects of smoking, well under half hold the industry mostly or completely responsible for smoker's health problems. These results suggest that public recognition is changing and the tobacco industry is on the defensive, but progress has thus far been limited considering the magnitude of the problem (Section 3.1) and the number and variety of parties suing the industry for damages world-wide (Section 1.4).

Given the tobacco industry's strategic management of its corporate image through sponsorship and industry funded youth prevention programs (Section 1.5), public education messages about the role and responsibility of the tobacco industry in sustaining the tobacco epidemic need to be strengthened.

Because the province's lawsuit against tobacco companies in a U.S. federal court was not successful (Section 1.1), Ontario should follow the lead of British Columbia, Quebec, and Newfoundland, as well as several private parties, and initiate proceedings within its own jurisdiction to recover health care costs due to smoking.

4.5 Implications for Monitoring, Evaluation, and Research

The most effective allocation of effort toward prevention, cessation, protection, denormalization, and infrastructure development needs to be carefully assessed, with routine monitoring, in-depth evaluation, and ongoing dialogue with the MOHLTC.

Our discussion of the health burden of smoking in Ontario (Section 3.1) suggests the need for economic research on a variety of tobacco-related issues, including the cost of tobacco use to the health care system and the Ontario economy as a whole, the economic impact of smoke-free policies, and the tobacco growing region's contribution to the Ontario economy in relation to its cost to Ontario tax payers.

Prevalence data on the smoking behaviour of men and women suggest that the issue of priority group designations for the OTS needs to be revisited (Sections 3.2.1 and 4.2).

Although compliance rates with sales-to-minors legislation among different types of vendors appeared to converge in 1999, a different pattern emerged in 2000 (Section 3.4), with supermarkets and independent convenience stores displaying better compliance and gas stations and chain convenience stores exhibiting less compliance. This change highlights the need for continued monitoring. Moreover, we need to survey the friends and families of smokers to see if they are aware that they are breaking the law by supplying minors with cigarettes.

Continued monitoring of tobacco industry activities (Section 1.5) and public attitudes toward the tobacco industry (Section 3.6.2) will help us to better understand the larger context in which OTS activities and outcomes are situated. More systematic tracking of municipal smoking restriction bylaws and ongoing monitoring of merchant compliance is critical to understanding the environment of smoker and non-smoker alike.

Given the limitations of existing surveys used for monitoring, particularly regarding content, sample design and sample size, and thus ability to conduct community-level analysis, a survey dedicated to tobacco control issues in Ontario needs to be initiated, with reliable funding from the MOHLTC. Among other outcomes, a

survey should be able to identify municipalities with high levels of smoking prevalence.

A system needs to be established for collecting timely reports from the PHUs on their tobacco control activities. Although PHUs play a vital role in education, cessation services, enforcement, and development of smoke-free public places, the current method of monitoring these activities used by the MOHLTC does not provide timely data for this annual report.

Although there are many effective school-based prevention programs and cessation programs, important research questions remain regarding which programs work best in which settings for which students.

4.6 Implications for the OTS as a Whole

A more intensive tobacco control effort is called for, with funding increasing from current levels to amounts approaching internationally recognized standards (Section 1.1). Increasing tobacco taxes to the Canadian average would provide ample new revenue for this purpose, while serving as a useful tobacco control measure in its own right.

Major strategic opportunities remain for the OTS, and critical high-risk groups, particularly youth aged 15-19, blue-collar workers, less educated adults, and men have yet to be effectively addressed. A multi-year plan with assured funding from the Ministry is needed, as is a more visible role for the Ministry to complement and strengthen that of the partners whose activities are described in Chapter 2. The changing focus of OTS partner activities from year-to-year (Section 2.1.1) and the results of Chapter 3 underscore the need for such a *long-term* strategy—one that allocates ongoing effort to each of prevention, protection, and cessation.

The varying support among Ontario adults for tobacco control policies, especially smoke-free bylaws and tax increases (Section 3.6.1), points to the need for strengthened and expanded education campaigns that inform the public about the health benefits of such policy initiatives including reduced consumption, increased quitting behaviour, decreased uptake of tobacco products, and less exposure to ETS.

