PROGRESS TOWARD OUR GOALS 1999/2000

SIXTH ANNUAL MONITORING REPORT

MONITORING THE ONTARIO

TOBACCO STRATEGY

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Ontario Tobacco Research Unit

October 2000

Suggested Citation: Ontario Tobacco Research Unit. *Monitoring the Ontario Tobacco Strategy: Progress toward our goals, 1999-2000.* Toronto: Ontario Tobacco Research Unit, 2000.

PREFACE

This Report covers the period April 1999-March 2000 and is the sixth annual OTRU report monitoring the progress of the Ontario Tobacco Strategy. Preparing it is one of the major contributions to the Strategy of the Ontario Tobacco Research Unit.

This Report covers the same ground as last year's Report 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 2. This follows the overview of tobacco control outside Ontario, which provides a context for interpreting progress. Strategy activities are now described in Chapter 3, where we distinguish between (a) resources and infrastructure, and (b) program delivery. This chapter also includes brief mention of the activities under the renewed OTS. However, since many of these activities had been in place for only a few months by the end of the reporting year, they will be covered more fully next year. 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 still not a conclusive evaluation of individual components or of the Strategy as a whole. However, more deliberate evaluation designs are being put in place under the renewed OTS and evidence from them will be included in next year's Monitoring Report.

ACKNOWLEDGEMENTS

OTRU staff who prepared this Report were Nicole de Guia, Katherine Osterlund, and Deanna Cape. They worked under the guidance of OTRU's Monitoring Work Group, chaired by Tom Stephens. Diana Kiesners was responsible for layout and production.

Thanks are due to those who reviewed an earlier version of this Report, and to *Tobacco News Online,* which was the source of much of the background material in Chapter 1.

Notwithstanding these important contributions, the interpretation and opinions expressed in this Report are the responsibility of the Principal Investigators of OTRU:

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EXECUTIVE SUMMARY

This Monitoring Report, the sixth in an annual series, describes progress toward the goals of the Ontario Tobacco Strategy (OTS). While not a formal evaluation, the report provides a context for reviewing the OTS in Chapter 1, provides quantitative data on potential impacts and outcomes in Chapter 2, summarizes the activities of the main OTS players in Chapter 3, and discusses the implications of these findings for reaching the OTS goals in Chapter 4.

Highlights

Highlights from Chapter 1. Context for Tobacco Control in Ontario

Continued Heavy Health Burden of Smoking (Section 1.1)

- Every year in Ontario, tobacco is responsible for almost 12,000 deaths (representing over 171,000 potential years of life lost due to premature deaths), and more than one million hospital days.

Promising Developments in Tobacco Control (Sections 1.2 and 1.3)

- This past year, the Ontario government initiated a major renewal of the Ontario Tobacco Strategy in response to the March 1999 report of the Minister's Expert Panel (Ashley et al., 1999). Funding for the OTS was increased by $4 million in 1999/2000, with a further $6 million to be added in 2000/2001. A total of 15 new projects were announced in January 2000 and an additional 11 in March 2000. Funding beyond March 2001 will be based on interim evaluation reports from the 26 projects.

- Per-capita spending in Ontario on tobacco control in 2000/2001 is projected to be $1.71, an increase from $1.16 in 1999/2000 and from $0.78 in 1998/1999. While this is the highest amount ever for tobacco control in Ontario and higher than any other province in Canada, it is still well below the $8.00 recommended by the Minister's Expert Panel (Ashley et al., 1999) and the U.S. Centers for Disease Control and Prevention (USDHHS, 1998).

- Notable developments at the national level included the launch of a lawsuit against a tobacco company, the introduction of federal regulations regarding health messages and graphics on cigarette packages, the release of findings from a large-scale national survey on tobacco use (CTUMS), the release of 10,000 pages of tobacco industry documents, modest increases in cigarette taxes in several provinces, and the endorsement of a renewed national strategy for tobacco control in Canada.

Cigarettes Continue to be Very Affordable in Ontario (Section 1.4)

- At a cost of $31.68 per carton of 200, cigarettes in Ontario continue to be cheaper than in any other province or bordering U.S. state. Ontario has the lowest tobacco tax in the country, less than half of the national average. If the price per carton in Ontario

were raised to the Canadian weighted average of $36.24, the additional revenue from Ontario tobacco taxes would amount to at least $270 million per year.

Highlights from Chapter 2. Progress toward OTS Objectives

Youth Smoking Still a Cause for Concern
(Section 2.1)

- Student smoking is up significantly since 1991, but may have reached a peak in 1997 for grade 7 students.

- Smoking continues to rise in high school through grade 11, regardless of whether smoking is defined as past-year cigarette use or 100 cigarettes in lifetime and some in past month use. Although Ontario has the second-lowest youth smoking rate in the country for ages 15-19 (25% compared to a national average of 28%), the rate far exceeds the goal for smoking in this age-group set when the OTS was initiated and the extent of smoking is higher than in many of the U.S. states.

- Ontario female youth have one of the lowest rates in the country (22%), whereas Ontario males are about average (27%).

Adult Smoking Slowly Declining
(Section 2.2)

- One quarter (25%) of Ontario adults smoke on a daily or occasional basis (28% of men, 23% of women). Although there has been little change in the prevalence of smoking in Ontario in recent years, there has been a slow decline in the proportion of the population who are daily smokers (from 27% in 1995 to 21% in 1999).

- Substantial differences in smoking rates persist by region in Ontario, ranging from a high of 32% in Southwestern Ontario to a low of 21% in Toronto.

Exposure to Environmental Tobacco Smoke (ETS) Adds to Risk for Some
(Section 2.4)

- One quarter (26%) of all Ontario households reported that at least one person smoked inside the home every day or almost every day. Among households with children under 12, this estimate was a little lower (17%). At a conservative estimate, almost one-fifth of Ontario children under 12 are exposed regularly to ETS in the home.

- Smoking restrictions in the workplace vary markedly by occupation. Eighty-five percent of those in professional/managerial positions have complete smoking bans at work compared to 69% in clerical/sales/service positions and only 50% in trades/farming occupations. This means that workers in blue-collar occupations are at higher risk for regular exposure to ETS.

Public Attitudes Favourable Toward Tobacco Control
(Section 2.5)

- Over three-quarters (77%) of the Ontario adult population supports, *at minimum*, restriction of smoking to enclosed, ventilated rooms in workplaces, with 70% supporting such restrictions in restaurants, and 46% in bars and taverns.

- There is substantial support among the Ontario adult population for a ban on event

sponsorship by tobacco companies (44%) and an increase in cigarette taxes (42%).

Sales to Minors May Be on the Decrease
(Section 2.7)

- There has been a marked decrease in the proportion of retailers in Ontario willing to sell cigarettes to minors, from 38% in 1998 to 21% in 1999. This may be an anomaly, since 1996-1998 data showed a clear increase. Results from next year's compliance check will help determine whether this is a real trend.

Highlights from Chapter 3. Activities of Strategy Partners

- The focus of most agencies continued to be on smoking prevention and protection from ETS, followed by smoking cessation.

- In addition to their ongoing activities, OTS partners initiated 26 new projects during the year, with new funds provided under the renewed OTS. Fourteen of these are province-wide in scope and 12 are specific to local communities. OTRU is coordinating an evaluation of the new projects and has developed a plan to evaluate the Strategy overall.

- Public health units continued to play an active role in tobacco control. Almost all provided smoking-cessation programs in the community, and all 37 provided information to the public on the hazards of ETS.

Implications

Implications for the OTS as a Whole

- Increasing cigarette prices in Ontario would provide a major boost to the effectiveness of the OTS on a number of fronts. This measure has been used effectively in Massachusetts, California and elsewhere to discourage youth from starting to smoke and to encourage established smokers to cut back on consumption. Increased prices would also indirectly contribute to the protection of non-smokers against ETS, as the overall consumption of cigarettes falls. Support for this tobacco control measure has been shown by the federal government in its increase in excise taxes in Ontario, Quebec, Nova Scotia, and New Brunswick in November 1999, and by the provincial government of Ontario in its matching of this increase.
- A $5 increase per carton would put Ontario's cigarette prices only at the Canadian average.

- Despite recent increases, Ontario's tobacco control expenditure of $1.16 per capita falls well short of the $8.00 per capita estimate recommended by the Minister's Expert Panel and the U.S. Centers for Disease Control. Meeting the CDC recommendation could be easily afforded with only a portion of the $270 million annually that would be generated in Ontario if cigarette prices were raised to the national average.

- Uniform and effective protection against ETS exposure in the workplace will not only help to ensure a safe working environment for all Ontario workers, but it will indirectly support workers who are trying to quit and may also help youth not take up smoking as they leave school and enter the workforce for the first time.

- A multi-year plan for tobacco control is required in order to provide the stable and sustained program efforts found to be successful in California, Massachusetts, and elsewhere.

Implications for Prevention

- Effective school-based prevention programs must be in place to address the continuous rise in smoking that occurs in high school through to grade 11. Projects under the renewed OTS that are important in this regard are the revised *Lungs Are for Life* curriculum and the activities of the province's 37 public health units described in Section 3.3.1.

- Better compliance with laws restricting sales to minors is likely to be encouraged by retailer education and more effective enforcement. New OTS projects relevant to education are underway in Toronto and Thunder Bay, while retailers are being supplied with new signs and enforcement guidelines are being developed.

- Even the best programs for youth are not likely to be very effective in the absence of policy changes. In particular, raising the low price of cigarettes must be the first priority in preventing tobacco smoking among youth.

- Further, restrictions on smoking at home (and at work) have been shown to be an effective preventive measure.

Implications for Protection

- Since exposure to environmental tobacco smoke at home continues to be widespread in Ontario, protective measures for children and adult non-smokers in those homes are called for. OTS-related projects that educate Ontarians about the dangers of ETS include the media campaign of the Heart and Stroke Foundation and the activities of public health units; other activities are directed at specific target groups such as pregnant women and new parents. Restricting smoking at home helps reduce teen smoking by providing a positive role model.

- Blue-collar, service and clerical workers face fewer restrictions on smoking at work than those in professional or managerial occupations. This increases their risk of developing smoking-caused disease. Province-wide legislation regarding smoking bans in all enclosed worksites, as called for by the Minister's Expert Panel,

may be the only effective solution to this disparity. In addition to protecting workers from ETS, such restrictions would also indirectly encourage smokers to quit and provide a health-promoting environment for youth who are entering the workforce for the first time.

Implications for Cessation

- Since sharp regional disparities in smoking remain, province-wide policy measures for smoking cessation may be needed. Two such measures are a price increase through taxation and effective restrictions on smoking in workplaces and public places.
- Although cessation has not been a continuing focus of many partner agencies, it does figure strongly in the renewed OTS at both the provincial level and in specific communities. Of particular note at the provincial level are the efforts to provide more effective cessation counselling through the offices of health professionals and directly through a Smokers' Helpline. However, continued funding is needed for these and related community-specific projects by the public health units and other players to help them meet their full potential.

Implications for Denormalization

- Given the relentless and innovative marketing of cigarettes by the tobacco industry and their continuing legal challenges to governments, there must be an equally persistent campaign to educate the public about the unethical and dishonest activities of the tobacco industry and about the need for a comprehensive tobacco control program.
- The ever-increasing availability of tobacco industry documents that shed light on their activities and newly accessible databases of tobacco counter-measures are potentially important tools in the overall strategy in Ontario. The renewed national strategy provides a supportive context.

Implications for Monitoring, Evaluation and Research

- With the renewal of the OTS, there has been an increased spending of public funds, as well as a heightened profile, for tobacco-control efforts. It has enabled not only the continued and enhanced monitoring of the OTS, but also more focused and rigorous evaluation of OTS projects. OTRU is now preparing for long-term evaluation of the OTS.
- A plan for ongoing evaluation that builds on current surveillance activities is needed to guide the OTS in its selection of activities.

CHAPTER 1. CONTEXT FOR TOBACCO CONTROL IN ONTARIO

This chapter highlights tobacco control developments in 1999/2000 from a provincial, national, and international perspective, and describes recent developments in the tobacco industry in Canada. It also provides background information on the health burden of smoking in Ontario.

Within this chapter the following issues are explored:

1.1 Health Burden of Smoking

- Latest estimates show that each year more than 11,600 Ontarians die from tobacco use. Tobacco use also accounts for over 171,000 potential years of life lost (PYLL) and more than one million hospital days in Ontario.
- Although these estimates are for 1992 (and are being updated), the current situation is unlikely to be any better. The overall smoking rate has changed little since 1992 (Fig. 13), while the overall population has grown.
- At the national level, annual tobacco-related deaths grew by 4% between 1991/1992 and 1995/1996 (from 33,498 to 34,728 (Single et al, 1999; Single et al, 2000).

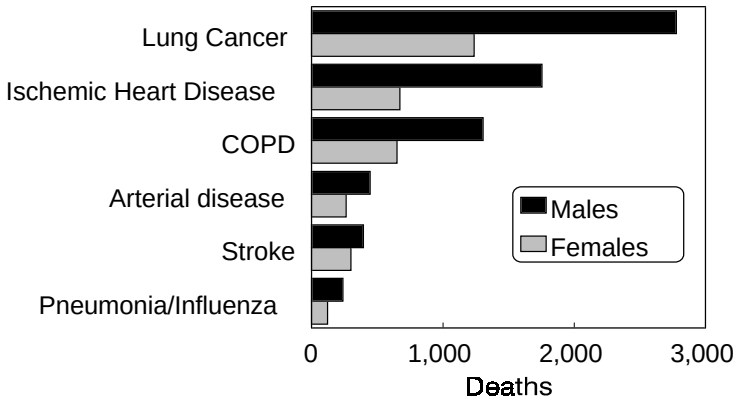
Table A: Deaths, Potential Years of Life Lost (PYLL), and Hospital Days Due to Tobacco Use, *Ontario 1992*

	Males			Females			Total		
	Deaths	PYLL	Hosp days	Deaths	PYLL	Hosp days	Deaths	PYLL	Hosp days
All Ages	7,932	109,798	596,414	3,717	61,642	412,323	11,649	171,440	1,008,737
0-19	40	2,973	4,728	32	2,565	4,792	72	5,538	9,520
20-44	202	7,752	29,730	93	4,248	35,698	295	12,000	65,428
45-64	2,249	48,143	171,506	909	24,000	88,412	3,158	72,141	259,918
65+	5,441	50,930	390,450	2,683	30,829	283,421	8,124	81,759	673,871

Source: Xie et al., 1996

- Major causes of tobacco-related deaths in Ontario are lung cancer, ischemic heart disease, chronic obstructive pulmonary disease (COPD), arterial disease, and stroke (see also Table 4-1, Appendix 4).
- In Ontario, twice as many men die from tobacco use as women. This gap is expected to narrow in the future, reflecting the historically converging trends in smoking between men and women (Section 2.2).

Fig. 1: Deaths Attributable to Tobacco Use, by Sex and Major Smoking-Caused Disease Type, Ontario 1992



Source: Xie et al., 1996
Note: COPD=Chronic Obstructive Pulmonary Disease

1.2 Ontario Government Activities

This section reports only on the activities of the provincial government. Since many important tobacco-control activities are actually conducted by various partners throughout the province and the federal government, a full appreciation of tobacco control in Ontario requires reading Chapter 3 and Appendix 3, as well as this brief section. Also highly relevant is Section 1.4 on the price of cigarettes — a joint federal-provincial responsibility in Canada.

In 1999/2000, the Ontario government initiated a major renewal of the Ontario Tobacco Strategy (OTS), in response to the February 1999 report of the Minister's Expert Panel (Ashley et al., 1999). The Ministry of Health and Long-Term Care added staff and a senior advisor, and funding for the OTS was increased by $4 million in 1999/2000, with a further $6 million to be added in 2000/2001. A total of 15 new projects were announced in January 2000 and an additional 11 were funded in February 2000, most with an approximate duration of 12 months. Funding beyond March 2001 will be based on interim evaluation reports from the 26 projects. Some of these projects are identified in Chapter 3 and Appendix 3. Next year's *Monitoring Report* will consider them in greater detail.

Recent funding for tobacco control in Ontario has increased as follows:

	$M	$ per capita
1998/1999:	9.0	0.78
1999/2000:	13.3	1.16
2000/2001:	19.7	1.71

The anticipated increase in 2000/2001 to at least $1.71 per capita is the highest amount ever in Ontario. It will also be the highest in Canada, unless British Columbia increases its expenditures from $1.61 per capita in 1999/2000 (Biener et al., 2000).

While the increase is commendable, even the highest amount falls short of the $8.00 recommended by the Minister's Expert Panel and the U.S. Centers for Disease Control as needed for an effective response to this major public-health scourge (Ashley et al., 1999; USDHHS, 1998).

1.3 Federal and National Developments

In May 1999, Health Canada announced the creation of an **Expert Committee on Nicotine and Tobacco Science** chaired by Dr. William Rickert. The purpose of this committee is to develop more effective ways to regulate tobacco products and evaluate smoking cessation aids.

In June 1999, Health Canada launched the **Tobacco Law Compendium** (TLC) — an internet-based database developed by the University of Ottawa's Faculty of Law, with funding from Health Canada. The TLC contains searchable summaries of Canadian cases, legislation and regulations concerning tobacco (including municipal by-laws) and access to legal literature (www.tobaccolaw.org).

In August 1999, a **new Bureau of Tobacco Control** was created in Health Canada. This Bureau integrated, for the first time, tobacco policy, research, regulation, compliance monitoring and public education functions into one unit (www.hc-sc.gc.ca/hppb/tobacco/).

In September 1999, Canada's Ministers of Health endorsed ***New Directions for Tobacco Control in Canada***, a renewed national strategy for tobacco control in Canada. This strategy sets the overall framework within which

governments and non-government organizations will take action individually and jointly in the area of tobacco control. The strategy builds on the longstanding goals of prevention, cessation and protection, with the addition of denormalization as a program goal.

In November 1999, Health Canada released approximately 10,000 pages of **tobacco industry documents** obtained by government officials during their May 1999 trip to the Guildford Depository in Guildford, England. The documents profile the marketing and promotional strategies used by tobacco companies and shed new light on the extent of the tobacco industry's scientific knowledge about the health consequences of tobacco use and the addictive nature of cigarettes. These documents were made available on the website of the National Clearinghouse on Tobacco and Health (www.cctc.ca/ncth/) and on CD by Physicians for a Smoke-free Canada. Health Canada will also release documents from a second trip to Guildford.

In November 1999, the federal government **increased excise taxes** by $0.60 per carton of 200 cigarettes for retail sale in the five provinces that cut their tobacco taxes in February 1994 — Ontario, Quebec, Nova Scotia, New Brunswick, and Prince Edward Island. These increases were matched by the provinces (see Section 1.4). The total price increase that resulted was approximately 4%.

In December 1999, Ottawa **filed a suit** in Syracuse, NY, claiming the RJ Reynolds Tobacco Company had defrauded the federal government of $1 billion from 1991 to 1996 by aiding and abetting the smuggling of cigarettes, primarily through the Akwesasne Indian Reserve. The government is also suing the Canadian Tobacco Manufacturers Council, claiming it was part of the conspiracy to cover up RJR-Macdonald's scheme to supply smugglers. **Jeffrey Wigand**, a former Brown and Williamson Vice-President and Head of Research, was appointed Special Advisor on these matters to Federal Health Minister Allan Rock and to Health Canada in December 1999. RJR filed a countersuit in U.S. Federal court to dismiss the Canadian government's lawsuit. (As of August 2000, this countersuit has been successful; the federal government is planning to appeal the verdict.)