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Appendix A: Internet WWW Addresses

Provinces and Territories

Alberta

Action on Smoking and Health (Western Canada)	www.ash.ca
Alberta Tobacco Reduction Alliance	www.atra.ab.ca
Alberta Health	www.health.gov.ab.ca

British Columbia

Tobacco Strategy	www.hlth.gov.bc.ca/tobacco
Workers' Compensation Board of B.C.	www.worksafebc.com/priority/smoke

Manitoba

Manitoba Health	www.gov.mb.ca/health/publichealth/environmentalhealth/tobacco.html

New Brunswick

Comprehensive Tobacco Use Reduction Strategy	www.gnb.ca/0053/en/tobacco
N.B. Coalition for a Smokefree Generation	www.geocities.com/nbsmokefree

Newfoundland & Labrador

Alliance for the Control of Tobacco	www.smokingsucks.ca/act

North West Territories

Health and Social Services	www.hlthss.gov.nt.ca

Nova Scotia

Tobacco Control Home	www.gov.ns.ca/quitnow
Tobacco Control Unit	www.gov.ns.ca/quitnow/tobacco_unit.htm

Nunavut

Territorial Government	http://www.gov.nu.ca

Ontario

Ministry of Health	www.gov.on.ca/health/english/program/tobacco/tobacco_mn.html
Canadian Cancer Society, Ontario Division	www.ontario.cancer.ca
Cancer Care Ontario (CCO)	www.cancercare.on.ca
Centre for Addiction and Mental Health	www.camh.net
Heart and Stroke Foundation of Ontario	www.heartandstroke.ca
Media Network (CCO)	www.media-network.org
Ontario Campaign for Action on Tobacco	www.ocat.org
Ontario Lung Association	www.on.lung.ca
Ontario Tobacco Research Unit	www.camh.net/otru
Program Training and Consultation Centre	www.ptcc.on.ca
Smoking and Health Action Foundation	www.nsra-adnf.ca

Quebec

Quebec Tobacco Control	www.msss.gouv.qc.ca/loi-tabac/f/sujets/tabagisme.htm

Saskatchewan

Tobacco Reduction	www.health.gov.sk.ca/ps_tobacco_reduction.html
Saskatchewan Coalition for Tobacco Reduction	www.sctr.sk.ca

Yukon

Yukon Tobacco Reduction Strategy	www.yukoncollege.yk.ca/prostudies/health/TOBACCO

National

AC Nielsen: Retailer compliance report	www.hc-sc.gc.ca/hppb/tobacco/pdf_english/tobcompfinal2000_01.pdf
Health Canada: Infotobacco	www.infotobacco.com
Health Canada: Tobacco Control Program	www.hc-sc.gc.ca/hppb/tobacco
National Clearinghouse on Tobacco and Health	www.ncth.ca
Population Surveys	
National Population Health Survey	www.hc-sc.gc.ca/hpb/lcdc/bc/nphs
Canadian Tobacco Use Monitoring Survey	www.hc-sc.gc.ca/hpb/lcdc/bc/ctums
Canadian Community Health Survey	www.statcan.ca/english/concepts/health
Youth Advisory Committee (Federal)	www.hc-sc.gc.ca/hppb/tobacco/yac

International

CDC	www.cdc.gov/tobacco
Society for Research on Nicotine and Tobacco	www.srnt.org
U.S. Master Settlement Agreement	www.ag.ca.gov/tobacco/msa.htm
World Health Organization	www.tobacco.who.int

Appendix B: OTS Province-Wide and Community Projects

Table B1. Province-Wide Projects, Classified by Principal Strategy and Main OTS Objective

Strategy	OTS Objective			
	Prevention	**Protection**	**Cessation**	**Infrastructure Support**
Educate				
General public	- Mass Media Campaign			
Youth	- TeenNet		- TeenNet, Leave the Pack,	
Smokers			- Quit Smoking 2000, Mass Media Campaign, Community Education Campaign[a]	
Build capacity				
Develop materials	- *Lungs are for Life*	- Youth-Smoke-free Living[b]		
Provide materials	- Addressing Teen Smoking[a] Retailer Signs[a], TeenNet	- Addressing Teen Smoking[a]	- Addressing Teen Smoking[a] Quit Smoking 2000, TeenNet	- Media Network, Web Enhancement[a]
Develop skills	- *TCA* Enforcement[a]	- *TCA* Enforcement[a]	- Clinical Intervention, Standards for Counsellors[b]	- Media Network, Student Bursaries[b] - Media Network
Build relationships				
Raise cigarette prices				
Regulate marketing				
Control retailing				
Assist smokers			- Smokers' Helpline, TeenNet	
Smoke-free spaces				
Monitor & evaluate	- Coordinated Evaluation, School Program Survey	- Coordinated Evaluation, School Ban Survey, ETS at Home, Economic Impact of Ban	- Coordinated Evaluation. School Program Survey, Pregnancy & Smoking, Youth Cessation Measures[b]	- Coordinated Evaluation, Long-term Evaluation Plan, Q2000 Survey, Enhanced CAMH Monitor[a], Economic & Health Costs

Note. Projects were funded through the entire 18-month period except as noted: [a]October 1999 – September 2000, [b]November 2000 – March 2001. *Projects in italics were substantially altered* after the initial 12 months. Some project titles have been edited for length.

Table B2. Communities with Projects, Classified by Principal Strategy and Main OTS Objective

Strategy	OTS Objective		
	Prevention	**Protection**	**Cessation**
Educate			
General public	- Simcoe, *Peterborough*	- Peel/GTA, *Ottawa*, Algoma[a]	- Algoma[a]
Youth	- Toronto, Algoma[a]	- Algoma[a], Grey-Bruce[a]	- Simcoe
Parents	- Simcoe, *Ottawa*	- Peel/GTA, *Ottawa*, Perth[b], Hastings/Prince Edward[b]	
Tobacco retailers	- Thunder Bay[a], Toronto, Simcoe		
Chinese population	- York Region[a]	- York Region[a]	- York Region[a]
Build capacity			
Develop materials	- Toronto (for schools)	- Peel/GTA	
Provide materials	- Algoma[a] (to schools), Toronto (to retailers)	- Peel/GTA	- Algoma[a] (to HS nurses)
Develop skills	- *Ottawa (teachers)*	- Perth[b]	- Algoma[a] (HS nurses), *Ottawa* (agency staff)
Raise cigarette prices			
Regulate marketing			
Control retailing			
Enforce *TCA*	- Toronto (re: sales to minors)		
Assist smokers		- Perth[b]	- Expectant couples/parents (Grey-Bruce[a]); Women, low-literacy (*Peterborough*); Marginal groups (*Ottawa*); Smoke-free buddies (Kingston[a]); Homewood clients (Waterloo/Wellington/ Dufferin[a])
Smoke-free spaces			
Implement new bylaw		- Simcoe, *Peterborough*, Waterloo[a], *Ottawa*, Perth[b], Hastings/Prince Edward[b]	
Support existing bylaw	- Toronto (re: school use)		
Enforce bylaw			
Monitor & evaluate	- Coordinated Evaluation (OTRU)	- Coordinated Evaluation (OTRU)	- Coordinated Evaluation (OTRU)

Note. Projects ran through the entire 18-month period except as noted: aOctober 1999 – September 2000, bOctober 2000 – March 2001. *Projects in italics were substantially altered* after the initial 12 months. Community projects include: Action on Tobacco (Simcoe County), Smoke-free Public Places and Workplaces (Peterborough Area), Not to Kids (Toronto), Tobacco-free Zones for Youth (Algoma), Community Programs (Ottawa), Retail Compliance Training Video (Thunder Bay), York Region Chinese Anti-tobacco Campaign (York Region), Breathing Spaces: Community Partners for Smoke-free Homes (Peel/GTA), Community-based Education Campaign on the Health Effects of Second Hand Smoke (Grey-Bruce), Smoke-free Living in Perth County (Perth County), Reducing Exposure to ETS in Hastings and Prince Edward Counties (Hastings and Prince Edward Counties), Smoke-free Public Places Bylaw Implementation (Waterloo Region), Smoke-free Buddies (Kingston), Ontario Smoking Cessation Initiative (Waterloo/Wellington/Dufferin).

Appendix C: Methods

Reporting Period
The reporting period for this Report is April 1, 2000 through March 31, 2001. Exceptions are noted in the main text.

Monitoring Process
This Report, like the six previous ones in this series, is intended to *monitor* progress toward the goals of the Ontario Tobacco Strategy. It is not intended as a formal evaluation of the Strategy. This Report summarizes information that reflects on progress toward Strategy objectives, by describing (a) related *activities*, (b) short-term *impacts* of those activities, and (c) trends in longer-term *outcomes*, such as reduced smoking. A formal evaluation in contrast would *link* Strategy exposure with outcomes and would require a more formal analysis than is possible with this Monitoring Report. For instance, we would want to account for tobacco industry activities, OTS funding, and implementation timeframe in relation to change in knowledge, attitudes, and behaviour. Nevertheless, we believe this year's Report offers some useful insights into the progress of the Ontario Tobacco Strategy.

Both quantitative and qualitative information were used for this Report. Qualitative information appears mainly in Chapter 2 on Agency Activities, and was obtained from partners active in the OTS. Further detail on the methods used to gather information about resource centres and community groups is provided in this Appendix (see Notes to Chapter 2). Quantitative data appear mainly in Chapter 3, and are used to describe trends in short-term impacts (e.g., per-capita sales of manufactured cigarettes) and longer-term outcomes (e.g., youth smoking rates) that should be affected by the Strategy's activities. The survey sources for these data are described in this Appendix (see Notes to Chapter 3).