In January 2000, Health Canada announced a proposal to introduce **regulations** to require tobacco manufacturers **to display health messages and graphics**, as well as information about diseases caused by smoking and how to quit smoking, on all tobacco product packaging. These regulations were passed by the House of Commons in June 2000 to come into effect December 23, 2000. The new health messages will occupy 50% of the front panel of cigarette packages, while smoking cessation and disease information will appear elsewhere on the package or as a package insert. Health Minister Alan Rock also announced the intention to require tobacco manufacturers to provide detailed information on the contents of tobacco products and on their research, marketing, sales, promotional and sponsorship activities (a suit brought by the tobacco industry to nullify this legislation was recently dismissed by the Quebec Superior Court).

In January 2000, Health Canada released the first results from the **Canadian Tobacco Use Monitoring Survey (CTUMS)**. CTUMS is a large-scale national survey designed to provide reliable, ongoing, consistent and detailed information on trends in tobacco use and the knowledge and attitudes of Canadians about smoking (Fig. 4-6, 31-32) (www.hc-sc.gc.ca/hpb/lcdc/bc/ctums/).

1.4 Price of Cigarettes, 1990/2000

The retail price of cigarettes, which is a major element in tobacco control, consists of several components. As of June 2000, when a carton of 200 cigarettes cost an average of $31.68 in Ontario, the price breakdown of components was as follows (Table B):

Table B: Cost Components of a Carton of 200 Cigarettes in Ontario, June 2000

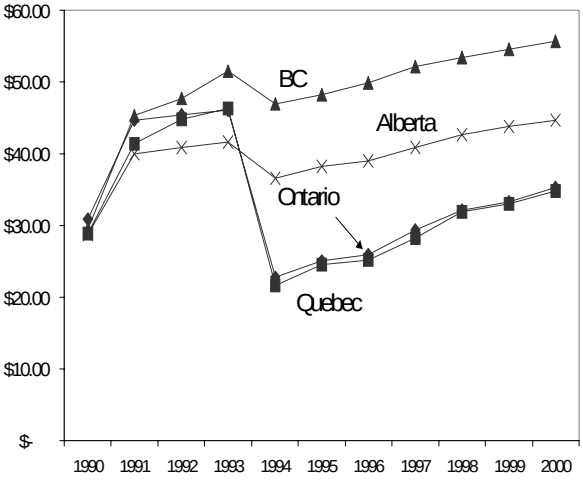
		% of Total
Manufacturer's cost (approx)	$10.30	33%
Federal excise tax	$ 3.25	10%
Federal excise duty	$ 5.50	17%
Provincial tobacco tax	$ 5.30	17%
Retailer and wholesaler markup	$ 3.20	10%
Provincial sales tax	$ 2.20	7%
Federal GST	$ 1.93	6%
TOTAL COST PER CARTON	$31.68	

Source: Finance Canada estimates

The price of cigarettes in Canada varies significantly across provinces. Though some of this difference can be accounted for by wholesale/retail margins, by far the largest difference is attributable to varying tax levels. Among the four largest provinces, since 1994 prices have been consistently lower in Ontario and Quebec than in BC and Alberta (Fig. 2).

In February 1994, the federal, Quebec and Ontario governments reduced tobacco taxes in response to the smuggling of tobacco products. The federal excise duty was reduced by $5 per carton across Canada, and by an additional $5 for each $5 reduction in provincial tobacco excise taxes. New Brunswick, Nova Scotia, and PEI followed suit.

Fig. 2: Cigarette Prices* in Four Canadian Provinces, Price per Carton of 200, 1990-2000



Source: Statistics Canada Prices Division, custom tabulations based on city averages (see Appendix 2.3).
* in 1993 $Can.

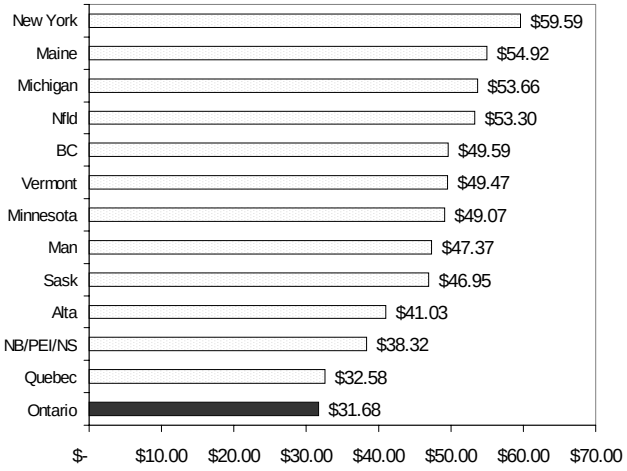
Table C: Provincial Tobacco & Sales Taxes on Carton of 200 Cigarettes, Feb. 2000

	Prov. Tobacco Taxes (PTT)	Prov. Sales Tax (PST)	Total Prov. Taxes (PTT+PST)
ON	$ 5.30	$2.20	$7.50
QC	$ 8.60	0	$8.60
NB	$ 8.30	$2.59	$10.89
NS	$ 9.64	$2.71	$12.35
PEI	$ 13.25	0	$13.25
AB	$ 14.00	0	$14.00
MB	$ 17.20	$2.91	$20.11
SK	$ 17.20	$2.49	$19.69
BC	$ 22.00	0	$22.00
NF	$ 22.00	$3.71	$25.71

Source: Finance Canada estimates

As Ontario levies lower taxes on cigarettes than any other province (see Table C), cigarettes in Ontario continue to be cheaper than in any other province or bordering U.S. state (Fig. 3).

Fig. 3: Average Prices of Cigarettes in Canadian Provinces and U.S. Border States, Per Carton of 200 ($CDN), Aug. 2000



Source: Smoking and Health Action Foundation, August 1st, 2000 (see Appendix 2.3).

This tax differential persists despite the tax increase announced in November 1999. It must be stressed that the price of cigarettes can be an even more effective deterrent to smoking than health education expenditures or bylaws restricting public smoking (Stephens et al., 1999).

If the price of a carton of cigarettes in Ontario were raised to the Canadian weighted average of $36.24 (CANSIM, April 2000), the additional annual revenue from Ontario smokers would amount to at least **$270 million**.[a] This calculation is based only on daily smokers, who make up 84% of all adult smokers in this province (Section 2.2). More detail on this calculation is available in Appendix 2, Section 3.

1.5 Significant Developments in Other Provinces

In 1997, **British Columbia** enacted the *Tobacco Damages and Health Care Costs Recovery Act*, aimed at recovering tobacco-related health-care costs from tobacco companies. In February 2000 the B.C. Supreme Court struck down this legislation, deeming it unconstitutional because the Act, as worded, was outside the province's jurisdiction. However, the court ruled that the province did have the right to recover costs from tobacco companies and that a claim could be pursued. British Columbia has since introduced new legislation to renew its legal battle against tobacco companies. **Quebec, Newfoundland, and New Brunswick** are considering legislation modeled after that in B.C. The province of **Manitoba** plans court action.

In **British Columbia**, a province-wide regulation banning smoking in all work places (including all restaurants, bars and taverns) came into effect on January 1st, 2000. However, court action struck down this Workers' Compensation Board regulation. At press time, revised regulations were under consideration.

In **Alberta,** the Pharmaceutical Association issued a statement that selling tobacco products conflicts with regulations of the Pharmaceutical Profession Act, which says pharmacists cannot sell "objectionable or unworthy products." This was presented to a government committee in February 2000.

[a] Annual consumption of cartons by Ontario's adult daily smokers multiplied by difference in carton price between Ontario and Canadian average.

1.6 Significant Developments in Other Countries

In March 2000, the **United States** Supreme Court ruled that the Food and Drug Administration does not have the authority to regulate tobacco. In response, President Clinton urged Congress to give the FDA this authority. A consequence of the Supreme Court ruling was the termination of a three-year-old federal program conducting random checks to determine if retailers are selling tobacco products to minors.

A bill before the U.S. Congress will require tobacco companies to list ingredients, including carcinogens, on larger cigarette pack warning labels. These labels would take up one-third of the front and rear panels of cigarette packages. Philip Morris Companies Inc. said it would be open to some government regulations on tobacco, such as selling to youth, developing safer products and revealing ingredients.

Hundreds of bills have been introduced in U.S. state legislatures in 1999 and 2000 aimed at determining how to spend $US 246 billion from the states' settlement with the tobacco industry. Many of these measures would allocate funds to address health-care issues, while only fractions are earmarked for tobacco prevention efforts. Although 44 states had passed or were considering legislation to use the settlement to prevent or reduce smoking by children, only eight states have committed to providing enough funding for comprehensive tobacco prevention and cessation programs, as defined by the guidelines issued by the Centers for Disease Control and Prevention.

New York State, in December 1999, announced that it will double the tax on cigarettes, which will raise the cost to more than $US 4.00 per pack to help pay for health insurance for nearly one million uninsured New Yorkers. This tax would be $1.11 per pack, the highest in the country.

The **British** government, in December 1999, won a legal battle to end tobacco advertising ahead of the 2001 **European Union** deadline, but was prevented from instituting the ban immediately. As part of government efforts to stem the flow of contraband into Britain, anyone caught smuggling alcohol or tobacco into the country will immediately have his or her vehicle impounded and sold.

The **Netherlands** are considering suing for damages from the country's tobacco industry for smoking-related health costs.

The **Australian** federal government is considering ending research and development concessions for the tobacco industry.

In **New Zealand** the government considered changing the law so that it could sue tobacco firms. It also considered forcing tobacco companies to label their products with the additives they put in cigarettes.

In March 2000, the **World Health Organization** called for public hearings on issues surrounding the *Framework Convention on Tobacco Control (FCTC)* and invited interested parties, including the tobacco industry, to submit written comments and testimonies. The hearings will give the public health community, the tobacco industry, and farmers an opportunity to make their case before the public.

1.7 Tobacco Industry Activities

In 1999/2000, there were widespread and often successful efforts by the tobacco industry to use the courts to forestall tobacco-control efforts by governments. This included legal challenges in

British Columbia (Section 1.5) and the United States, federally (Section 1.6) and at the state level.

Anticipating that a Florida jury would hand down a large punitive damage award, tobacco companies lobbied state governments to pass legislation to protect industry assets. Georgia, Kentucky, Virginia and North Carolina have passed or are being urged to pass bills that would lessen the financial obligation of the tobacco industry during the appeal process.

Philip Morris Companies Inc. and **RJR Tobacco Holdings Inc.** must pay $1.72 million in damages to a California ex-smoker and her family. This is the first time RJR has been told to pay for smoking-related illnesses.

In February 2000, **British American Tobacco** agreed to sell its 71% stake in Toronto-based Rothman's Inc. for $314.3 million. This divestiture was required after BAT took over IMASCO for $10.6 billion.

CHAPTER 2. PROGRESS TOWARD OTS OBJECTIVES

This chapter provides a description of some short-term impacts and longer-term outcomes of tobacco control activities in Ontario.

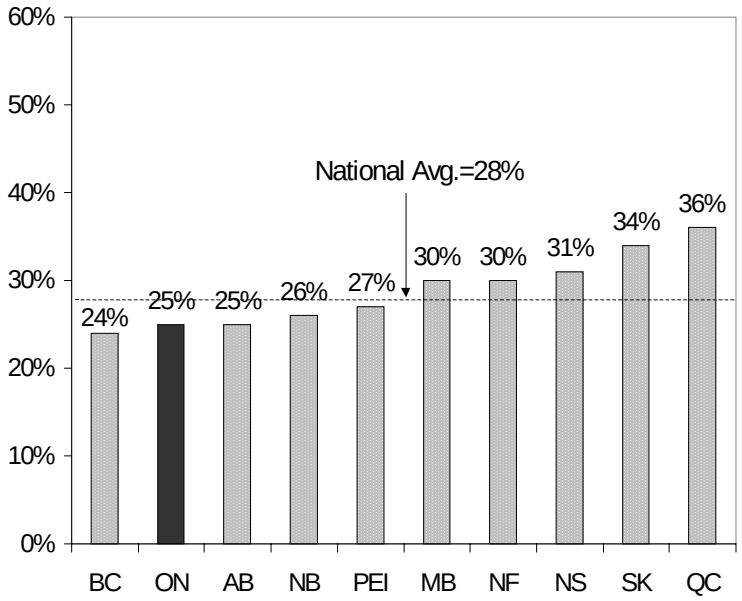
To establish a causal relation between tobacco control activities and outcomes, a much more complex research design would be required – one that relates program exposure to program outcomes and which accounts for tobacco industry promotion and the normal delays encountered in any comprehensive program directed at deeply ingrained public and private behaviour. Nonetheless, this monitoring report does provide a description of the tobacco-control situation within Ontario, which should lead to increased awareness of progress and opportunities for enhancing the Ontario Tobacco Strategy.

In this chapter:

2.1 Youth Smoking: Prevalence

- There are marked differences across the provinces in smoking among youth aged 15-19. Quebec has the highest rate (36%) while British Columbia has the lowest (24%). Ontario is ranked second lowest (25%).
- Analysis of smoking rates by sex shows that Ontario females have one of the lowest rates in the country (22%) whereas Ontario males are about average (27%) (data not shown).
- Analysis of smoking by age group shows that Ontario ranks second-lowest in the country for both youth aged 15-17 (20%) and youth aged 18-19 (32%).

Fig. 4: Current Smoking, by Province, Age 15-19, Canada 1999



Source: CTUMS (Feb.-June 1999) (Health Canada, 2000)

The Canadian Tobacco Use Monitoring Survey (CTUMS)

Launched in 1999, Health Canada's CTUMS is a new *national* data collection vehicle that was developed mainly to track changes in smoking status and amount smoked, especially for populations most at risk, such as 15- to 24-year-olds. It is an important data source for youth smoking because it covers non-student youth, a hard-to-reach population (see Appendix 2 for more information on CTUMS).

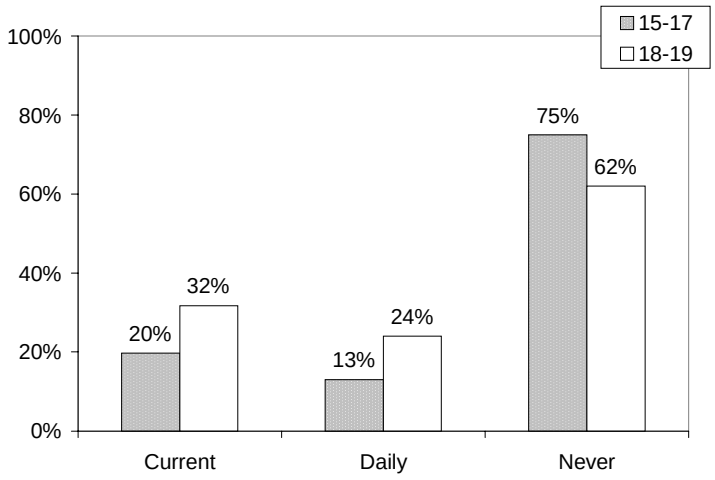
Half of the annual sample of 20,000 persons is allocated to persons ages 15-24, and this sample is divided equally among the provinces. CTUMS is only the second survey in Canada to be so intensively devoted to youth tobacco use (after the 1994 Youth Tobacco Survey), and its topic coverage is broad: use of cigarettes and other forms of tobacco, age of initiation, access to cigarettes, cessation, use of cessation aids, readiness to quit, environmental tobacco smoke (ETS) exposure, restrictions on smoking at home, attitudes toward tobacco-control policies, beliefs about "light" cigarettes, and awareness of tobacco industry sponsorship activity. Not all of these topics appear in this report, as some were asked only in the second wave, which took place from July through December of the survey's first year. These topics will be reported in next year's *Monitoring Report*.

Figures 4-6 provide data for youth ages 15-19 from Wave 1 of CTUMS (Feb.-June 1999). The definition of current smoking used here is that used in the Survey of Smoking in Canada in 1995; that is, current smokers are those who report smoking daily or occasionally.

2.1 Youth Smoking: Prevalence

- There is a marked difference in the prevalence of smoking and amount smoked between ages 15-17 and 18-19.
- Daily smoking rates are much higher for youth aged 18-19 (24%) compared to those aged 15-17 (13%).
- The proportion of former smokers is 6% or fewer in these age groups (data not shown).
- On average, youth aged 18-19 smoked 16.1 cigarettes per day compared to 12.3 cigarettes for those aged 15-17 (data not shown).

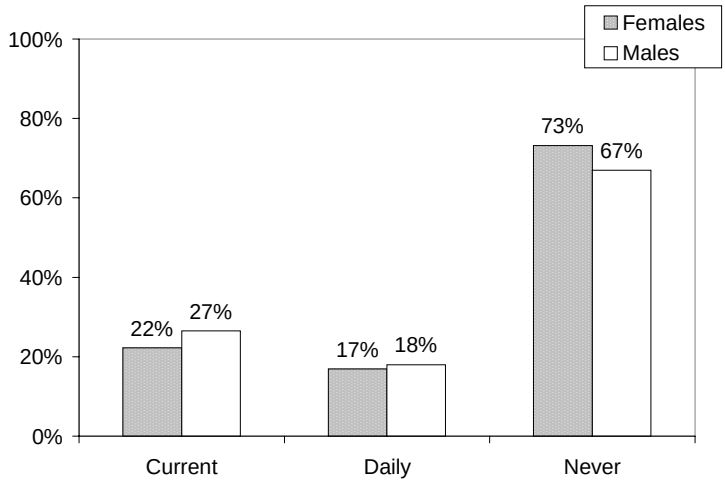
Fig. 5: Smoking Status of Youth, by Age Group, Ontario 1999



Source: CTUMS (Feb.-June 1999), custom tabulations

- Daily smoking rates among youth aged 15-19 are about the same for males (18%) and females (17%).
- The proportion of former smokers is 6% or fewer among both sexes (data not shown).
- Female daily smokers smoked, on average, 15.0 cigarettes per day compared to 13.9 for males (data not shown).

Fig. 6: Smoking Status of Youth, by Sex, Age 15-19, Ontario 1999

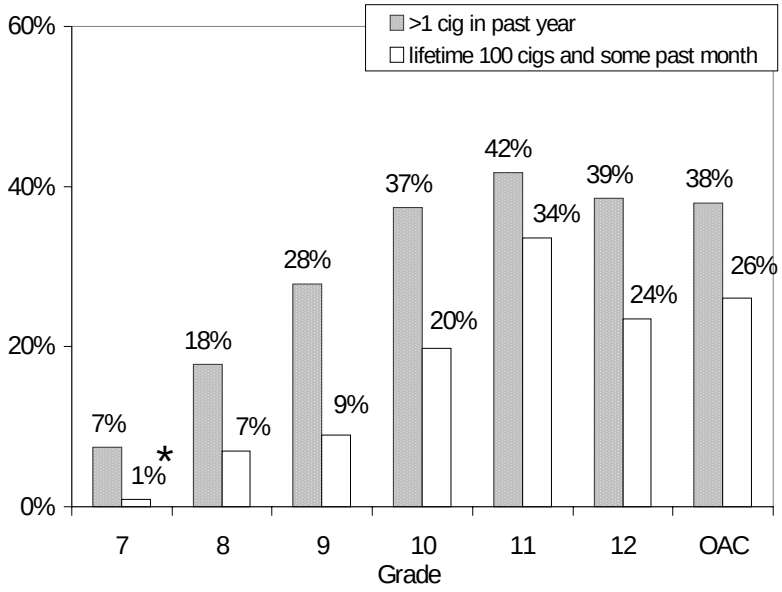


Source: CTUMS (Feb.-June 1999), custom tabulations

2.1 Youth (Student) Smoking: Prevalence

- Smoking rates among student youth are highest in grade 11, regardless of whether smoking is defined as *past year cigarette use* or *past month-100 cigarettes lifetime use*.
- Smoking *increases* significantly from grades 7 to OAC and from grades 9 to OAC when defined as past year use and past month-100 cigarettes lifetime use, respectively.
- Past year smoking rates are always higher than those of past month-100 cigarettes lifetime, as the former also includes recent quitters, beginners, and those who smoked >1 month ago.

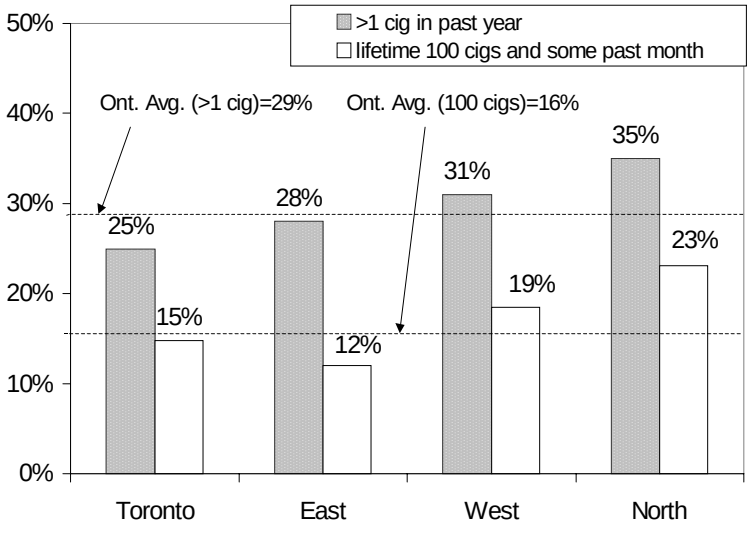
Fig. 7: Student Smoking Using Two Definitions, by Grade, Ontario 1999



*Small cell size: interpret data with caution.
Source: Ontario Student Drug Use Survey, CAMH

- Smoking rates among students are highest in Northern Ontario, regardless of how smoking is defined.
- Rates do not differ significantly by region when based on the past year definition of current smoker.
- Rates in Eastern Ontario are significantly lower than Northern Ontario when based on the past month-100 cigarettes lifetime use definition.
- Due to limited sample size the seven official provincial Health Planning Regions (see Table 2-1) have been collapsed into four broad regions.

Fig. 8: Student Smoking Using Two Definitions, by Region, Grades 7-13, Ontario 1999

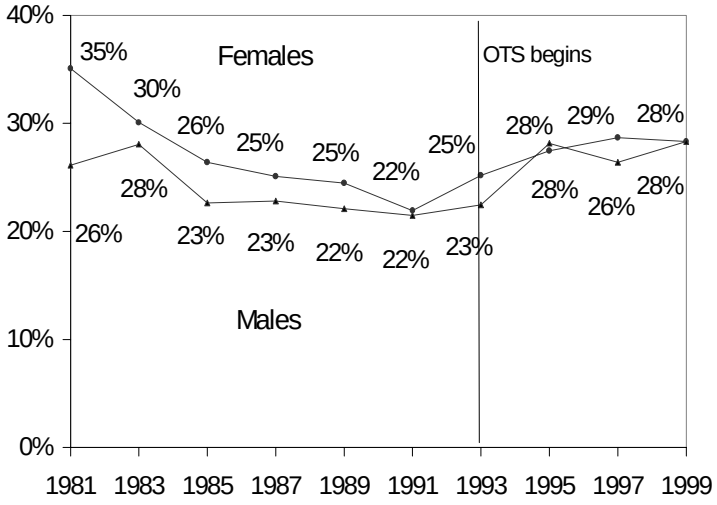


Source: Ontario Student Drug Use Survey, CAMH

2.1 Youth (Student) Smoking: Prevalence

- In 1999, 28% (±3.8) of Ontario students in Grades 7, 9, 11 and 13 reported smoking more than one cigarette in the past year.
- The annual prevalence of smoking *decreased* significantly from 1981 to 1991 and *increased* significantly from 1991 to 1999 (Table 4-2, Appendix 4).
- Most of the 1991-1999 increase occurred before 1995; between 1991 and 1994, the availability of cheap cigarettes increased, first from smuggling and then, in 1994, from a substantial tax decrease.
- There has been no significant sex difference in smoking prevalence since 1981. In three of the past five survey years, rates for young males and females were identical.

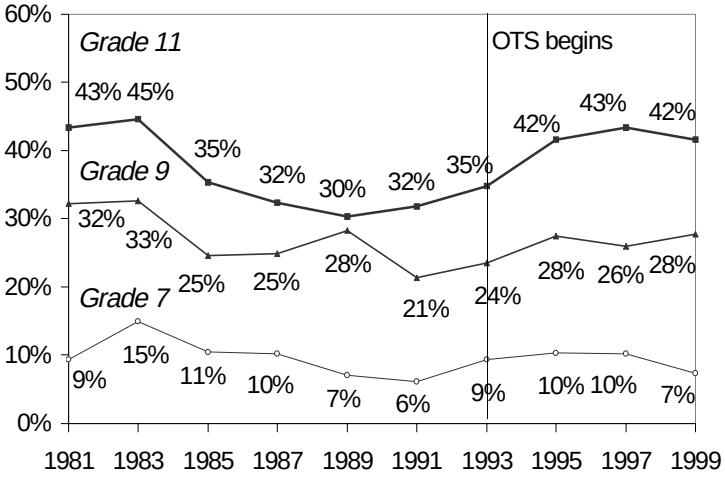
Fig. 9: Students Using More Than One Cigarette in Past Year, by Sex, Grades 7, 9, 11, 13, Ontario 1981-1999



Source: Ontario Student Drug Use Survey, CAMH

- Cigarette use in the past year *decreased* significantly in all grades from 1981 to 1991, but in 1999 was similar to levels in the early 1980s.
- Increases have occurred since 1991 in grades 9 and 11, but use among grade 7 students may be starting to decline. Continued monitoring will establish whether this trend continues in the next survey in 2001. In 1999, rates of smoking were similar to those in the early 1980s.

Fig. 10: Students Using More Than One Cigarette in Past Year, by Grade, Ontario 1981-1999

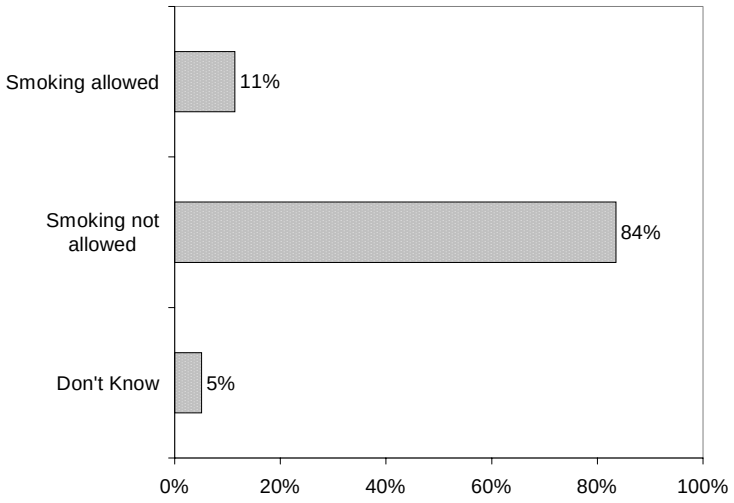


Source: Ontario Student Drug Use Survey, CAMH

2.1 Youth (Student) Smoking: Smoking on School Property

- A large majority (84%) of Ontario students are aware that smoking is not allowed on school property, but 16% are uninformed or misinformed, the latter perhaps due to a lack of enforcement of smoking bans.
- Smokers are slightly more aware than non-smokers of the smoking ban on school property; there are no differences by sex (data not shown).
- At least 85% of students in grades 7-8 and 11-13 are aware that smoking is not allowed on school property; however, fewer than 75% of students in grades 9 and 10 are aware of this fact (data not shown).

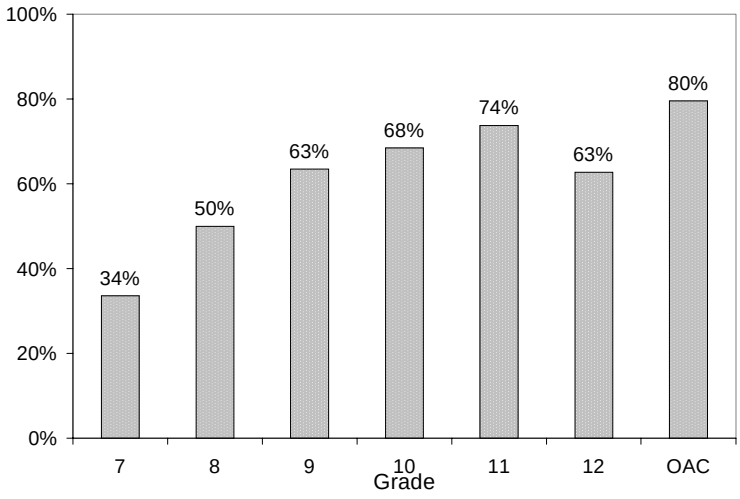
Fig. 11: Students' Perceptions Regarding Smoking on School Property, Grades 7-13, Ontario 1999



Source: Ontario Student Drug Use Survey, CAMH

- Two-thirds of youth smokers report usually leaving school property to smoke during school hours (the remaining third, however, may not necessarily smoke during school hours, as a smoker is defined here as having more than one cigarette in the past 12 months).
- With the exception of grade 12, there is a clear increase from grade 7 to OAC in the proportion of smokers who usually leave school property to smoke.
- An OTRU/York University Study in mid-2000 will shed more light on the school smoking ban and its impact.

Fig. 12: Youth Smokers Who Usually Leave School Property to Smoke, by Grade, Ontario 1999

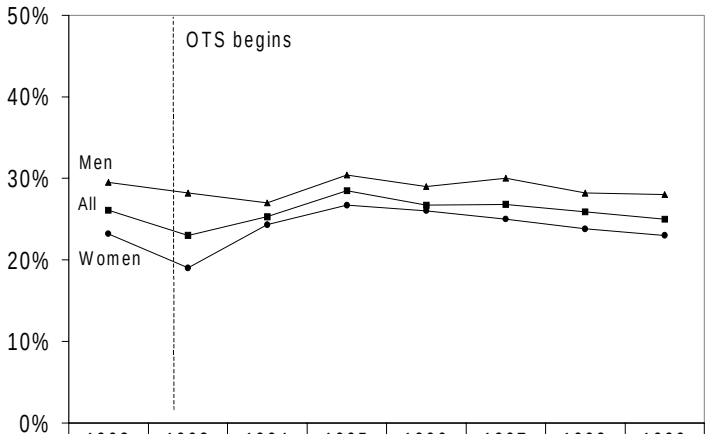


Source: Ontario Student Drug Use Survey, CAMH

2.2 Adult Smoking: Prevalence

- 25(±2)% of Ontario adults currently smoke on a daily or occasional basis. This rate is not significantly different from 1992, although recent trends are favourable (see Table 4-3, Appendix 4).
- 28(±3)% of Ontario men currently smoke daily or occasionally. This rate has not changed significantly since 1992.
- 23(±3)% of Ontario women smoke daily or occasionally. This rate decreased significantly from 1992 to 1993, and increased significantly from 1993 to 1995, corresponding with a large drop in cigarette taxes in 1994 (Section 1.4).
- Smoking rates have been consistently higher among men than women, but differences were statistically significant only in 1993 and 1999.

Fig. 13: Current Cigarette Smoking, by Sex, Age 18+, Ontario 1992-1999

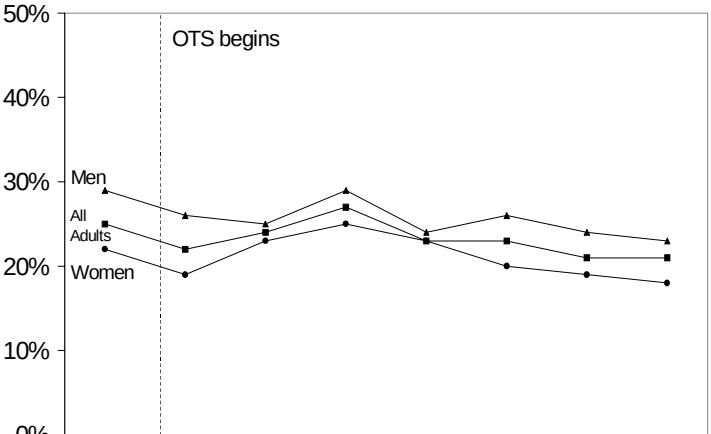


	1992	1993	1994	1995	1996	1997	1998	1999
Men	30%	28%	27%	30%	29%	30%	28%	28%
All Adults	26%	23%	25%	29%	27%	27%	26%	25%
Women	23%	19%	24%	27%	26%	25%	24%	23%

Source: CAMH Surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor, 1996-1998; CAMH Monitor, 1999

- 21(±2)% of Ontario adults currently smoke every day. This represents a significant decrease since 1995 when 27% of adults smoked daily, but is not significantly lower than the 1992 rate of 25%. (Table 4-4, Appendix 4).
- 23(±3)% of Ontario men and 18(±3)% of Ontario women currently smoke every day.
- Among smokers in 1999, men were significantly more likely than women to smoke daily: 84% of male smokers used cigarettes every day, compared to 78% of female smokers (data not shown).

Fig. 14: Daily Cigarette Smoking, by Sex, Age 18+, Ontario 1992-1999



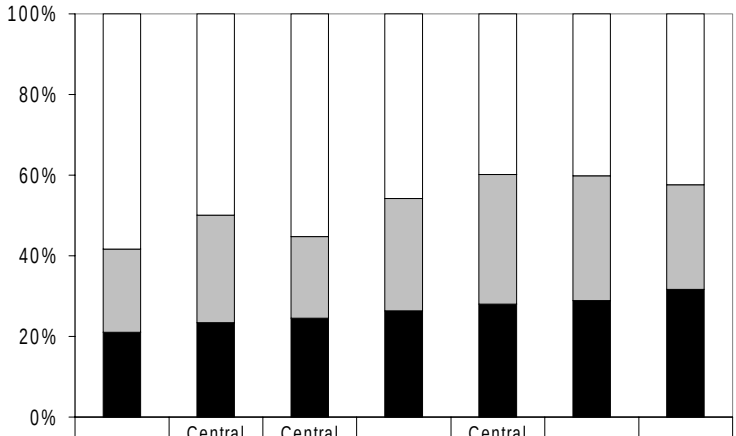
	1992	1993	1994	1995	1996	1997	1998	1999
Men	29%	26%	25%	29%	24%	26%	24%	23%
All Adults	25%	22%	24%	27%	23%	23%	21%	21%
Women	22%	19%	23%	25%	23%	20%	19%	18%

Source: CAMH Surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor, 1996-1998; CAMH Monitor, 1999

2.2 Adult Smoking: Prevalence

- Substantial differences in smoking rates persist in Ontario, ranging from 21% in the Toronto region to 32% in Southwestern Ontario.
- The highest proportion of never smokers was found in Toronto (58%), and the lowest was in both the North and South Central regions (40%).
- Quit ratios (the proportion of ever smokers who have quit) range from 43% in Southwestern Ontario to 54% in the Central Western region.

Fig. 15: Smoking Status, by Health Planning Region, Age 18+, Ontario 1999



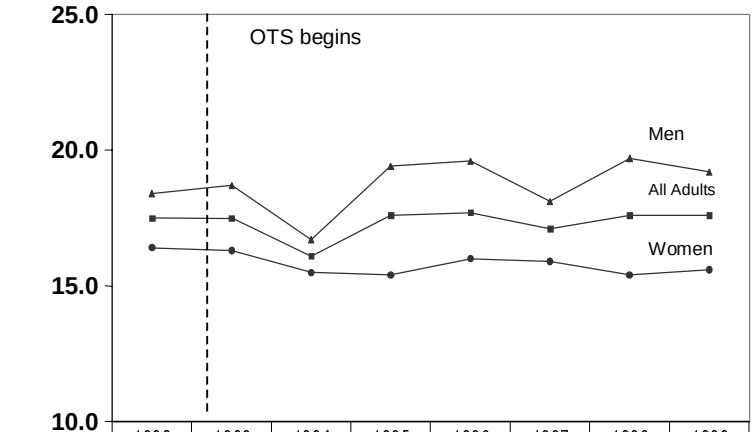
	Toronto	Central West	Central East	East	Central South	North	Southwest
Never	58%	50%	55%	46%	40%	40%	42%
Former	21%	27%	20%	28%	32%	31%	26%
Current	21%	23%	25%	26%	28%	29%	32%

Source: CAMH Monitor, 1999

2.2 Adult Smoking: Level of Use

- In 1999, the average number of cigarettes smoked by daily smokers was 17.6, which is not significantly different from the previous years in the reporting period.
-
- Male daily smokers consume an average of 19.2 cigarettes per day. This is significantly more than the female average of 15.6 per day.

Fig. 16: Mean Number of Cigarettes Smoked Daily, by Sex, Daily Smokers, Age 18+, Ontario 1992-1999



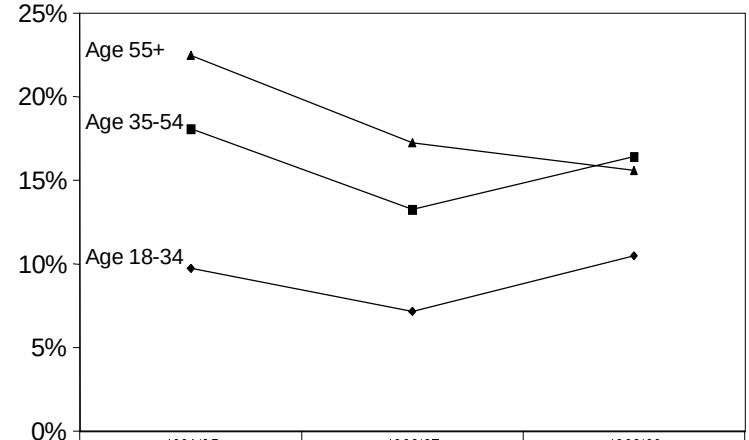
	1992	1993	1994	1995	1996	1997	1998	1999
Men	18.4	18.7	16.7	19.4	19.6	18.1	19.7	19.2
All Adults	17.5	17.5	16.1	17.6	17.7	17.1	17.6	17.6
Women	16.4	16.3	15.5	15.4	16.0	15.9	15.4	15.6

Source: CAMH Surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor, 1996-1998; CAMH Monitor, 1999

2.2 Adult Smoking: Dependence

- The Heaviness of Smoking Index (HSI) is a scale based on time to the first cigarette each morning and number of cigarettes per day. Those scoring 5 or 6 on the scale are considered highly dependent, and represent a population that is typically non-responsive to cessation programs.
- Older smokers (age 55+) were consistently more likely to be highly dependent than the youngest age group (age 18-34). By 1998/9, the proportion of highly dependent smokers in the middle category (35-54) had converged with the proportion in the oldest age category.
- From 1994/5 to 1998/9, the proportion of highly dependent smokers in the 55+ age category declined by 7 percentage points.