Notes to Chapter 1

Price Per Carton of 200 Cigarettes in Four Provinces 1990-2001 (Fig.2) was estimated using the following method: The average retail price of cigarettes in each province was calculated using a simple average of the retail prices in select cities, and was deflated by the Consumer Price Index (CPI), all items, 1993=100 (CANSIM, Statistics Canada). Price data by cities from 1990 to 1993 were obtained from the Consumer Prices and Price Indexes (Cat. no. 62-010-XPB), Statistics Canada. Data from 1994 onward were from custom tabulations from Statistics Canada, Price Division. Because federal and provincial budget announcements are typically made in the spring, October prices were used for our calculations, except for 2001 where the most current (April) price was used. Prices are based on observational studies (i.e., actual retail prices in select cities).

Price Per Carton of Cigarettes by Province and U.S. Border States, April 2001 (Figure 3) was provided by the Smoking and Health Action Foundation and was based on tax rates and estimates of product costs provided by Finance Canada. Price estimates from Finance Canada are not based on observation studies. Reported prices have taken into account wholesale price increases in April and November 2000, and a tax increase in April 2001 of $4 per carton in low-tax provinces (NB, PE, NS, ON, and PQ). Finance Canada's estimated product cost does not reflect the diverse selling conditions across the country (e.g., discounting activity that takes place in large urban centres)

As a result, these price data are overestimates. For example, in April 2001, the retail price for a carton of cigarettes was $35.55 in Toronto compared to $36.81 in Thunder Bay and $37.87 in Ottawa (Statistics Canada, Price Division, custom tabulations).

Per Capita (Age 15+) Legal Sales of Cigarettes and Cigarette Equivalents, Selected Provinces 1989-2000 (Figure 4). Data represent tobacco sales reported to Health Canada by Canadian tobacco companies. For 1989-1999, data were obtained from Health Canada's Internet web site (*www.hc-sc.gc.ca/hppb/tobacco/ehd/tobacco/sales.htm).* For 2000, data were obtained from the Non-Smoker's Rights Association, courtesy of Health Canada. For 1989-1999, data represent the 3 largest manufacturers of tobacco products (e.g., Imperial Tobacco Canada Ltd., Rothmans, Benson & Hedges Inc., and JTI-Macdonald Corporation). For 2000, data represent an additional 4 smaller manufacturers (i.e., Grand River, Choice, Bastos, and Tremblay). Because the 3 largest manufacturers have 99% market share, ranking of per-capita sales among provinces is not significantly affected by adding the small firms in 2000.

Sales are calculated as the sum of cigarettes and cigarette equivalents (e.g., fine-cut or "roll-your-own"), the latter converted to cigarette sales using 0.7 grams of fine-cut to 1 cigarette. Per capita consumption was calculated by dividing the total cigarette sales by the population aged 15 and over. Population estimates from July of each year are from Statistics Canada (CANSIM Matrix 6367-6377). Tobacco sold in kits (e.g., PrestoPak) is not included in the fine-cut sales in the year 2000 due to a change in reporting practice. Although kits represents only a small percentage of overall sales, this change needs to be considered when interpreting year 2000 figures relative to previous years.

Cigarette sales are wholesale sales and do not necessarily reflect retail sales to consumers. Because wholesalers might stockpile tobacco (e.g., in anticipation of a tax increase), total consumption in any one period could be overestimated and be followed by an artificial drop in the next reporting period. Interprovincial smuggling between low-tax and high-tax provinces might also lead to an overestimation of consumption in one province relative to the other. In addition, the location of a large distributor in Alberta has inflated the province's sales relative to those in British Columbia and Saskatchewan.

Notes to Chapter 2 (Agencies)

Ontario Tobacco Strategy Partner Agency Questionnaire

The purpose of the questionnaire was to systematically gather information on the tobacco-related activities of OTS partner agencies. This year's questionnaire was initially developed in 1998 with input from the Ministry of Health and COMMIT (an OTS demonstration site, funded by the Ministry's Health Promotion Branch), and minor refinements were made to it over the past two years.

A key senior contact person at each of the 11 agencies surveyed completed the questionnaire in May/June of 2001. The questionnaire was intended to cover the tobacco-related activities, either in progress or complete, that occurred over the reporting period: 1 April 2000 through 31 March 2001. Activities that took place after this period were not included in the present report.

The questionnaire contained five items in total. Question numbers 1-3 asked for summaries of the organization's tobacco-related activities. Several categories were used for the first question:

- information resources
- direct services
- networking and collaborative activities
- policy change initiatives
- other OTS activities

The questionnaire provided an opportunity for each agency to expand upon descriptions of the above categories as they pertained to the agency's tobacco control activities during the reporting period. Other questions asked the respondent to estimate the proportion of effort devoted to each of the OTS objectives of prevention, protection, and cessation for all OTS-related activity in 2000/2001. Another question asked to what extent each of 10 given priority groups were intended to be long-term beneficiaries of the agency's 2000/2001 tobacco reduction activities. A final open-ended question asked the respondent to provide some thoughts on the directions of the agency over the past five years and the intended directions for the agency over the next year and beyond.