Fig. 17: Highly Dependent Smokers, by Age,
Daily Smokers, Age 18+, Ontario, 1994/95 to 1998/99

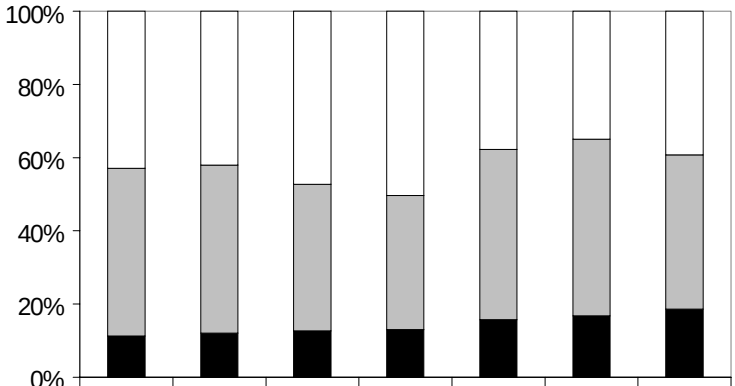


	1994/95	1996/97	1998/99
18-34	9.7%	7.2%	10.5%
35-54	18.1%	13.3%	16.4%
55+	22.5%	17.3%	15.6%

Source: CAMH Surveys: Ontario Alcohol and Other Drug Opinion Survey 1994-1995; Ontario Drug Monitor, 1996-1998; CAMH Monitor, 1999. (Pooled datasets)

- The proportion of daily smokers with moderate or high dependence (scoring 3-6 on the Heaviness of Smoking Index) was highest in Eastern Ontario (65%) and lowest in the Central West region (50%).
- There were important differences across the regions in the proportion of daily smokers who were highly dependent, ranging from 11% in Central East Ontario to 19% in the North.

Fig. 18: Smoking Dependence,
by Health Planning Region,
Daily Smokers, Age 18+, Ontario 1998/1999



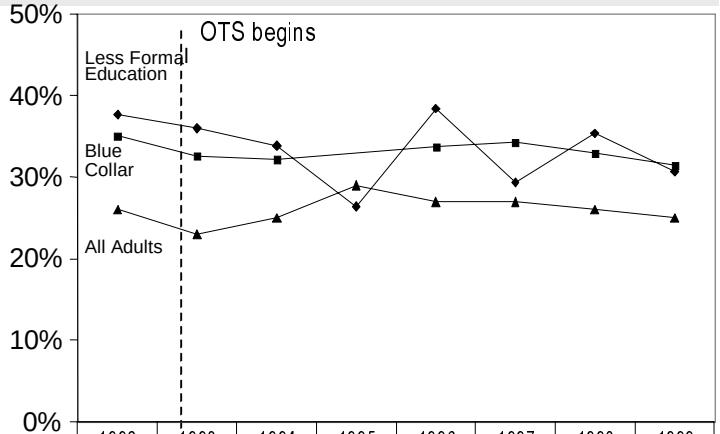
	Central East	Central South	Toronto	Central West	South West	East	North
Low	42.9%	42.1%	47.3%	50.3%	37.8%	35.0%	39.2%
Mod.	45.8%	45.9%	40.0%	36.6%	46.6%	48.3%	42.2%
High	11.3%	12.1%	12.6%	13.1%	15.7%	16.7%	18.6%

Source: Ontario Drug Monitor, 1998; CAMH Monitor, 1999. (Pooled data).

2.3 Adult Smoking: Selected Target Groups

- Rates of smoking among blue collar workers (those with unskilled or semi-skilled clerical/sales, trades, or farming occupations) were significantly and consistently higher than in the general population from 1992-1999.
- Smoking rates among adults with less formal education (adults who have not completed high school) fluctuated between 1992 and 1999, but were significantly higher than the general population estimate in most years.
- Smoking prevalence among these target groups appears to have declined from 1992 to 1999, but these differences are not statistically significant.

Fig. 19: Current Smoking by Selected Target Groups, Age 18+, Ontario 1992-1999

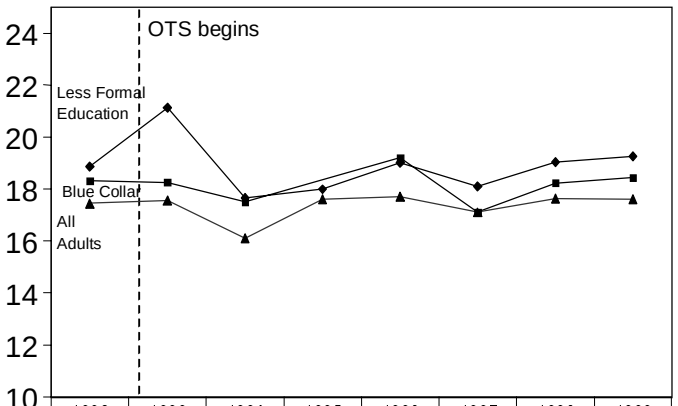


	1992	1993	1994	1995	1996	1997	1998	1999
Less Edu.	38%	36%	34%	26%	38%	29%	35%	31%
Blue Collar	35%	33%	32%	--	34%	34%	33%	31%
All Adults	26%	23%	25%	29%	27%	27%	26%	25%

Source: CAMH Surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor, 1996-1998; CAMH Monitor, 1999

- Rates of cigarette consumption among daily smokers have not changed significantly in the general population or these target populations from 1992-1999 (data for blue collar workers in 1995 are not presented as occupational category data were not available).
- In 1999, although cigarette consumption was higher in the target populations, these differences were not statistically significant.
- Blue collar workers and those with less formal education have been identified by the OTS as target groups due to their historically high rates of tobacco usage.

Fig. 20: Mean Number of Cigarettes Smoked Daily, by Selected Target Groups, Daily Smokers, Age 18+, Ontario 1992-1999



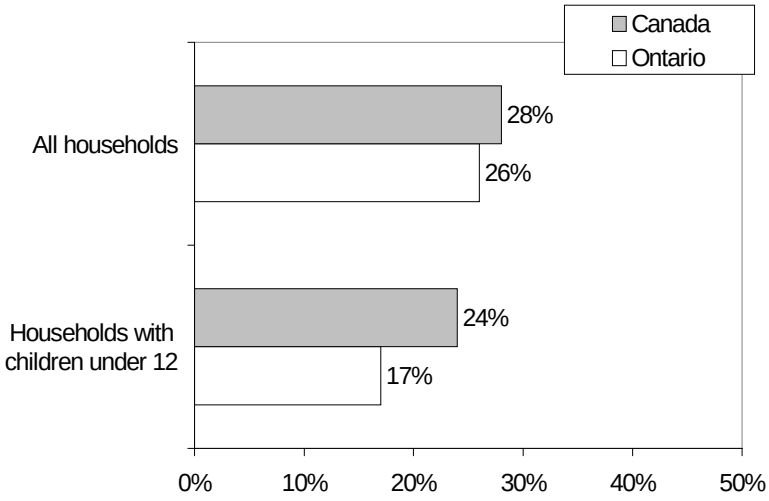
	1992	1993	1994	1995	1996	1997	1998	1999
Less Edu.	18.9	21.1	17.7	18.0	19.0	18.1	19.0	19.3
Blue Collar	18.3	18.3	17.5	--	19.2	17.1	18.2	18.4
All Adults	17.4	17.5	16.1	17.6	17.7	17.1	17.6	17.6

Source: CAMH Surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor, 1996-1998; CAMH Monitor, 1999

2.4 Exposure to Environmental Tobacco Smoke (ETS): At Home

- In early 1999, 26% of all Ontario households reported that at least one person smoked inside the home every day or almost every day, compared to 28% nationally. Estimates were lower among households with children under 12, and the difference between Ontario and Canada was greater in this category (17% vs 24%).
- Of the Ontario households with regular smokers *and* children under age 12, half (49%) reported that 10 or more cigarettes were smoked on a typical day (data not shown).
- These data are reported by *household* and, as there may be more than one child per household, these figures are conservative estimates of the number and proportion of *children* who may be regularly exposed to ETS in the home.

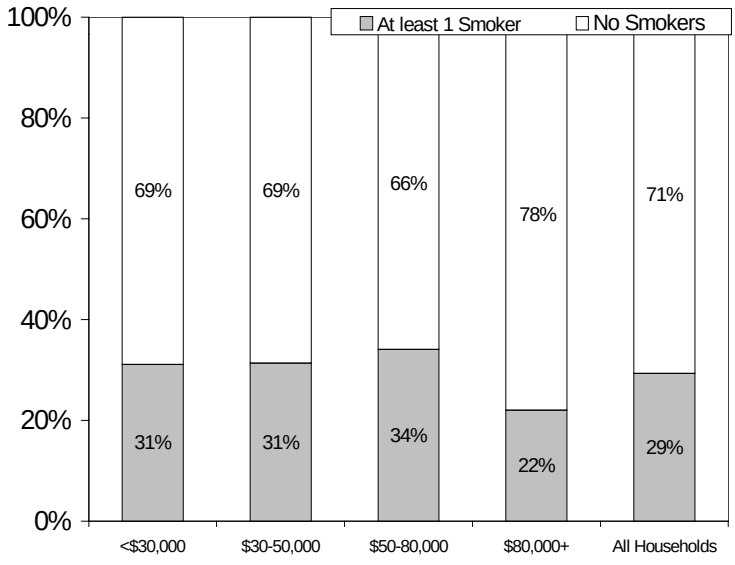
Fig. 21: Households with Regular Smoking Inside Home, Canada and Ontario 1999



Source: CTUMS, Feb.-June 1999, custom tabulations

- Data from a provincial survey show that, in 1999, 29% of Ontario adults reported one or more people regularly smoked in the home. This estimate is quite similar to that from the national survey above.
- Among adults reporting household income, the relatively well-off (over $80,000 per annum) are significantly less likely to report that a regular smoker lives in their household (22%), in comparison to households that have lower annual income.

Fig. 22: One or More Smokers in the Household, by Household Income, As Reported by Ontario Adults, 1999

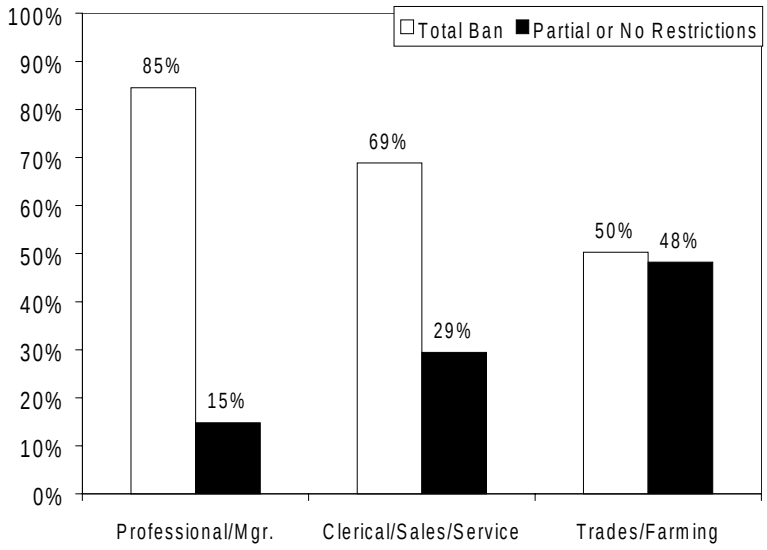


Source: CAMH Monitor, 1999

2.4 Exposure to Environmental Tobacco Smoke (ETS): At Work

- Overall, 70% of people who work outside their home reported that there was a complete ban on smoking indoors at their workplace; 29% reported only partial or no restrictions.
- Total smoking bans are most common for professionals and managers and least common for the trades and farming sector. Among the latter group, there is about an equal likelihood of only partial bans or no restrictions at all. Elevated exposure to ETS thus adds to the risk of higher smoking levels among blue collar workers (Section 2.3).
- Smokers are significantly less likely than non-smokers (not shown) to report that their workplace had a complete ban on smoking in place in 1999 (55% vs. 77% respectively).

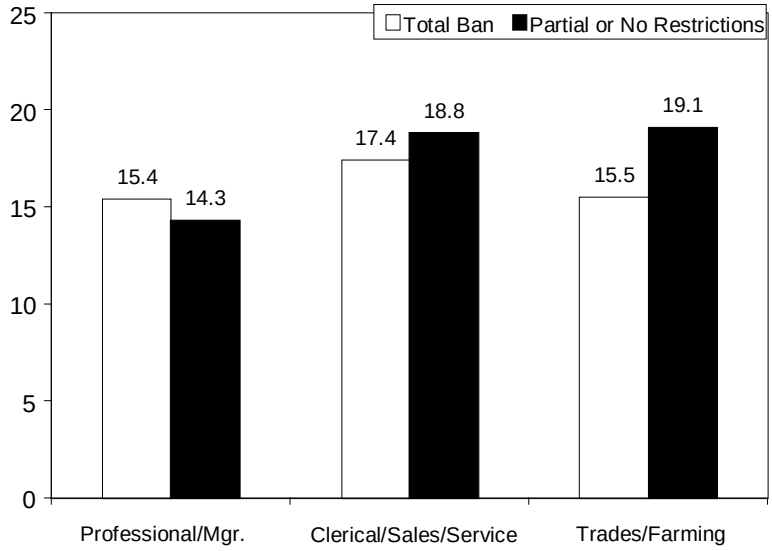
Fig. 23: Smoking Restrictions at Work, by Occupation, Age 18+, Ontario, 1999



Source: CAMH Monitor, 1999

- Bans on smoking may also be associated with less smoking by smokers subject to those bans. This is most clear for those in trades and farming occupations, where average daily cigarette consumption is 3.6 cigarettes lower than when there are no or partial bans. However, small samples mean that these differences are not statistically significant.
- In addition to the protection from ETS afforded all workers when workplace bans are in place, such bans may also benefit some smokers by encouraging them to reduce their daily consumption.

Fig. 24: Mean Number of Cigarettes Smoked Daily, by Occupation and Smoking Restrictions at Work, Daily Smokers, Age 18+, Ontario 1999

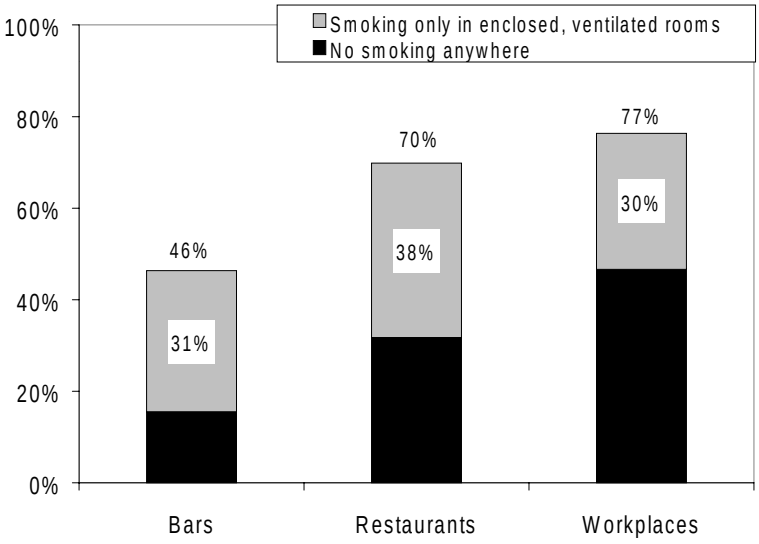


Source: CAMH Monitor, 1999

2.5 Public Attitudes Toward Tobacco Control

- A large majority of the public supports, at minimum, restriction of smoking to enclosed, ventilated areas in workplaces and restaurants (77% and 70%, respectively). Almost half (46%) of Ontario adults support this measure, at minimum, in bars and taverns.
- Almost half (47%) of Ontario adults support a *total* ban on smoking in workplaces. One-third (32%) support a *total* ban in restaurants. Only 15% support a *total* ban in bars and taverns. Total bans protect both staff and patrons in these establishments.
- Levels of support have changed little since 1998.

Fig. 25: Public Support for Smoking Restrictions in 3 Public Places, Age 18+, Ontario 1999



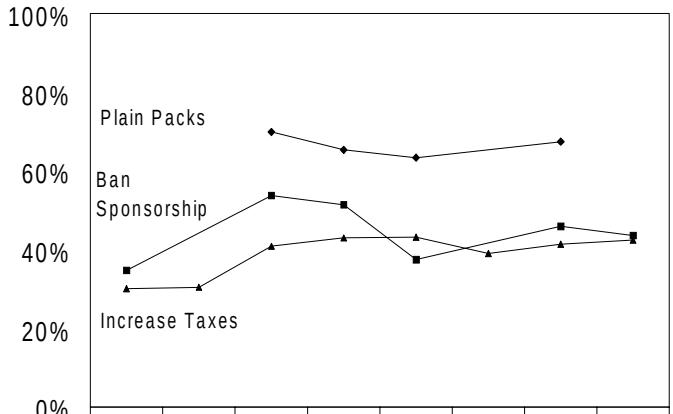
Source: CAMH Monitor, 1999

- Smoking status is a good predictor of attitudes towards smoking restrictions in public places (Table 4-6). Across all three locations, current smokers are significantly less likely to support restrictive smoking policies than non-smokers (former and never smokers). The data show only small differences between former and never smokers.
- Women are significantly more likely than men to support restrictive smoking policies in all three locations under study.
- Age also predicts support for restrictive smoking policies. Overall, the youngest age group (18-34) tends to be least supportive. Differences in support by age were statistically significant for workplaces and bars and taverns, but not for restaurants.

2.5 Public Attitudes Toward Tobacco Control

- From 1992 to 1999, support for higher cigarette taxes increased significantly from 30% to 42%. The highest support recorded in this period was in 1994-96 (41%-43%), following a substantial decrease in cigarette taxes early in 1994.
- From 1992 to 1999, support for a ban on event sponsorship by tobacco companies increased significantly from 35% to 44%, but was highest in 1994, at 54%.
- There has been consistent strong support for plain packaging of cigarettes to discourage smoking among youth, ranging from 63% to 70%.