When necessary, other sources were consulted in order to gain a fuller understanding of the agency's tobacco-related activities: websites, annual and activity reports, pamphlets, and other contact persons within the organization.

Notes to Chapter 3 (Analyses)

Health Burden

Table 1: Deaths and Potential Years of Life Lost (PYLL) Due to Tobacco Use, Ontario 1997.

The smoking attributable mortality and hospital days were estimated using the following epidemiological Population Attributable Fraction formulas (PAF):

(1) $PAF = (Pn + PxRx + PcRc - 1)/(Pn + PxRx + PcRc)$

where: Pn, Px, and Pc are smoking prevalence of never, former, and current smokers.
Rx and Rc are the risks associated with each smoking related disease of former and current smokers relative to never smokers.

Multiplying the reported number of deaths and hospital days in the specific age/sex category by the above PAFs provided the estimates of the smoking-attributed deaths and hospital days. The product of smoking-caused deaths and the life expectancy from an abridged life table gave the premature deaths or PYLL associated with smoking.

We estimate the smoking prevalence by sex, and by 5-year age groups using the National Population Health Survey 1996/97 Microdata file. (Sample weights were used in all calculations.)

Relative risks of more than 90 smoking related causes of death are from Single et al. (1996).

Death data by ICD-9 codes, sex, and by age group, were obtained from Statistics Canada, Health Indicators (CD-ROM). This CD also provided life expectancy statistics. Data pertaining to hospital

days were drawn from the hospital morbidity database of the Canadian Institute for Health Information, courtesy of the Central East Health Information Partnership.

Estimation of Smoking Behaviours

Sample surveys are designed to provide an estimate of the actual value of a particular characteristic in the population, such as the percentage of Ontario adults who report using cigarettes. All adults in the province are not surveyed, however, so that the true population percentage is unknown and is estimated from the sample. Some sampling error will be associated with this estimate. Confidence intervals provide a range around percentage values that indicate the interval within which the true population percentage lies. In this report, 95% confidence intervals are used. This means there is a 95% chance that the given confidence interval will contain the true value of the quantity being estimated.

Tests of Significance

Formal tests of statistical significance have not always been performed. One should therefore interpret trends that arise from comparisons with caution. Whether estimates that are statistically significant differ from a *practical* standpoint is for the reader to judge.

A Word of Caution

This report groups together current data from various surveys and sources. Direct comparison of results from different surveys may not always be appropriate, as the surveys may have employed different sampling schemes, question wording, and questionnaire formats. In addition, the population of interest and purpose of study can vary between surveys and research organizations. *Please exercise caution when comparing results of different surveys.*

AC Nielsen Tobacco Compliance Survey, 1995-2001

Research teams made up of two Nielsen observers (one a minor, 15 to 17 years of age, and the other an adult over 19 years of age) were sent into a randomly selected sample of retail establishments (N=5,024) in 25 cities and towns across Canada's ten provinces between November 3 2000 and January 16, 2001 (AC Nielsen, 2001). Previous surveys had taken place during the summer months, so this change in timing allowed for comparisons between retailer compliance while school was in session, and while it was not.

The minors in this study attempted to buy a name brand cigarette, but were given clear instructions about how to withdraw from the attempted sale. In no instances was a purchase actually made.

The senior member of the research team was responsible for supervising the younger partner and for carrying out a visual inspection of the retailer's place of business for the purpose of observing and recording compliance with the posting of mandatory signs under the *Tobacco Act* or similar provincial legislation. These individuals were also responsible for collecting information on in-store tobacco advertising and promotions.

The methodology for the most recent 2001 survey is identical to those of the 1998 and 1997 surveys. The methodology of the 1997 survey closely resembles that of the 1996 and 1995 surveys, except for an increase in the proportion of 17-year-old shoppers. It was found in the past that it was easier for older teens to purchase cigarettes. To make the test more difficult, Health Canada requested that the proportion of stores visited by 17-year-olds be increased to 50%, compared to 25% and 19% in 1995

and 1996, respectively. More detail on these surveys can be obtained from the AC Nielsen reports (AC Nielsen, 1995-2001).