Fig. 26: Public Support for Various Tobacco Control Policies, Age 18+, Ontario 1992-1999



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

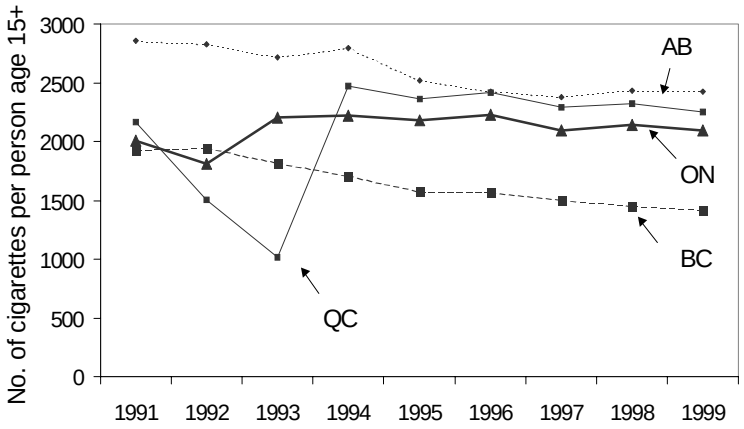
Source: CAMH Surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor, 1996-1998; CAMH Monitor, 1999

- Table 4-7, Appendix 4 shows levels of support in 1999 for these tobacco control policies, by smoking status, age, and sex (data were not available in 1992-3, 1997 and 1999 on support for plain packs).
- Current smokers were significantly less likely to support increasing cigarette taxes and sponsorship bans than former and never smokers (16% vs. 46% and 55% respectively). Never smokers were most supportive of these policies, with former smokers slightly less supportive than never smokers.
- Women were significantly more likely than men to support bans on tobacco company sponsorship of events (50% vs. 38%), and somewhat more likely than men to support increasing cigarette taxes (47% vs. 38%).
- The differences based on smoking status and sex parallel those for attitudes towards restricting public smoking.
- There were no significant differences across age groups on support for increasing cigarette taxes or banning sponsorship, although support for both was highest among those aged 35-54.

2.6 Sales of Cigarettes and Smoking Cessation Medications

- In 1999, there were 2,092 cigarettes sold for each person aged 15+ in Ontario, according to Statistics Canada's wholesale sales data. Per-capita tobacco sales in Ontario have changed little since 1993, while they have declined steadily in Alberta and British Columbia. Sales in Quebec have parallelled those in Ontario since 1994.
- It is important to note that these trends represent the *legal* sale of cigarettes, and do not account for the volume of smuggled cigarettes in Ontario and Quebec during the period 1991-1993.

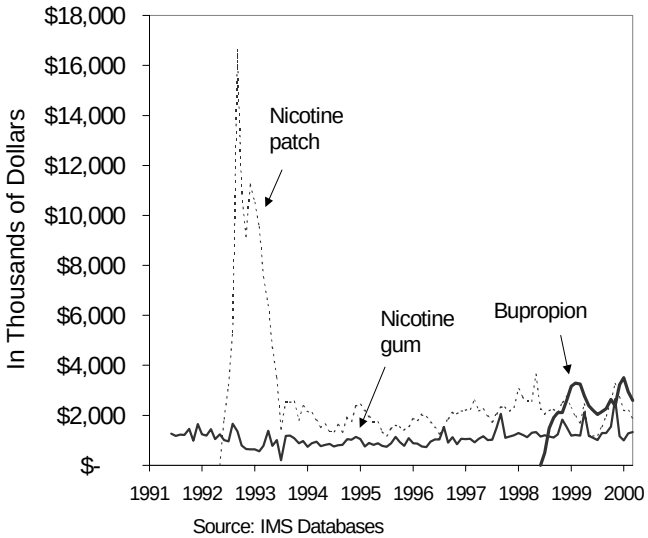
Fig. 27: Per Capita (Age 15+) Legal Sales of Cigarettes and Cigarette Equivalents in Four Canadian Provinces, 1991-1999



Sources: Population estimates from Statistics Canada. Sales of cigarettes based on monthly shipment data provided by the three major tobacco companies to Health Canada and obtained under Access to Information. Fine-cut converted to cigarette equivalents at 0.7 g per cigarette (See Appendix 2.6).

- There are only three forms of drugs approved by Health Canada for smoking cessation: nicotine patch, nicotine gum, and bupropion (Zyban®). Both the nicotine patch and gum are available over the counter in Ontario, while Zyban® is available only by prescription.
- Sales for these drugs combined totalled over $72 million in Canada in 1999 and $26 million for Jan-April 2000. The highest peak in sales for the nicotine patch occurred in 1992-1993, following its introduction to the marketplace. Total sales in 1993 were just slightly higher than 1999 levels at $74 million.

Fig. 28: Monthly Sales of Nicotine Patch, Nicotine Gum, and Bupropion in Canada, 1991-2000

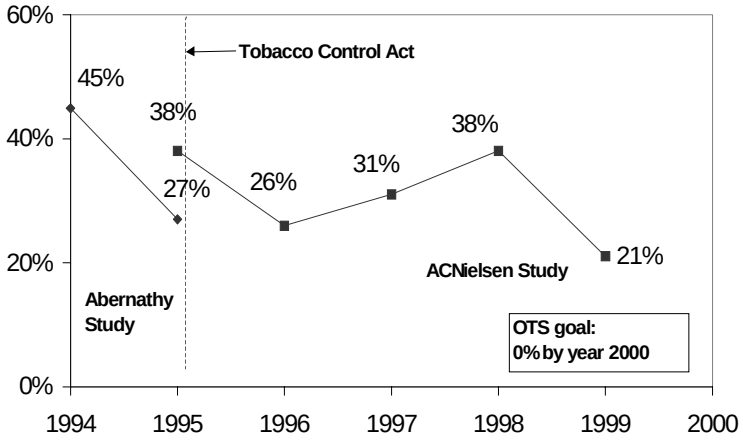


Source: IMS Databases

2.7 Sales to Minors: Compliance Checks

- The proportion of retailers in Ontario willing to sell cigarettes to minors decreased from 38% in 1998 to 21% in 1999 (ACNielsen, 1998-1999). All four Ontario cities in the study (Sudbury, Ottawa, Toronto, Windsor) had decreases in percent of retailers willing to sell to minors; all but Sudbury had double-digit decreases.
- In 1994, at the time of the passage of the *Tobacco Control Act*, Abernathy (1994, 1996) found that 45% of retailers agreed to sell cigarettes to minors. This dropped to 27% in 1995. Looking at the AC Neilson data, since 1995, progress has been somewhat erratic, but favourable overall.

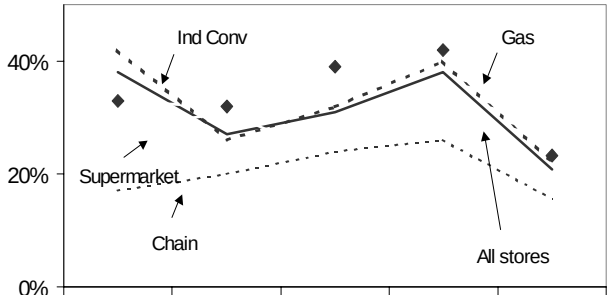
Fig. 29: Retailers Who Were Willing to Sell Cigarettes to Minors, Ontario 1994-1999



Source: Abernathy 1994, 1996; ACNielsen 1995-1999

- In 1999 compared to 1998, there was a marked *decrease* in sales to minors across all types of establishments surveyed.
- Since 1996, minors have been able to obtain cigarettes most readily in gas stations and convenience stores.
- The contrast between types of retail operations is now less than it was previously.

Fig. 30: Retailers Who Were Willing to Sell Cigarettes to Minors, by Type of Operation, Ontario 1995-1999



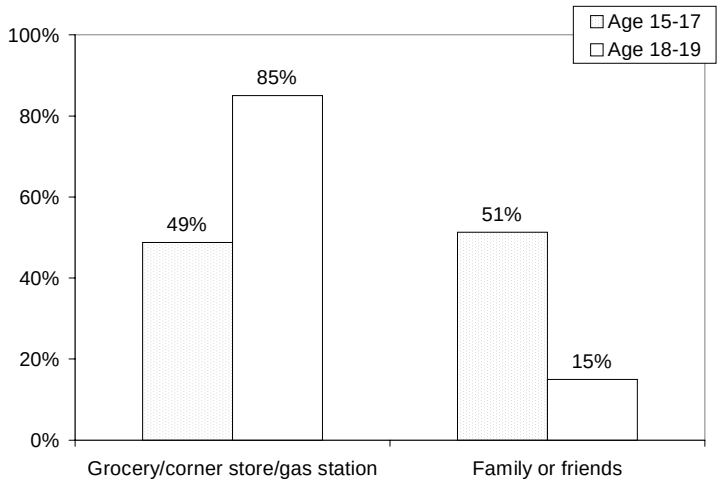
	1995	1996	1997	1998	1999
All stores	38%	27%	31%	38%	21%
Gas stations	33%	32%	39%	42%	23%
Ind. convenience	42%	26%	32%	40%	22%
Supermarkets	28%	31%	23%	27%	15%
Chain convenience	17%	20%	24%	26%	16%

Source: ACNielsen 1995-1999

2.7 Sales to Minors: Youth Reports

- About half of smokers in the 15-17 age group report buying their own cigarettes from gas stations, grocery and corner stores, which represents a violation of sales-to-minors legislation.
- Half report obtaining their cigarettes through family or friends, which is also a violation of the law.
- Most smokers aged 18-19 report purchasing their own cigarettes from grocery, corner stores, or gas stations. For 18-year-old youth, these sales are a violation of sales-to-minors legislation.

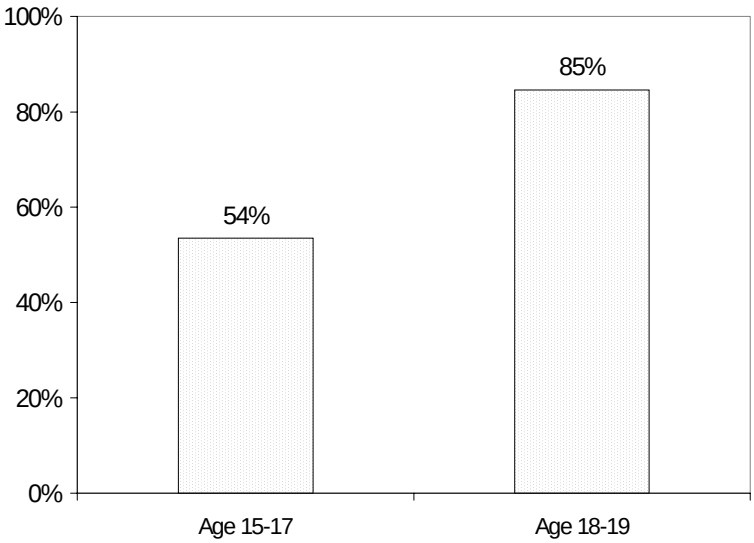
Fig. 31: How Teen Smokers Usually Obtain Their Cigarettes, by Age Group, Ontario 1999



Source: CTUMS 1999 (Feb.-June)

- Of youth aged 15-17 who had ever bought cigarettes from stores, just over half (54%) report *ever* being asked their age.
- A large majority (85%) of smokers aged 18-19 report *ever* being asked their age when buying cigarettes in stores.
- Since these are reports of lifetime experience, it is normal that incidence would increase with age. To assess changing practices over time requires data on recent (not lifetime) practice, however.

Fig. 32: Teen Smokers Asked Age When Buying Cigarettes in Store, by Age Group, Ontario 1999



Source: CTUMS 1999 (Feb.-June)

CHAPTER 3. ACTIVITIES OF STRATEGY PARTNERS

This section describes the tobacco control activities of the major players in the Ontario Tobacco Strategy (OTS) in 1999-2000, including the agencies that were funded under the renewed OTS and whose activity dates officially from January 2000 (Sections 3.2.7 and 3.3.6).

Agencies are grouped according to whether they provide resources and infrastructure for the OTS (Section 3.2) or deliver services and programs at the community level (Section 3.3). It should be noted, however, that some agencies provide both and may appear in either section.

With the exception of the section on Public Health Units (3.3.1), agency activities in 1999/2000 are described according to: (a) information resources produced and/or distributed, (b) services provided, (c) networking and collaborative activities, and (d) policy change initiatives, where relevant.

Background information on the agencies is in Appendix 3.

3.1 Summary of OTS

3.2 Resources and infrastructure:

- Ontario Campaign for Action on Tobacco
- Council for a Tobacco-Free Ontario
- National Clearinghouse on Tobacco and Health
- Program Training and Consultation Centre
- Smoking and Health Action Foundation
- Ontario Tobacco Research Unit
- Other Agencies

3.3 Community programming:

- Public Health Units
- Centre for Addiction and Mental Health
- The Canadian Cancer Society — Ontario Division
- Heart and Stroke Foundation of Ontario
- The Ontario Lung Association
- Other Agencies

3.4 New OTS Objectives

3.1 Summary of OTS Activities

Table D: Proportion of Effort Devoted to OTS Objectives in 1999/2000, as Reported by Agencies

	Prevention	Protection	Cessation
Resources and Infrastructure	**%**	**%**	**%**
OCAT	25	65	10
CTFO	40	45	15
NCTH	30	34	36
PTCC	10	25	65
SHAF	70	15	15
OTRU	33.3	33.3	33.3
Community Programming			
CAMH	60	10	30
CCS – Ont.	10	40	50
HSFO	25	75	0
Ontario Lung Assoc.	50	20	30
Public Health Units	35*	35*	30*
Average	**35%**	**36%**	**29%**

* As estimated from the Mandatory Health Programs and Services Guidelines, 1997.

- The focus of most agencies continues to be on smoking prevention and protection from ETS, followed by smoking cessation.
- Although agencies may choose to emphasize different OTS objectives, progress on any one objective has impact on the others. For example, successful smoking prevention and cessation efforts may reduce the need for efforts toward protection from ETS; similarly, reduced smoking in public places for the sake of protection supports prevention and cessation efforts by making smoking less visible and less "normal."
- These are approximate proportions, as estimated by the agencies.

Table E: Intended Long-Term Beneficiaries* of Agencies' Efforts in Tobacco Control, as Reported by Agencies

	Tobacco Control Group**	General Public	Adults	Women	Youth	Blue-collar Workers; Less-educated Individuals	Ethnic Minorities
Resources and Infrastructure							
OCAT	✓✓	✓✓	✓	✓✓***	✓✓		
CTFO	✓✓	✓✓	✓✓	✓✓***			
NCTH	✓✓						
PTCC	✓✓		✓	✓✓	✓✓	✓	
SHAF	✓✓	✓✓	✓✓	✓✓	✓✓	✓	✓
OTRU	✓✓	✓✓	✓	✓✓***	✓✓		
Community Programming							
CAMH		✓✓			✓✓		
CCS - Ont.		✓✓	✓✓	✓✓			
HSFO		✓✓			✓✓		
Ontario Lung Assoc.		✓✓	✓	✓***	✓✓	✓✓	✓
Public Health Units		✓✓	✓✓	✓✓	✓✓	✓	✓
Total	**6/11**	**9/11**	**8/11**	**8/11**	**8/11**	**4/11**	**3/11**

* As defined in the Tobacco Strategy Framework in the Ministry of Health Ontario Tobacco Strategy Overview (October 15, 1993).
** Research and program delivery: health organizations and units; tobacco control researchers; community workers
*** Including pregnant women

✓✓ denotes a major beneficiary
✓ denotes an important but not major beneficiary

- For the agencies involved in community programming, the intended beneficiaries are almost unchanged from a year ago.
- The continued low emphasis on blue-collar workers, less educated Ontarians, and ethnic minorities is consistent with the relatively low emphasis on cessation (see Table D).
- The general public is the most frequently mentioned intended beneficiary, perhaps because of the long-term focus of this question. Whether such a broad focus is the most effective for tobacco control requires further analysis.

3.2 Resources and Infrastructure

3.2.1 Ontario Campaign for Action on Tobacco (OCAT)

Information Resources

Website: The OCAT website (Appendix 3), launched in May 1999, specializes in reporting major studies on the health effects of second-hand smoke and the economic effects of tobacco use. It is intended for a broad range of users, with or without scientific backgrounds. The site has received 50,000 hits since its launch.

Information Products: As of March 2000, OCAT has restarted its *Campaign Updates*. These report on tobacco advocacy initiatives at all three levels of government, assign them priorities and provide advice on how/whether to participate. The *Updates* are circulated to health units, interagency councils, local offices of OCAT member agencies and other interested parties.

Networking and Collaborative Activities

OCAT helped to manage the Ontario Medical Association's Clinical Tobacco Intervention Program, a program funded under the renewed OTS (see 3.2.7). It also assisted in discussions between the three major OCAT member agencies on renewed local inter-agency cooperation (Appendix 3).

Policy Change Initiatives

OCAT concentrates most of its resources in this area. The primary focus of OCAT in 1999/2000 has been two-fold:

- assisting municipal councils, local interagency councils and health units across the province in passing smoke-free by-laws;
- directing the campaign that resulted in the passage of a 100% smoke-free by-law for the City of Toronto.

OCAT also provided assistance to the Waterloo and Peel Regions, Peterborough, Guelph, Windsor and Sudbury in their successful campaigns to pass or implement environmental tobacco smoke (ETS) by-laws. Ongoing campaign assistance was provided to Niagara Region, Sault Ste. Marie, Kingston, York Region and London.

Intended Directions for 2000 and Beyond

A major portion of OCAT's work will involve the renewal of the Tobacco Control Act (TCA) and the Smoking in the Workplace Act. OCAT will continue to advocate tax increases on cigarettes, and will assist federal initiatives, including the Federal Bill S-20, and the new federal package warnings proposed by Health Minister Allan Rock.

3.2.2 Council for a Tobacco-Free Ontario (CTFO)

Information Resources

The mandate of CTFO is to develop program supports for National Non-Smoking Week (NNSW). In 2000, the theme of the "Quit Smoking 2000" contest, launched as part of NNSW, remained "Smoke-Free Comes in Small Steps." This "quit and win" contest was

developed under the renewed OTS. Its purpose is to motivate smokers to quit; by entering the contest and remaining smoke-free, they become eligible for a substantial prize. A secondary purpose is to facilitate the involvement of local Councils on Smoking and Health and raise their profile within their communities.

Kits for NNSW, consisting of fact sheets, pamphlets, resources, draft media releases and evaluation forms, were distributed to local councils on smoking and health. An interim evaluation indicated a total registration of 12,500 smokers across Ontario. A multi-faceted evaluation plan will examine process and outcome indicators of implementation and outcomes.

Networking and Collaborative Activities

CTFO supported meetings of regional smoking and health councils through teleconferencing or face-to-face meetings. This facilitated an exchange of information regarding regional activities and discussion of future directions. CTFO supported teleconference and face-to-face meetings of its Board of Directors, providing a forum to discuss issues, activities and directions for the Council. CTFO continued its provincial partnership with the Program Training and Consultation Centre (PTCC), the Health Communication Unit of the University of Toronto, and the Ministry of Health and Long-Term Care (MOHLTC) in a three-year program designed to promote local media-based messages via local councils and regions. Within the reporting period, the Council expanded to include three new local councils.

Policy Change Initiatives

CTFO was a supporter of the national *Tobacco OR Kids* campaign, along with other provincial and national health-care organizations.

Intended Directions for 2000 and Beyond

The MOHLTC will not be renewing funding to CTFO but instead will be working with non-governmental organizations to deliver the mandate of CTFO. Therefore, CTFO's plans for the future are uncertain.

3.2.3 National Clearinghouse on Tobacco and Health (NCTH)

Information Resources

Website: This includes the NCTH Library catalogue online, Frequently Asked Questions, Statistics, The Photo Gallery and web links. The number of hits, as well as user sessions, on the website have tripled in the last year to 1,948,966 hits and 203,803 sessions.

Library: The NCTH library currently holds over 25,000 items, and its development continues to be a priority. In this reporting period, 540 items were acquired, including journal articles, monographs, cartoons and news releases.

Information Products: For the first time, the NCTH produced a summary of tobacco taxation data for Ontario and published it on their website.

Tobacco Free Times: The NCTH Program, in partnership with PTCC (see below), published the *Tobacco Free Times (TFT),* targeting health intermediaries in Ontario. While the NCTH published the *TFT* on their website, the PTCC

distributed printed copies in both official languages.

Direct Services Provided

An objective of NCTH is to provide a system of information delivery for all health intermediaries in Canada, including Ontario. To this end, in September 1999, NCTH held a planning workshop that brought together federal, provincial, and territorial governments, non-governmental organizations such as the Canadian Cancer Society, and volunteers and friends of the NCTH. These efforts will conserve paper-based information resources and will expand electronic access to information resources.

Networking and Collaborative Activities

This year NCTH produced a mock-up of a web page designed to promote all OTS resource groups. In partnership with the PTCC, NCTH became the official tobacco control affiliate for the Canadian Health Network, and also participated in the coordination of all information resources under the Ministry of Health.

Intended Directions for 2000 and Beyond

The NCTH program has become more client-focussed and continues to strive for improvement in this area. Although the library collection is not presently accessible for those outside of Ottawa, NCTH intends to become a one-stop electronic portal for tobacco control information. The 25,000-item library collection will be available electronically to all Ontarians on the website while the 1-800 telephone line will be maintained to assist those without electronic access who require paper-based materials. In the future, NCTH expects to continue to provide tobacco control information to Ontario intermediaries. NCTH will also be developing monitoring tools to help it provide better data to all funders and reporting agencies.

3.2.4 Program Training and Consultation Centre (PTCC)

Information Resources

The PTCC's distribution of resources tripled over the last year, from 6,500 items in 1998/1999 to over 18,000 in 1999/2000, which included 190 unique products. Resources addressed all objectives of the OTS, with primary emphasis on cessation. Recipients of resources were members of PTCC's target audiences, namely public health units, local tobacco-free councils, community health centres, and health resource centres. The PTCC continued to develop new products this year, focusing on brief interventions for cessation, smoking on school property, and media campaigns to promote nonsmoking. The resources to support media campaigns were developed as part of a collaborative project funded by OTS renewal funds.

A major OTS initiative related to information resources is the OTS Resources Dissemination Service (RDS). The purpose of this is to identify, review and distribute tobacco resources that meet both scientific and practical criteria. This year was a year of steady growth for the RDS, resulting in a catalogue of resources, web-based promotions and services, and an inventory and warehousing system for tobacco resources.

Direct Services

The PTCC held 18 workshops in 1999/2000 on 8 different topics with a total of 510 participants. The Centre completed 20 on-site consultations, which reached nearly 400 people, 4 times greater than 1998/1999. Main OTS objectives addressed by on-site consultations were cessation and protection. Main topics were cessation for women, brief interventions for cessation, and environmental tobacco smoke in public places and the home. In 1999/2000, 565 off-site consultations were completed, compared to 363 last year. Most of these were from PTCC's toll-free telephone line. Other off-site consultation methods included: regular mail, electronic mail, fax and the PTCC website.

Networking and Collaborative Activities

PTCC completed 202 collaborations in 1999/2000, compared to 161 in the previous year. Of these, 121 were collaborations with individuals and 81 with committees, all for the purpose of networking, co-directing activities or identifying ways PTCC could facilitate action. Throughout 1999/2000 the PTCC participated on 26 committees, which included 12 new committees this past year. The new committees were for a wide range of tobacco-related initiatives (youth, teens, low-literacy) and are intended to move forward on the realignment of the health promotion resource system. Several collaborative projects were funded by sources other than the PTCC's core budget or the RDS. Projects included both provincial and national activities.

Policy Change Initiatives

Major initiatives included consultations on nonsmoking by-law development and collaborations on realignment of the health promotion resource system.

Intended Directions for 2000 and Beyond

Throughout its seven-year history, the PTCC has provided information, training and consultation services to over 4,200 individuals. The PTCC will continue to serve its main client groups and expand its reach to workplace personnel and other intermediaries who offer individual smoking cessation counselling. The review and dissemination of tobacco resources will continue to grow with the RDS. The PTCC will also enhance links between types of services, such as on-site consultations and information resources. The PTCC will continue to extend its reach and impact, both provincially and nationally, by collaborating on tobacco-control projects.

3.2.5 Smoking and Health Action Foundation (SHAF)

Information Resources

Information Products: New information resources developed in the fiscal year included charts, papers, journal articles and fact sheets on tobacco industry practices, economics, tobacco taxes and prices in Canada, smuggling, alternate nicotine delivery, and tobacco package warnings. SHAF's intended users are other health and human service agencies, public health units, legislators and policy makers, other tobacco control agencies, the media and the general public.

Tobacco News Online: *Tobacco News Online* (TNO) provides daily Canadian and international news on tobacco-related issues via email to a subscriber list of over 400

organizations and individuals, including federal and provincial government officials, health and human service organizations, academics, researchers, scientists and legal experts.

SHAF/NSRA Website: In conjunction with the Non-Smokers Rights Association (NSRA), this website was launched in October 1999, and is maintained and regularly updated with the latest documents and material (Appendix 3). Of note is the compendium of tobacco industry documents and accompanying commentary entitled *Cigarette Smuggling: A Global Weapon against Public Health Measures.* The website receives an average of 2,000 hits a month and is accessed by government, health organizations, the media, academics and students, among others.

Direct Services Provided

SHAF's direct services include speaking engagements, presentations, and participation in seminars and on panels. A large part of its service is responding to numerous requests for information and expert panel assistance from researchers and academics, health organizations and units, medical officers of health, educators, municipal governments, and the Ontario government on a wide range of tobacco-related issues. SHAF also assists numerous members of the public via phone, email and mail with smoking-related problems and explains relevant by-laws and laws regarding ETS. SHAF responds to a large volume of requests from the media for research and background materials and information on current issues. In 1999/2000, SHAF responded to requests for information on tobacco industry practices, tobacco taxation and smuggling, litigation for recovery of health care costs, tobacco-package warnings, youth prevalence and consumption, effectiveness of mass media campaigns, ETS issues in the home and workplace, Canadian smoking patterns, and many more.

SHAF provided ongoing research support to: the Ontario government's legal team on its recovery of health care costs litigation and potential litigation on smuggling; the OCAT in support of ETS municipal by-law development; the NCTH in its preparation of tobacco-related material; the Non-Smokers' Rights Association by conducting research and providing information on tobacco packaging and labeling, taxation and smuggling, and tobacco industry documents.

Networking and Collaborative Activities

In 1999/2000, SHAF was the main researcher and drafter of *The Burden of Tax Cuts: Tobacco Taxes and Public Health in the 1990s*, released jointly by the NSRA, the Canadian Cancer Society (CCS) and Physicians for a Smoke-free Canada. SHAF collaborated with OTRU in the preparation of two manuscripts for publication and a policy statement on alternative nicotine delivery. It assisted in the development of the Ontario Medical Association's policy paper *Rethinking Stop-smoking Medications: Myths and Facts* (June, 1999). It collaborated with OCAT to bring Dr. Jeffrey Wigand to Toronto for a public lecture and press conference in order to publicize practices of the Canadian tobacco industry. It continued to participate in meetings in Ontario with Canadian pharmaceutical companies selling nicotine replacement therapy (NRT) products as part of an overall effort to integrate tobacco control principles in the private sector.

SHAF had representatives on the OTRU advisory board and the OCAT executive committee.

Policy Change Initiatives

Virtually all of SHAF's work relates to policy change. Some highlights of the past year include:

- *Tobacco Act* regulations on tobacco package warnings
- taxation and smuggling
- tobacco industry denormalization

SHAF produced the sample cigarette packages with coloured graphic warnings and accompanying explanatory material disseminated by the national *Tobacco OR Kids* campaign.

Intended Directions for 2000 and Beyond

SHAF staff will spend a considerable portion of their time locating, analyzing and reporting on tobacco industry documents from document depositories and other sources. It is crucial to retain this document research capacity to react to new developments, as industry documents can shed light on virtually any issue that arises in tobacco control. It will continue to provide evidence in support of a return to higher tobacco taxes. SHAF will research and monitor tobacco industry practices in sponsorship advertising, both leading up to and after the restrictions set out in Bill C-42 come into force on October 1, 2000. It will continue to provide research and information in support of initiatives related to ETS reform in Ontario, in particular a revised *Smoking in the Workplace Act* and a revised *Tobacco Control Act*. SHAF will provide input into Ontario's process of cost recovery, including possible alternatives to using the "RICO" statutes (*Racketeer Influenced and Corrupt Organizations Act*). SHAF will also continue to monitor issues and conduct ongoing research to advance the case for alternate forms of nicotine delivery, and to educate the public on tobacco industry and tobacco product denormalization. It will continue to provide its website as an information resource, along with the *TNO* service, to a wide range of health groups and government officials.

3.2.6 Ontario Tobacco Research Unit (OTRU)

Information Resources

During the reporting period, OTRU produced 11 working papers describing original tobacco research, 11 issues and 1 index issue of *Current Abstracts on Tobacco*, 3 special reports, and 1 issue of *Tobacco Research News*. These were distributed to more than 250 tobacco-control researchers, programmers, policy-makers, and public health experts, mainly in Ontario. The Fifth Annual Report monitoring the OTS was released in November, at the Ontario Public Health Association's annual conference. The OTRU website registered approximately 600 hits per month during the reporting period.

Producing and distributing information resources accounted for 25% of OTRU's effort.

Direct Services Provided

OTRU's primary direct services are the library service it provides to its investigators and the monitoring and evaluation advice it supplies to the community. This year there were 7 new and 36 ongoing research projects.

Library Services: 26 major literature searches were conducted for tobacco-control research projects: 4 for affiliates, 1 for public health, and 21 for investigators. There are over 320

searches on file as well as more than 4,000 electronically catalogued documents.

Consultations: Seven major consultations and many minor consultations were conducted in person or by phone with policy-makers, community groups, courts and health professionals. OTRU also responded to numerous *ad hoc* queries from the media and public health professionals.

Workshops: Planning continued for a workshop in June 2000 on Monitoring Maternal Smoking during Pregnancy.

Conferences: OTRU investigators made 56 presentations at various national and international conferences, in addition to the Ontario Public Health Association (OPHA) annual conference.

Networking and Collaborative Activities

OTRU ran the OTS-L listserv (70 subscribers) to help coordinate implementation of the renewed Ontario Tobacco Strategy (OTS). It also acted as a resource for information about the monitoring and evaluation of OTS programs funded by the Ministry of Health. OTRU ran OTRU-NET (127 subscribers), a forum for tobacco investigators to participate in discussions of priority areas in research, project development, funding issues, and any other relevant topic. It held a meeting at OPHA to release last year's monitoring report.

Committees: OTRU investigators took part in 29 committees, which included community members, policy-makers and university academics. OTRU participated in 4 meetings of the OTS Steering Committee. OTRU's Advisory Board consisted of representatives of 14 organizations; it held 4 meetings in the reporting period.

OTRU-NET: There were 127 subscribers to this electronic forum.

Tobacco Research News: 252 individuals and organizations received one issue of the OTRU newsletter.

OTRU participated in the OTS Resource Centre Workshop Group, coordinated the evaluation of 26 OTS projects, and responded to *ad hoc* queries from Ministry of Health and Long-Term Care staff and resource centres.

In addition to the Pregnancy Workshop, three other projects were approved in January 2000 to be funded with OTS money: a range of activities under the rubric of surveillance, a study of ETS in Ontario homes, and coordination of the evaluations of 26 "partner projects."

Intended Directions for 2000 and Beyond

This year OTRU conducted a strategic planning exercise to review its mission and mandate, and to map out OTRU's strategic directions for the years 2000-2005. As a result of this exercise, OTRU revised its mission statement to read: "We are a network that fosters and conducts research, monitoring and evaluation contributing to programs and policies to eliminate tobacco-related health problems in Ontario."

3.2.7 Other Players in the Renewed OTS

Several new projects funded under the renewed OTS added to the resources and infrastructure for tobacco control in Ontario. Involved agencies new to the annual monitoring report are described in this section.

Central West Health Planning Information Network, Hamilton-Wentworth District Health Council

Development of Recommendations and Guidelines for Enforcement of the TCA: This project, funded through the renewed OTS, has four dimensions. First, it proposes to develop and maintain the infrastructure that will allow public health units to share, through interactive media, information and experiences regarding tobacco enforcement and policy development. Second, it will identify the supports needed by public health units to carry out a program of comparable and valid vendor compliance checks across the province and the supports needed to assist them in laying charges and securing prosecutions under the TCA. Third, the project will develop guidelines for use by public health units for carrying out vendor compliance checks and laying charges. Finally, it will prepare recommendations for the Ministry regarding the supports they might provide to health units with respect to the TCA.

Council for a Tobacco-Free Waterloo Region

Smoke-Free Public Places By-law Implementation: On January 1, 2000, the Region of Waterloo implemented the second stage of its tobacco control by-law wherein all public places became smoke-free. CTFWR has undertaken an educational and promotional campaign to support the implementation of the by-law. More specifically, the campaign had the overall purpose of ensuring that the by-law was not weakened prior to January 1, or within three months thereafter.

Ontario Medical Association, Ontario Pharmacists Association, Ontario Dental Association

Clinical Tobacco Intervention Program: This project was developed to train physicians, pharmacists and dentists on how to approach smokers about quitting and prevent young people from starting to smoke. The intervention represents a logical extension of work begun earlier by the Ontario Medical Association.

Cancer Care Ontario

Ontario Tobacco Strategy Media Network: The purpose of this project is to support the development of the overall tobacco control strategy through enhancing media coverage of tobacco and tobacco control issues. Specifically, the Media Network aims 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.

University of Toronto, Health Communication Unit (HCU), Centre for Health Promotion

Mounting Existing Paper Documents on the Web in Redesigned Formats for Interactive Use: The purpose of this project is to increase the quality and quantity of web-based communication directed primarily to youth (and related secondary audiences) that supports the long-term goals of the OTS. The immediate

target group is community-based agencies serving youth. The project has four phases: (1) promotion and recruitment of participating agencies; (2) training, consultation and distribution of educational resources to prepare organizations to contract for websites; (3) provision of website enhancements by participating suppliers; and (4) evaluation.

TeenNet/CyberIsle: This is a web-based program to deliver health information to teens in an alternative manner to traditional classroom-based programs. This project is developing and evaluating new components for CyberIsle's smoking prevention and cessation modules. The overall purpose is to determine and develop ways in which information technology can be used effectively for health promotion with youth.

3.3 Community Programming

3.3.1 Public Health Units

Background

Under the *Health Protection and Promotion Act*, boards of health are required to provide or ensure the provision of at least minimum levels of public health programs and services set by the Minister of Health and Long-Term Care. These standards are set out in *The Mandatory Health Programs and Services Guidelines*,[b] which were updated in December 1997. As of January 1998, municipalities and the Province have equal responsibility for funding public health programs. Tobacco-free living is a major area of focus in these guidelines, and tobacco-related content is mainly under the "Chronic Disease Prevention" subsection, with minor references under "Sexual Health and Reproductive Health."

To monitor the progress of Ontario's 37 boards of health in meeting these standards, the Ministry of Health and Long-Term Care collected aggregate information on board of health activities through the *Ministry Performance Indicator Questionnaire (MPIQ)—Chronic Disease Prevention Indicators* in July 1999 (reporting on 1998 activities). Findings from the survey on 1999 activities (scheduled to be conducted in summer 2000) were not available at the time of this Report; 1998 survey findings are reported below (Abernathy, 2000).

[b] The *Guidelines* are available on the web at http://www.gov.on.ca/health/english/pub/pubhealth/manprog/manprog.html

Smoking Cessation

In 1998, almost all (35 of 37) boards of health provided smoking cessation programs in the community; 31 provided brief contact interventions for smokers who wanted to quit. Women, youth, and men were the most common populations reached by these programs and interventions (Fig. 33).

All 37 boards of health provided information to the public on quitting smoking through community media information services. Posters and telephone advice lines were the most common methods of disseminating this information (Fig. 34).

Fifteen of 37 boards of health provided worksite smoking cessation programs and 23 provided links with other cessation programs. Twenty-nine boards provided smoking cessation materials for worksites. In providing these services and materials, 29 boards of health reported working with occupational health and safety personnel, 27 with workplace personnel, 7 with local trade/labour groups, and 6 with business associations.

Environmental Tobacco Smoke (ETS)

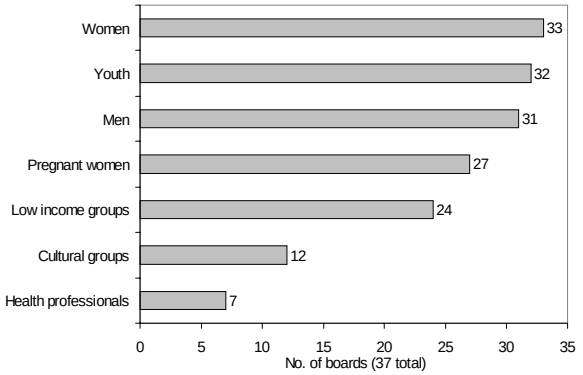
Ontario boards of health participated in several types of ETS-related activities in 1998.

All 37 boards provided information to the public on the risks of second-hand smoke and on strategies for attaining smoke-free spaces. Posters, telephone advice lines, and newspapers were the most common means of disseminating this information.

In 1998, 33 of 37 boards of health provided support for municipal by-law development to reduce the exposure of the public to second-hand smoke; these activities included promoting and consulting on policy development (28 and 23 boards, respectively) and supporting policy implementation (14 boards).

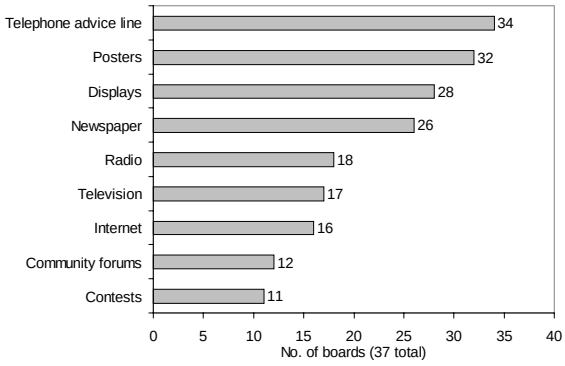
Twenty-six boards of health provided support for by-law development to reduce smoking in workplaces. The primary purposes of these activities were: promoting development of policies (24 boards), consulting on approval of policies (18 boards) and supporting policy implementation (11 boards).

Fig. 33: Groups Targeted by Boards of Health Smoking Cessation Programs and Interventions, 1998



Source: 1998 Ministry Performance Indicator Questionnaire (MPIQ), Ministry of Health and Long-Term Care

Fig. 34: Methods Used by Boards of Health to Disseminate Information on Smoking Cessation, 1998



Source: 1998 MPIQ, Ministry of Health and Long-Term Care

Schools
Almost all (36 of 37) boards of health supported the implementation of school activities (e.g., annual awareness events, student-led school-wide initiatives) related to tobacco awareness and cessation. Thirty-three boards of health reported covering tobacco-related topics when they assisted school boards, school advisory councils, principals and teachers to review and implement health-related curricula.

Eighteen boards of health provided a continuing education session for teachers that included tobacco-related topics.