Canadian Tobacco Use Monitoring Survey, Health Canada

The Canadian Tobacco Use Monitoring Survey (CTUMS) was administered between February 1 and December 31 2000. The main objective of CTUMS is to track changes in smoking status and amount smoked, especially for populations most at risk, such as 15- to 24-year-olds. The target population was all persons 15 years of age and older living in Canada, excluding residents of the Yukon, Northwest Territories, Nunavut, and full-time residents of institutions. The survey was conducted by telephone using computer-assisted interviewing techniques. Only non-proxy responses with the selected person were accepted.

To ensure that the sample was representative of Canada, each of the 10 provinces was divided into strata or geographic areas, with the exception of Prince Edward Island (one stratum for entire province), and of both Toronto and Montreal, which had three strata each. The sample design was a two-phase stratified random sample of telephone numbers. First, households were selected using random digit dialing. In the second phase, one or two individuals (or none) were selected based on household composition. The two-phase design was utilised in order to over-represent individuals in the 15-24 year age range, a population most at risk. The first wave of CTUMS data was collected in February-June 2000, and the second from July-December 2000. A total of approximately 20,000 people were interviewed, and this represents the second full year of survey data collection for the CTUMS. More detail on this survey can be obtained from Health Canada's CTUMS Fact Sheet Series (Health Canada, 2001).

Centre for Addiction and Mental Health Surveys

Ontario Alcohol and Other Drug Opinion Survey (OADOS), 1992-1995

The Ontario Alcohol and Other Drug Opinion Surveys (OADOS) were conducted yearly from 1992 to 1995 by the Centre (Ialomiteanu & Bondy, 1996). These surveys examined the use of alcohol, tobacco and other drugs as well as attitudes toward tobacco control policies. They involved a telephone interview of a representative sample of Ontario residents, aged 18 and older, living in private residences and speaking either English or French. Some relatively minor variation from year to year occurred in terms of questionnaire content, question wording, and data coding.

The sample sizes for the 1992, 1993, and 1995 surveys were roughly 1,000, while the 1994 sample was approximately 2,000. Response rates were 63%, 65%, 63%, and 63% respectively. More detail on these surveys can be obtained from the OADOS User's Guide (Ialomiteanu & Bondy, 1996).

Centre for Addiction and Mental Health Monitor (CAMH Monitor) 1999-2000 (formerly the Ontario Drug Monitor 1996-1998)

In 1996, the Centre replaced the OADOS series of surveys with the Ontario Drug Monitor (ODM). In 1999, the ODM was renamed the Centre for Addiction and Mental Health Monitor (CAMH Monitor). The CAMH Monitor is an aggregation of independent monthly surveys conducted by the Institute for Social Research at York University. In 2000, 12 independent monthly surveys were conducted (January-December). A final sample of 2,406 respondents participated, representing an effective response rate of 61%.

A two-stage probability design is used. Each month, a sampling frame is obtained of all active area codes and exchanges in Ontario. Within each regional stratum (strata based on telephone exchanges), a random sample of telephone numbers is chosen with equal probability of selection. Within selected households, one respondent aged 18 or older, who can complete the interview in English or French, is selected according to which household member has the most recent birthday. More detail on the CAMH Monitor 2000 and the ODM 1996-1998 can be obtained from the Technical Guides (Adlaf et al., 2000; Adlaf et al., 1999a; Adlaf et al., 1998; Adlaf et al., 1997).

Ontario Student Drug Use Survey 1981-2001

The Centre has conducted the Ontario Student Drug Use Survey every two years since 1977. It is the longest ongoing study of adolescent drug use in Canada. The survey monitors the use of alcohol, tobacco, and other drugs among Ontario students. For each of the 12 surveys, the target population is composed of all students enrolled in the public or Catholic regular school systems. Thus, it excludes those enrolled in private schools, special education classes, those institutionalized for correctional or health reasons, those on Indian reserves and Canadian Forces bases, and those in the far northern regions of Ontario (about 7% of Ontario students).

Each survey is based on a random probability design. The 1977 and 1979 surveys employed different stratification than subsequent years and are therefore excluded from this report. Surveys from 1981 to 1997 had a single-stage sample design (board cluster) stratified by grade (grades 7, 9, 11, and 13) and region (North, West, East, and Toronto), which resulted in the selection of more school boards and schools. In 2001, the OSDUS employed a two-stage (school first, then class clusters) sample design stratified by region (same regions used in previous surveys). The 1999 and 2001 designs differed from earlier surveys in three important ways:

- all students in grades 7 through 13 (OAC) were surveyed
- schools, rather than school boards, were the primary sampling unit
- students in Northern Ontario were oversampled

As in previous surveys, the sampling frame was based on the Ontario Ministry of Education and Training's 1999 MIDENT file, which provided the information on student enrolment figures.

Students from 41 school boards participated in the 1999 survey. In total, data from 106 schools, consisting of 272 classes, comprised the final sample. The overall participation rate of students was 71%, which corresponds to an unweighted sample of 4,211 students (750 in grade 7; 691 in grade 8; 702 in grade 9; 806 in grade 10; 561 in grade 11; 388 in grade 12; and 313 in grade 13). The final sample of 4,211 students represents approximately 916,200 Ontario students in grades 7 through 13. More detail on this survey can be obtained from the report by Adlaf et al. (2001, forthcoming).

Ontario Tobacco Research Unit Surveys

Provincial Survey of Tobacco Use, Knowledge about Health Effects, and Attitudes Toward Tobacco Control Measures, 2000. ("Q2000 Study")

The Q2000 is a population-based telephone survey undertaken in Ontario in 2000 (Northrup, 2001). The adult population aged 18 years and older was sampled using a two-stage probability-based design. The Institute for Social Research at York University conducted the interviews, 1,607 of which were completed (response rate = 60%). The Q2000 examines tobacco use, including smoking cessation, purchasing practices, household smoking, knowledge about the health effects of tobacco, and attitudes

toward tobacco control and the tobacco industry. It builds on and is linked to previous studies of Ontario adults in 1983, 1991, and 1996 by the same investigators, enabling trends to be examined.

Survey of School Smoking Prevention and Cessation Programs
This survey builds on the results of the national Survey of School Smoking Prevention Programs in 1992-93 and the subsequent 1995 survey in Ontario in which both smoking prevention and alcohol use curricula were studied. Information from 168 schools representing 52 school boards was collected on a variety of topics including the priority and goals of tobacco control education, the types of tobacco control programs and materials used and available in Ontario schools, the amount of time devoted to teaching tobacco control education, the availability of training, and obstacles to teaching tobacco control education.

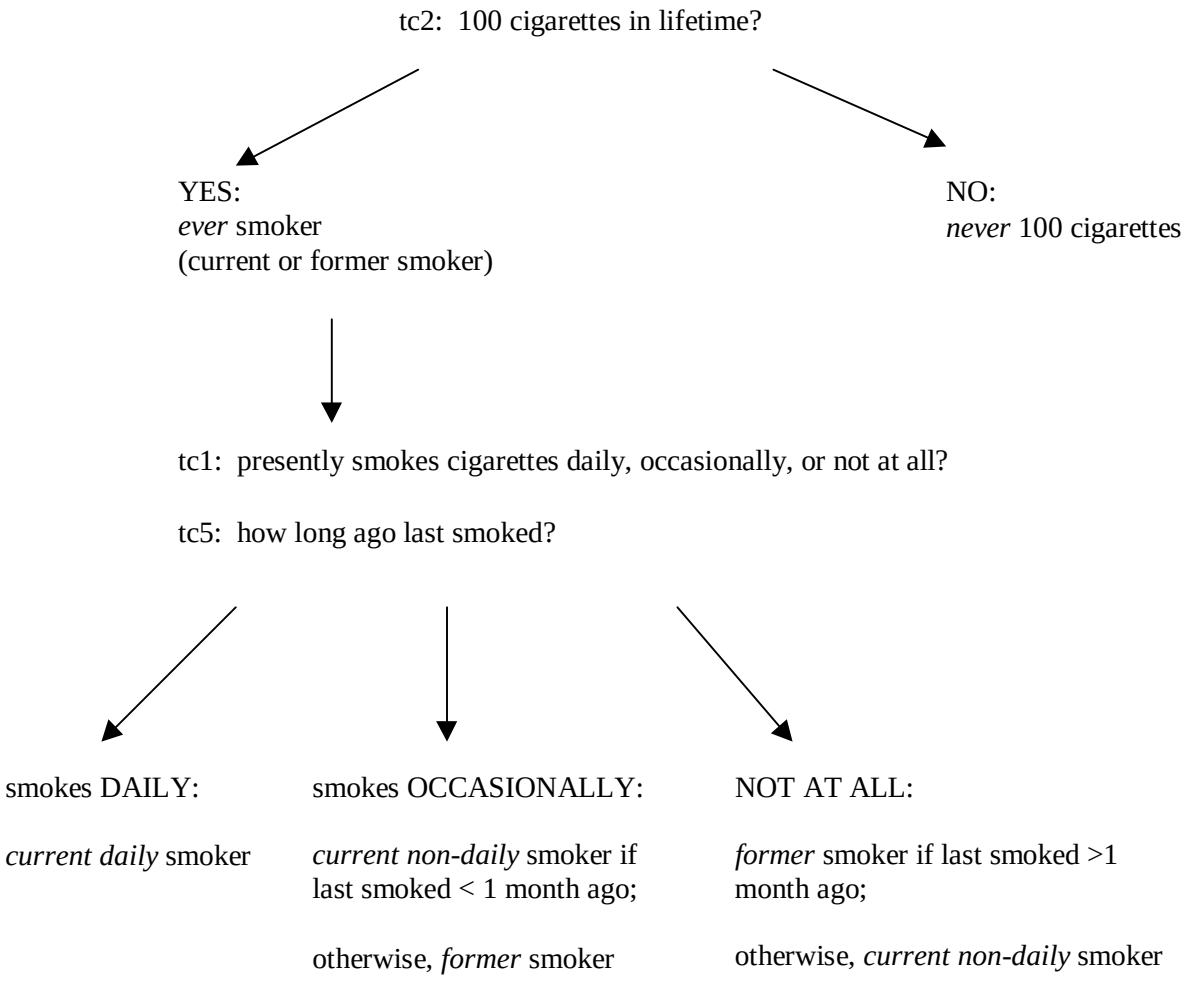
Survey Data Definitions
Smoking Status
Smoking status definitions differ across the various surveys.