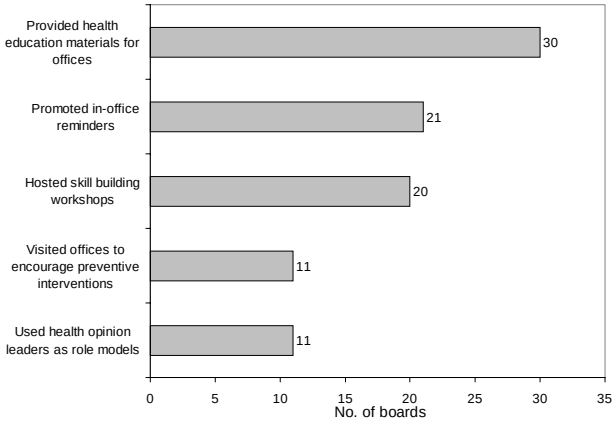
Workplaces
Almost all (36 of 37) boards of health addressed issues related to tobacco-free living when providing consultation, assistance, and health promotion resources to workplaces.

Eighteen boards of health promoted and provided a two-hour educational event that included tobacco-related topics to occupational health practitioners and others who may influence employee health.

Twenty-eight boards of health promoted the need for smoke-free workplaces. Telephone advice lines, posters and pamphlets were the most common methods used to promote this objective.

Health Professionals
Boards of health worked with health professionals in several ways to enhance their knowledge and skills to help patients stop smoking (Fig. 35). Provision of health education materials for offices was the most common means of assisting health professionals.

Fig. 35: How Boards of Health Worked with Health Professionals to Help Patients Quit Smoking, Ontario 1998



Source: 1998 MPIQ, Ministry of Health and Long-Term Care

Intended Directions
Technical Review Committees have been working on revision of the 1997 Mandatory Health Programs and Services Guidelines. This includes the "Chronic Disease and Injuries" section, where the tobacco-free living requirements and standards are found.

3.3.2 The Centre for Addiction and Mental Health (CAMH)

Information Resources

Pamphlets and Booklets: 70,956 English and 8,225 French copies of *Facts about Tobacco, Do You Know — Tobacco* and *About Smoking* were distributed to health professionals and the general public through the CAMH's Information Centre and Marketing Department.

Library: The Centre maintains an extensive public library that includes tobacco-related material. Access is available to researchers, health professionals, and the general public.

Surveys: In the 1999 calendar year, fieldwork was conducted for the annual *CAMH Monitor* (formerly the *Ontario Drug Monitor*). In addition, CAMH released the 1999 report of the biennial Ontario Student Drug Use Survey (OSDUS). These surveys provide data on tobacco use and attitudes in the adult and adolescent populations, respectively, in Ontario. Both data sets are used extensively in Chapter 2.

Direct Services Provided

Treatment Services for Smokers: The Centre has expanded its smoking treatment services this year, with new clinics for the general public, and specialty programs for clients with concomitant mental health or addiction problems. Services nearly doubled, with 324 new clients seen and 1,022 appointments in these programs. Another 850 addiction treatment clients received two-hour education sessions about smoking and cessation.

Training of Professionals: The Centre provides residency training for physicians in smoking-cessation treatment and this year added a smoking-cessation workshop to its Education and Training Calendar.

INFO-CAMH: This toll-free drug and alcohol information line provided two taped tobacco-related messages to the general public in English and in French.

Clinical and Research Seminar (CARS) Series: Guest speakers in the tobacco field (researchers at CAMH, the University of Toronto, and Canadian and international universities and organizations) participated in this weekly seminar series.

Consultation and Support: The Centre provided consultation and support to 22 community coalitions, such as councils on smoking and health, on a variety of tobacco issues, mainly regarding municipal by-law development.

Community Presentations/Training: CAMH responded to dozens of requests for presentations and training on drug-related issues in which tobacco use was a recurring topic of discussion.

Networking and Collaborative Activities

ACTION Program: In collaboration with PTCC and Ontario Public Health Association (OPHA), CAMH trained more than 35 educators and health professionals, who in turn delivered this alcohol, cannabis, and tobacco use prevention program to grades 7, 8, and 9 students in Ontario schools and communities.

***Opening Doors* Program**: CAMH collaborated with various community agencies to implement this personal and social skills-building program that targeted high-risk grade 9 students and their parents in 32 sites (23 English, 9 French) across Ontario. The program aimed to reduce the risks for all types of drug use, including tobacco.

Sponsorship/Membership: CAMH is a co-sponsor of OTRU, and an associate member of Council for a Tobacco Free Ontario, and was a sponsor of the *Tobacco OR Kids* campaign. CAMH is also a sponsor of the graduate collaborative program on Alcohol, Tobacco, and Other Psychoactive Substances (ATOPS) at the University of Toronto.

Intended Directions for 2000 and Beyond

Over the next year, CAMH intends to expand its *Opening Doors* and *ACTION* programs. In addition, work will be underway to co-ordinate smoking-cessation programs, and to integrate smoking information into the other mental health and addiction services offered by the Centre.

3.3.3 The Canadian Cancer Society — Ontario Division (CCS)

Information Resources

The CCS has 44 tobacco-related information products that raise awareness about the impact of tobacco use and encourage prevention and cessation. Twenty-one products are available in French. Three products are targeted to youth, 4 to women and the remainder to all adults. Between April 1999 and March 2000, 787,000 information products were distributed through the CCS Cancer Information Service and other agencies such as public health units and the Heart Health Networks. The adult "stages of change" materials were revised to create three new *One Step at a Time* products: *For smokers who want to quit*; *For smokers who don't want to quit*; and *If you want to help a smoker quit*.

Direct Services Provided

A smokers' helpline has been developed with funding under the renewed OTS. The purpose of this project is to establish a telephone helpline that will provide smoking cessation assistance in Ontario through self-help materials, support and referral. The target audience is adult smokers and, secondarily, those who influence them, such as friends and family. While the primary outcome is successful cessation, an important secondary outcome will be increased access to support for Ontarians who wish to quit.

The CCS Cancer Information Service provided information and referral. As well, outreach was provided to children and youth through school displays, information packages and presentations. Outreach to adults was through displays and presentations.

Networking and Collaborative Activities

CCS units are encouraged to work with and through local community agencies, tobacco coalitions, schools and local media to disseminate information. Collaborative activities undertaken during National Non-smoking Week 2000 included: displays in elementary and high schools, universities, colleges, recreation centres, libraries, local tobacco coalitions and Regional Cancer Centres; the distribution of materials; articles in local newspapers; provision of support to the CTFO "Quit and Win" campaign with *One Step at a Time* materials; and support of by-law initiatives.

Policy Change Initiatives

CCS continues to play an active role in OCAT and the development and implementation of the OTS. Staff and volunteers participated in letter-writing campaigns to support various anti-tobacco legislation and by-law changes. An advocacy kit was provided to local CCS units to support efforts related to local by-law changes.

Intended Directions for 2000 and Beyond

Over the next year the CCS — Ontario Division will focus more of its OTS effort on smoking-

cessation strategies. It will also evaluate its existing resources and collaborations, especially working through OCAT. CCS will continue its advocacy efforts in support of anti-smoking legislation at the municipal, provincial and federal levels. It is hoped that the smokers helpline will receive continued funding from the Ministry of Health and Long-Term Care.

3.3.4 Heart and Stroke Foundation of Ontario (HSFO)

Information Resources

The Foundation has an inventory of 18 tobacco-related fact sheets and pamphlets (9 available in French). In the reporting period, about 143,000 copies of these materials were distributed to health professionals and the public through the toll-free line, area offices, Heart Health Networks, the national website, and special events. The Foundation also distributed tobacco-related information specific to women. Callers could also get this information through the toll-free Healthline (in Ontario).

A $3.2 million education initiative is currently part of the renewed Ontario Tobacco Strategy. This project proposes to use "high-quality, existing creative product," delivered via television, complemented with supportive messages in print media. The overall purpose is stated as a desire to "identify Ontarians who view tobacco products as socially acceptable to some degree and convince them that they are not acceptable." It is suggested that this will be accomplished through an attempt to "reposition tobacco use as an unacceptable practice." The campaign is intended to "portray tobacco as a highly addictive and hazardous product that also hurts those around the smoker, and creates enormous health, societal, and economic burdens." The campaign began to air on television in April 2000.

Networking and Collaborative Activities

The Foundation is taking the lead role in the media campaign, which also involves the Lung Association, Cancer Society, Non-smokers' Rights Association, OCAT, and Cancer Care Ontario, and is an active member of the Ontario Coalition Against Tobacco (OCAT).

Policy Change Initiatives

As a member of OCAT, the Foundation was involved in dozens of advocacy initiatives at the municipal level to create smoke-free public places in 1999/2000.

Intended Directions for 2000 and Beyond

The Foundation intends to focus most of its OTS effort toward fundraising and participating in OCAT's advocacy activities in support of strong tobacco control policies. The Foundation will continue distribution of the HeartSmart™ Family Fun Pack and other information.
The Foundation hopes to once again lead the continued development of a mass media campaign to make tobacco use less socially acceptable in the minds of Ontarians.

3.3.5 The Ontario Lung Association

Direct Services Provided

***Lungs Are for Life* School Program and *Get on Track*:** *Lungs are for Life* is a school-based smoking prevention program that is delivered across Ontario by classroom teachers and public health professionals. The program varies with the ages of the students and uses discussion, role playing, videos, games, and demonstrations to encourage children and youth to explore their own ideas about smoking and to make informed decisions based on fact, not peer pressure. This past year the program reached over 150,000 students from kindergarten to grade 12. As well, the *Get On Track Stop Smoking* guide continues to be an effective resource for those smokers wishing to quit. Individual clients, public health departments and workplaces are the recipients of this guide. Under the renewed OTS, a major review and revision of the program was initiated during the year.

Intended Directions for 2000 and Beyond

Over the next year, the Ontario Lung Association plans to play a significant role in offering advice and support to the Ontario Tobacco Strategy. In addition, through ongoing partnerships, the Lung Association is developing a revised version of the *Lungs Are for Life* program so that young people throughout Ontario continue to receive effective and relevant smoking prevention education. Intended to be a four-year initiative, the Lung Association is working in partnership with the Ontario Physical and Health Education Association and leaders in curriculum development to keep the program consistent with new Ministry of Education curriculum requirements and public health guidelines.

3.3.6 Other Players in the Renewed OTS

Homewood Behavioural Health Corp./Boehringer Ingelheim (Canada) Ltd

Smoking Cessation Initiative Pilot Project: This project involves a smoking cessation program offered by Homewood Health Group and Boehringer Ingelheim (Canada). Registrants are classified as either dependent or independent quitters and are assigned accordingly to either a self-directed program or a program that includes counsellor support. While the purpose is clearly to encourage and support cessation, a significant secondary objective is to explore the effects of removing barriers to recruitment.

3.4 New OTS Initiatives

As noted throughout this report, the OTS received a major infusion of new funds and renewed political commitment part-way through the reporting period for this report. By March 2000, 26 initiatives were underway to prevent smoking, protect non-smokers, or support cessation. Another three projects for research, monitoring and evaluation purposes accompanied the program projects and all of these have been noted in section 3.2 and 3.3.

These new projects, like the ongoing agency activities, use a variety of strategies to progress toward OTS objectives. The province-wide projects emphasize education and infra-structure, to lay the groundwork for substantial future progress (assuming continued funding), and focus on cessation and prevention (Table F). The community-specific projects use a wider array of strategies and appear to address all three OTS goals with roughly equal emphasis (Table G). Taken together, this may represent an effective combination of approaches.

Table F. New Province-Wide OTS Initiatives, Classified by Objective and Strategy

Strategy	Prevention	Protection	Cessation	Reinforcement/Synergy
Education				
• **general public**	Mass Media Campaign		Helpline	
• **youth**	TeenNet Lungs are for Life		TeenNet, Leave the Pack, Quit Smoking 2000	
• **smokers**			Mass Media Campaign Community Education	
Assistance to Smokers				
• general public			Helpline	
Infrastructure				
• **develop materials**	**Lungs are for Life** TeenNet		TeenNet	Media Network
• **provide materials**	Tobacco Retailer signs Addressing Teen Smoking	Addressing Teen Smoking	Addressing Teen Smoking	Media Network Web Enhancement
• **build relationships**			Quit Smoking 2000	Media Network
• **develop skills**	*TCA* Enforcement	*TCA* Enforcement	Clinical Intervention	Media Network
Monitoring, Evaluation & Research				
	School Program Survey Coordinated Evaluation	School Ban Survey ETS at Home Economic Impact of Ban Coordinated Evaluation	School Program Survey Coordinated Evaluation Pregnancy Workshop	Coordinated Evaluation Long-term OTS Evaluation Plan Prov. Survey of Tobacco Use Enhanced CAMH Monitor Economic & Health Costs

Note: Classification here is by the principal strategy in use by the project; some employ multiple strategies with equal emphasis and this is shown in the table. Similarly, projects are listed under their principal stated objective, but several have more than one objective and this is shown.

Table G: New Community-Specific OTS Initiatives, Classified by Objective and Strategy

Strategy	Prevention	Protection	Cessation
Education			
• **general public**	Re. sales/supply (Simcoe, Peterborough, Toronto) Awareness of modeling (Algoma)	Mass media (GTA+ Coalition) Awareness of modeling (Algoma)	Awareness of modeling (Algoma)
• **youth**	In schools (Simcoe, Ottawa, Algoma) Mass media (Ottawa)	Tobacco-free elem. Schools (Algoma) Homes & cars (Grey-Bruce)	Tobacco-free Schools (Simcoe)
• **post-sec students**			10 campuses (Brock U)
• **parents**		Homes & cars (Ottawa)	
• **Chinese speakers**	Re. Health effects (York)	Re. Health effects (York)	Re. Health effects (York)
• **tobacco retailers**	Training (Thunder Bay, Toronto)		
Retail Controls			
• **enforcement**	Sales to minors (Toronto)		
Smoke-free spaces			
• **implement by-law**		Simcoe, Peterborough	
• **support by-law**		Waterloo, Ottawa	
• **enforcement**	Use in schools (Toronto)		
Assistance to Smokers			
• **all smokers**			Homewood, Kingston
• **target groups**			Expectant/parents (Grey-Bruce) Women, low-literacy (Peterborough) Marginal groups (Ottawa)
Infrastructure			
• **develop materials**	For schools about TCA (Toronto)		
• **provide materials**	For school-based programs (Algoma) To tobacco retailers (Toronto, Thunder Bay)		To HS nurses (Algoma) HS nurses (Algoma), Agency staff (Ottawa)
• **develop skills**	Gr 7-8 teachers (Ottawa)		
Monitoring, Evaluation & Research			
	Coordinated Evaluation (OTRU)	Coordinated Evaluation (OTRU)	Coordinated Evaluation (OTRU)

Note: Classification here is by the principal strategy in use by the project; some employ multiple strategies with equal emphasis and this is shown in the table. Similarly, projects are listed under their principal stated objective, but several have more than one objective and this is shown.

CHAPTER 4. IMPLICATIONS FOR THE OTS

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

This discussion is organized around the three OTS goals of prevention of smoking, protection of non-smokers, and encouragement of cessation, as well as overall strategic considerations, denormalization of smoking, and the ongoing monitoring and evaluation of the strategy.

Relevant sections in earlier chapters are referenced.

4.1 Implications for the OTS as a Whole

The low level of cigarette taxation in Ontario relative to all other provinces and neighbouring states (Section 1.4) provides a major opportunity for increasing the effectiveness of the OTS on a number of fronts simultaneously. High cigarette prices have been used effectively in Massachusetts, California and elsewhere to discourage youth from starting to smoke and to encourage established smokers to cut back on consumption. Increased prices would also contribute, indirectly, to protection for non-smokers as the overall consumption of cigarettes falls. Fortunately, both the federal and Ontario governments have recently recognized the key role of tobacco taxation in a comprehensive tobacco-control program, and Premier Harris is on record as supporting an increase. The question at this time appears to be about the size and timing of the increase. A hike of $5 per carton would bring Ontario's cigarette prices to the Canadian average.

While the 1999 increase in funding for the OTS (Section 1.2) is welcome and places Ontario in the front rank of provinces in the tobacco-control effort, current expenditures of $1.16 per capita fall well short of the $8.00 recommended by the Minister's Expert Panel and the U.S. Centers for Disease Control. Meeting the CDC recommendation could be easily afforded with only a portion of the $270 million annually that would be raised in Ontario with tobacco taxes at the national average (Section 1.4).

Uniform and effective protection against ETS exposure in the workplace will not only help to ensure a safe working environment for all Ontario workers, but it will indirectly support workers who are trying to quit and may also help youth not take up smoking as they leave school and enter the workforce for the first time.

A multi-year plan for tobacco control is required in order to provide the stable and sustained program efforts found to be successful in California, Massachusetts, and elsewhere.

4.2 Implications for Prevention

The continuous rise in smoking that occurs in high school through Grade 11 (Section 2.1) reinforces the importance of effective school-based prevention programs. There may be an encouraging trend among the cohort currently entering grade 8, which should be reinforced with school-based and other policies including an expanded enforcement effort that further raises compliance with sales-to-minors restrictions (Section 2.7). Projects under the renewed OTS that are important in this regard are the revised *Lungs Are For Life* curriculum (Section 3.3.5) and the activities of the province's 37 public health units (Section 3.3.1). Better compliance with laws restricting sales to minors is likely to be encouraged by retailer education and more effective enforcement. New OTS projects relevant to education are underway in Toronto and Thunder Bay, while retailers are being supplied with new signs and enforcement guidelines are being developed.

Even the best programs for youth are not likely to be very effective in the absence of policy changes. In particular, raising the low price of cigarettes must be the first priority in preventing tobacco smoking among youth.

Further, restrictions on smoking at home (and at work) have been shown to be an effective preventive measure.

4.3 Implications for Protection

Since exposure to environmental tobacco smoke (Section 2.4) at home continues to be about as widespread as the overall prevalence of smoking (Section 2.2), protective measures for children and non-smokers in those homes are called for. Educating the smokers in question is the strategy most likely to meet wide acceptance, and it figures prominently among projects under the renewed OTS, some of which are aimed at the general public, e.g., the media campaign of the Heart and Stroke Foundation (Section 3.3.4) and the activities of public health units (3.3.1), while others are directed at specific target groups such as pregnant women and new parents. Restricting smoking at home helps reduce teen smoking by providing a positive role model.

Exposure to ETS at work is uneven (Section 2.4). Province-wide legislation prohibiting smoking in workplaces, as called for by the Minister's Expert Panel (Ashley et al., 1999), may be the only effective answer for this disparity. Given the association between worksite restrictions on smoking and amount smoked (Section 2.4), extending restrictions could also be an indirect means to encourage cessation and prevent youth from starting to smoke.

4.4 Implications for Cessation

While there has been little change in the overall prevalence of smoking in Ontario in recent years, or in the average amounts consumed by smokers, there has been a slow decline in the proportion of the population who are daily smokers (Section 2.2). Sharp regional disparities in smoking remain, however, suggesting that province-wide measures are needed. Two such measures are a price increase through taxation (Section 4.1) and increased access to cessation supports. Although cessation has not been a continuing focus of many partner agencies (Table D), it does figure strongly in the renewed OTS at both the provincial level (Table F) and in specific communities (Table G). Of particular note at the provincial level are the efforts to provide more effective cessation counselling through the offices of health professionals (Section 3.2.7) and directly through a Smokers' Helpline (Section 3.3.3). These and related community-specific projects by the public health units (Section 3.3.1) and other players (Sections 3.3.2, 3.3.6) will need continued funding if they are to meet their full potential, however. The new federal Expert Committee on Nicotine and Tobacco Science (Section 1.3) may be able to provide useful guidance on these and other cessation measures.