CAMH 1999-2000; ODM 1996-1998
Smoking status estimates from the CAMH Monitor 1999-2000 and the ODM were calculated using the flowchart in Fig. 22 (in order to establish a more consistent methodology for deriving the smoking status variable).

OADOS 1992-1995
Current smoker: Answered YES to "At the present time do you smoke cigarettes?", and is understood to include both daily and non-daily smokers. All those who report quitting are included in the category *former smokers*.

OSDUS 1981-2001
Tobacco use (CAMH definition): Use of more than one cigarette in the past 12 months. (In contrast, the definition that Health Canada uses is “More than 100 cigarettes in lifetime and some during the last month.”)

Figure 29. Derivation of Smoking Status, CAMH Monitor



Source: Adlaf, Ialomiteanu, & Paglia (2001).

Appendix D: Deaths Attributable to Tobacco Use

Table D. Deaths Attributable to Tobacco Use, by Sex and Smoking-Caused Disease, Ontario 1997

Year 1997	**Deaths**			**PYLL**		
Diseases	**Males**	**Females**	**Total**	**Males**	**Females**	**Total**
Cancers	3,359	1,655	5,014	50,625	30,672	81,298
Lung Cancer	2,643	1,394	4,037	39,253	26,137	65,390
Oesophageal Cancer	179	49	228	2,945	784	3,729
Bladder Cancer	129	34	163	1,607	458	2,065
Pancreatic Cancer	87	68	154	1,423	1,226	2,649
Lip & Oropharyngeal Cancer	111	43	154	2,015	857	2,872
Renal Cancer	88	30	118	1,424	537	1,961
Laryngeal Cancer	74	11	84	1,153	172	1,325
Stomach Cancer	45	17	62	746	315	1,061
Other Cancers	3	10	13	59	186	245
Heart and Circulatory Disease	2,466	1,426	3,892	38,350	20,310	58,660
Ischaemic Heart Disease	1,513	663	2,176	25,832	9,769	35,602
Stroke	410	367	777	5,680	5,599	11,279
Arterial Disease	361	246	607	4,216	2,732	6,948
Heart Failure, Ill-defined	89	64	153	1,112	726	1,838
Cardiac Dysrhythmias	64	49	113	1,023	717	1,740
Pulmonary Circulatory Disease	29	36	66	486	768	1,254
Respiratory Disease	1,589	1,010	2,599	15,557	12,126	27,684
COPD	1,354	844	2,198	13,319	10,468	23,788
Pneumonia & Influenza	235	167	402	2,238	1,658	3,896
Digestive Disease Ulcers, Crohn's Disease	11	12	22	148	224	373
All Other Conditions	15	10	25	399	200	599
Pediatric Diseases (<1 year) Stillbirths, SIDS, Low Birth Weight	26	21	47	1,959	1,667	3,626
TOTAL	7,492	4,164	11,656	107,482	65,676	173,158
Rate per 100,000 population	135	73	104	1,933	1,149	1,536
As % of all deaths, or all PYLL	18	11	15	17	12	15

Year 1992	**Deaths**			**PYLL**		
	Males	**Females**	**Total**	**Males**	**Females**	**Total**
TOTAL	7,932	3,717	11,649	109,798	61,642	171,440
Rate per 100,000 population	152	69	110	2,103	1,154	1,623
As % of all deaths, or all PYLL	21	11	16			

PYLL = Potential Years of Life Lost. COPD = Chronic Obstructive Pulmonary Disease. SIDS = Sudden Infant Death Syndrome.
Source: Single & Luk (forthcoming) and Xie, Rehm, Single, & Robson (1996).