4.5 Implications for Denormalization

Given the relentless and innovative marketing of cigarettes by the tobacco industry, and their continuing legal challenges to governments (Section 1.7), there needs to be an equally persistent campaign to educate the public about the unethical and dishonest activities of the tobacco industry and about the need for comprehensive tobacco control.

The ever-increasing availability of tobacco industry documents that shed light on its activities and newly accessible databases of tobacco countermeasures (Section 1.3) have the potential to become important tools in the overall strategy in Ontario. The renewed national strategy provides a supportive context.

4.6 Implications for Monitoring, Evaluation and Research

The renewal of the OTS brings with it increased spending of public funds and a heightened profile for tobacco-control efforts. This in turn requires not only continued monitoring of the type reported in Chapters 1 to 3 of this sixth annual report, but expanded monitoring and more focused and rigorous evaluation. This currently takes the form of several new projects by OTRU and assistance to all the partners in the renewed OTS in conducting evaluations of their own activities (Tables F and G). OTRU is preparing recommendations for the long-term evaluation of the OTS.

A plan for ongoing evaluation that builds on current surveillance activities is needed to guide the OTS in its selection of activities.

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APPENDIX 1: OTS GOALS AND OBJECTIVES

In 1992, the Ontario government established objectives and a set of goals for the Ontario Tobacco Strategy (OTS) for 1995, and for the year 2000.

When these goals and objectives were reviewed in 1999 by the Minister's Expert Panel (Expert Panel, 1999), the three goals were endorsed, but in the absence of a comprehensive plan for meeting them, the quantitative target levels and dates for the more specific objectives were not endorsed. The Monitoring Reports will continue to use the substance of the objectives for reporting progress, and will refer to specific targets if and when these are revised by the Ministry.

The OTS has three overall objectives: prevention, protection, and cessation. Specifically, these focus on:

- preventing non-smokers, particularly children and adolescents, from starting to use tobacco;
- protecting the population from exposure to environmental tobacco smoke; and
- support for smoking cessation initiatives.

The goals are:

By 1995

- Make all schools, workplaces and public places smoke-free.
- Eliminate tobacco sales to minors.

By 2000

- Reduce tobacco sales by 50 percent.
- Reduce the proportion of 12 to 19 year-olds who smoke to 10 percent.
- Reduce the proportion of women 20 and over who smoke to 15 percent.
- Reduce the proportion of men 20 and over who smoke to 15 percent.
- Eliminate the use of tobacco products by pregnant women.

APPENDIX 2: METHODS

1. APPROACH TO MONITORING

Monitoring Process

This Report, like the five 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 the 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, on the other hand, would *link* activities, impacts, and outcomes and would require a more formal analysis than is possible with this Monitoring Report. Nevertheless, we believe it offers some useful insights into the progress of the Ontario Tobacco Strategy.

Both quantitative and qualitative information were used for this Report. Quantitative data appear mainly in Chapter 2, 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 below).

Qualitative information appears mainly in Chapter 3 on Strategy Activities, and was obtained from government and non-government sources, especially the partners active in the OTS. Further detail on the methods used to gather information about resource centre and community activities is also provided in this section.

Reporting Period

The reporting period for this Report is April 1, 1999 through March 30, 2000. The information in Chapter 3 is based mainly on this time period. In Chapter 2, however, information outside this period is sometimes included because the data are the most recent and are readily available. For example, youth smoking patterns in Ontario were obtained from the Canadian Tobacco Use Monitoring Survey (CTUMS) February-June 1999 as this data was the most recent and provided inter-provincial comparisons.

2. TOBACCO-RELATED DEVELOPMENTS IN CANADA AND BEYOND (CHAPTER 1)

Ontario's Expenditures on Tobacco Control

According to Ministry of Health and Long-term Care staff, the base funding for the OTS was $9 million prior to the renewal in 1999/2000, made up of $4 million for the resource centres and Heart Health and $5 million for tobacco-related activities by the public health units. An additional $4.3 million of the new $10 million announced in January 2000 was added to the 1999/2000 amount. This was estimated as follows: of the $6.3 million for single-source projects, 50% was allotted to the period October 1999 through March 2000 to reflect the actual activity period. Similarly, 25% of the $2.7 million for community grants was allotted to the fiscal year for activity between January and March 2000.

The 2000/2001 total of $19.7 million consists of the $9 million base from 1998/1999 + $5.7 million (the balance of the $10 million announced January 2000 and spent after April 1) + approximately $5 million approved in September 2000 for the period ending March 31, 2001. This does not include any new money for community grants, which had not been announced at the time this report was being prepared.

Reports on Federal, National, Provincial, and Industry Activities

A letter was developed and mailed to OTRU affiliates and National Strategy to Reduce Tobacco Use (NSTRU) members. These letters asked for a listing and brief description of major developments affecting tobacco control between April 1, 1999 and March 31, 2000. Specifically, initiatives to do with health, revenue, agriculture, and justice were highlighted. Responses were mailed or faxed back.

Reports on International Activities

A letter was developed and mailed to individuals abroad known to OTRU. We asked for a 15-minute telephone interview in which major developments in international tobacco control could be discussed. We were interested in initiatives to do with health, revenue, agriculture and justice that might affect tobacco control.

3. CIGARETTE TAXES AND PRICES (CHAPTER 1)

Data for *Cigarette Prices in Four Canadian Provinces, Price per Carton of 200, 1990-2000* (Fig. 2) were estimated with the following procedure: the average retail price of a carton of 200 cigarettes in each province during a specific year was multiplied by a ratio of the Canadian all-items Consumer Price Index (CPI) for the reference year (in this case, 1993) to the specific year.

The average retail price of cigarettes in each province was calculated using a simple average of the retail prices in the corresponding cities. Up until 1994, Statistics Canada published monthly prices by city in the Consumer Prices and Price Indexes (Cat. no. 62-010-XIB). Data for the period of 1995-May 2000 were obtained through Statistics Canada Price Division for a nominal fee. Because federal and provincial budget announcements are typically made in the spring, October prices were used for our calculations. It must be noted that these prices are based on observational studies, i.e. actual retail prices in the cities.

The Canadian all-items CPI for each year was obtained through CANSIM.

Data for *Average Prices of Cigarettes in Canadian Provinces and U.S. Border States, Per Carton of 200 ($ CDN), 2000* (Fig. 3) were obtained from Finance Canada and the Smoking and Health Action Foundation. These are *estimated* product costs only, and do not necessarily reflect diverse selling conditions across the country. The result is that Finance Canada's price data are *overestimates* because they do not take into account the discounting activity that takes place in large urban centres. An example of this discounting is the following: in May 2000, the retail price for a carton of cigarettes was only $28.49 in Toronto compared to $32.80 in Thunder Bay and $34.50 in Ottawa (Statistics Canada, Price Division, custom tabulations). Price estimates from Finance Canada are NOT based on observational studies.

To estimate the additional revenue gained if the Ontario price per carton was the same as the average Canadian price, first an estimate of the number of cartons consumed per year by daily smokers in Ontario was calculated. The rate of daily smoking in Ontario (21%) was multiplied by the Ontario population aged 18+ (8,789,409), multiplied by the average cigarettes per day smoked (17.6/day), multiplied by 365 days in a year and divided by 200 cigarettes per carton. The resulting figure was multiplied by the difference in price between Ontario ($31.68) and Canada overall ($36.24). In this way, we arrived at an additional revenue of $270,345,626.

The monthly average retail price of a carton of 200 cigarettes for Canada as a whole was obtained through CANSIM, as were population estimates.

4. SURVEY DATA SOURCES (CHAPTER 2)

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.

Where 95% confidence intervals are provided, as in the tables in Appendix 2, they can be used by the reader to test the significance of the differences between independent samples (e.g., year-to-year comparisons). If individual 95% confidence intervals do not overlap for two independent groups (e.g., males and females), then the corresponding significance level (*p*-value) for testing the equality of the two groups would be less than 0.05. In fact, this test has been show to be quite conservative, "approximately equivalent to hypothesis testing for differences at the p=0.005 level" (Bull, 2000). Unfortunately, as this test is conservative, it may overlook smaller but still significant differences. Thus, for example, if the *lower* limit of an estimate for males does not overlap the *upper* limit of an estimate for females, the estimates can be interpreted as being highly significantly different from a statistical perspective (whether these differences are significant 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.*

ACNielsen Tobacco Compliance Survey 1995-1999

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=5,023) in 25 cities and towns across Canada's ten provinces between July 12 and September 3, 1999 (ACNielsen, 1999).

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 1999 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 ACNielsen reports (ACNielsen, 1995-1999).

***Canadian Tobacco Use Monitoring Survey,* Health Canada**

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 for the first wave of CTUMS was all persons 15 years of age and older living in Canada, excluding residents of the Yukon, Northwest Territories and 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). 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 first wave of CTUMS data was collected in Feb\ruary-June 1999. These data are based on 5,000 individuals aged 15-24 and 5,000 individuals aged 25+ across Canada, with a distribution of 500 individuals in each of the two age groups per province. More detail on this survey can be obtained from Health Canada's CTUMS Fact Sheet Series (Health Canada, 2000).

***Ontario Alcohol and Other Drug Opinion Survey (OADOS)* 1992-1995, CAMH (formerly the Addiction Research Foundation) (Ialomiteanu and Bondy, 1996)**

The Ontario Alcohol and Other Drug Opinion Surveys (OADOS) were conducted yearly from 1992 to 1995 by CAMH. 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 and Bondy, 1996).

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

In 1996, CAMH 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 1999, 12 independent monthly surveys were conducted (January-December). A final sample of 2,436 respondents participated, representing an effective response rate of 67%.

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 1999 and the ODM 1996-1998 can be obtained from the Technical Guides (Adlaf et al., in press; Adlaf et al, 1999a; Adlaf et al., 1998; Adlaf et al., 1997).

***Ontario Student Drug Use Survey 1981-1999,* CAMH**

The *Ontario Student Drug Use Survey* has been conducted every two years since 1977 by CAMH. 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. 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.

The 1977 and 1979 surveys employed different stratification than subsequent years and are therefore excluded from this report.

In 1999, the OSDUS employed a two-stage (school first, then class clusters) sample design stratified by region (same regions used in previous surveys). The 1999 design 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 38 school boards participated in the 1999 survey. In total, data from 111 schools, consisting of 285 classes, comprised the final sample. The overall participation rate of students was 77%, which corresponds to an unweighted sample of 4,894 students (766 in grade 7; 798 in grade 8; 905 in grade 9; 638 in grade 10; 750 in grade 11; 590 in grade 12; and 447 in grade 13). The final sample of 4,894 students represents approximately 923,000 Ontario students in grades 7 through 13. More detail on this survey can be obtained from the report by Adlaf et al. (1999b).

5. SURVEY DATA DEFINITIONS

Smoking Status

Smoking status definitions differ across the various surveys.

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*.

Daily smoker: At the present time, reports smoking one or more cigarettes per day.

CAMH 1999; ODM 1996-1998

Smoking status estimates from the CAMH Monitor 1999 and the ODM were calculated using the flowchart in Fig. 36 (in order to establish a more consistent methodology for deriving the smoking status variable.

OSDUS 1981-1999

Tobacco use (CAMH definition): Use of more than one cigarette in the past 12 months.

Tobacco use (Health Canada definition): More than 100 cigarettes in lifetime and some during the last month.

Heaviness of Smoking Index (HSI)

The HSI index is based on points given for the time to first cigarette (TAC) and number of cigarettes per day (CPD) (Heatherton et al., 1989):

TAC is scored:

<=5 minutes - 3 points
6-30 minutes - 2 points
31-60 minutes - 1 point
>60 minutes - 0 point

CPD is scored:

1-10 - 0 points
11-20 - 1 point
21-30 - 2 points
≥31 - 3 points

Low scores (0-2) indicate low dependence on nicotine while scores ranging from 5-6 indicate high dependence.

6. CANADIAN TOBACCO SALES (CHAPTER 2)

The three major Canadian tobacco companies report monthly domestic and export tobacco sales to Statistics Canada. Data used here were obtained from Health Canada under the *Access to Information Act*.

Total sales are obtained by adding cigarette sales with cigarette equivalent sales, the latter based on fine-cut (i.e., "roll-your-own") sales. Fine-cut is converted to cigarette equivalents at 0.7 grams per cigarette.

Per capita consumption is calculated by dividing the total cigarette sales by the population aged 15 and over for each province.

Data on tobacco sales have certain limitations. These data are based on sales to wholesalers and do not necessarily reflect retail sales to consumers. For example, wholesalers may stockpile tobacco in anticipation of a tax increase. While smuggling of Canadian cigarettes exported to the U.S. has been largely eradicated, interprovincial smuggling between low-tax and high-tax provinces still occurs. Some tobacco recorded as sold in Ontario is smuggled to Manitoba and other western provinces. Note that both stockpiling and smuggling would lead to an overestimate of total consumption in the province, followed, in the former case, by an artificial drop in consumption.

7. AGENCY ACTIVITIES (CHAPTER 3)

A questionnaire was developed to systematically gather information on the tobacco-related activities of 10 agencies. This questionnaire was developed in 1998 with input from the Ministry of Health and COMMIT, and minor refinements were made to it this year. It was sent to a key senior contact person at each of the agencies. The questionnaire contained five items in total. Question numbers 1-3 asked for summaries of the organization's tobacco-related activities, either in progress or complete, for the April 1, 1999 through March 31, 2000 reporting period. Several categories were used for question one:

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

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 1999/2000. Another question asked to what extent each of the given priority groups were intended to be long-term beneficiaries of the agency's 1999/2000 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.

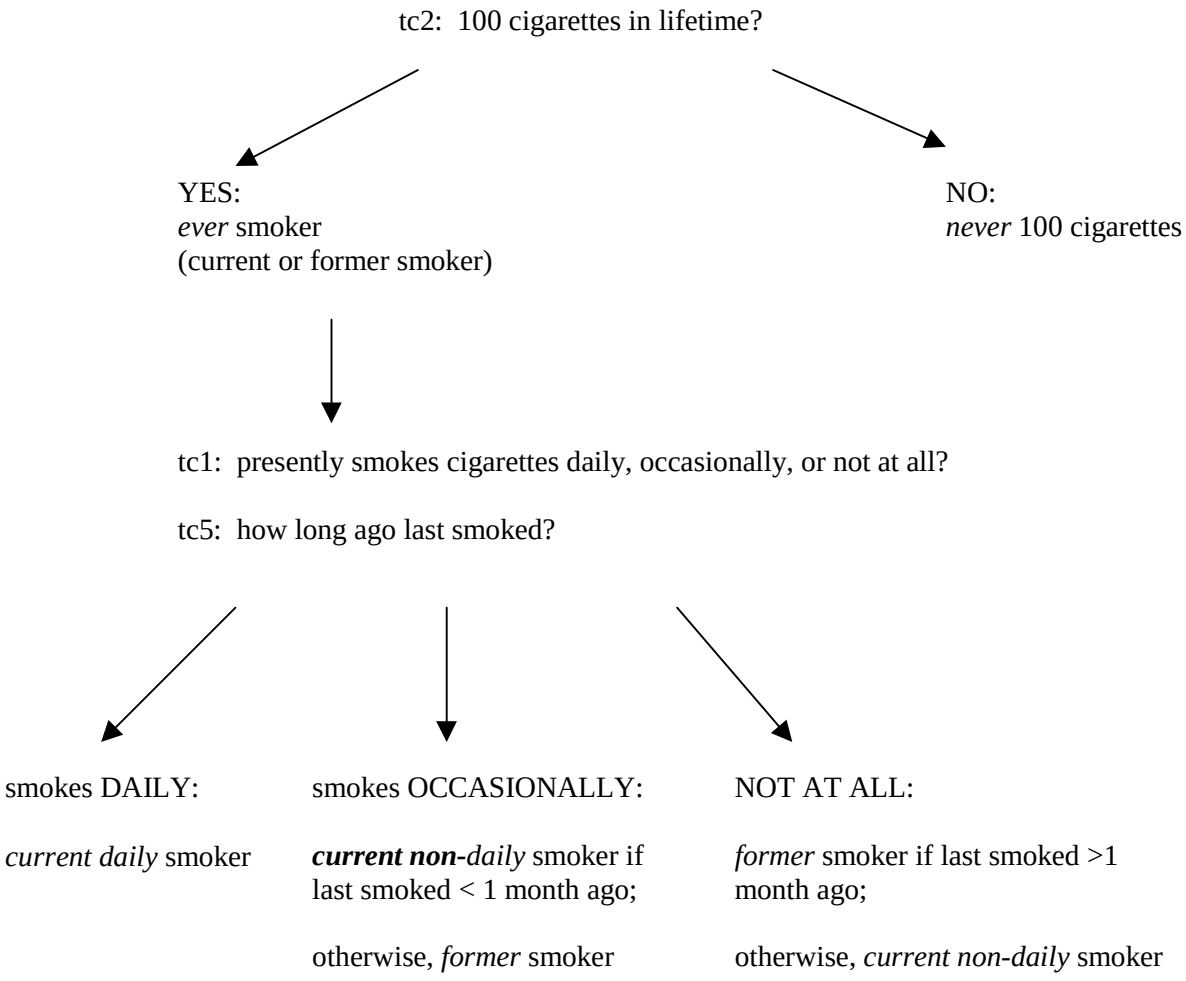
When necessary, other sources were consulted in order to gain a fuller understanding of the agency's tobacco-related activities: websites, annual and activity reports, pamphlets, and other contact persons within the organization.

8. TABLES AND FIGURES (Appendix 2)

Table 2-1: Ontario Health Survey (OHS) Planning Regions (Ontario Ministry of Health, 1999)

OHS Planning Region	Counties (23 Local Areas)
South West	**Essex** Kent, Lambton Elgin, Oxford, Middlesex Bruce, Grey, Perth, Huron
Central South	Niagara Hamilton-Wentworth Brant, Haldimand-Norfolk
Central West	Halton Peel Wellington, Dufferin Waterloo
Toronto	
Central East	Northumberland, Victoria, Haliburton, Peterborough Durham York Simcoe
Eastern Region	Ottawa-Carleton Renfrew, Prescott & Russell, Stormont, Dundas & Glengarry Lanark/Leeds/Grenville, Hastings, Prince Edward, Frontenac, Lennox & Addington
North	Algoma, Cochrane Manitoulin, Sudbury (R.M.), Sudbury (T.D.) Muskoka, Parry Sound, Nipissing, Timiskaming Thunder Bay, Kenora, Rainy River

Fig. 36: Derivation of Smoking Status*
CAMH Monitor



* Based on Mills et al., 1994.

APPENDIX 3: BACKGROUND ON OTS PARTNERS

Ontario Campaign for Action on Tobacco

- Website:
www.ocat.org

- **Background**

The Ontario Campaign for Action on Tobacco (OCAT), founded in 1992, is an advocacy network 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-Smoker's Rights Association, and Cancer Care Ontario. Its first campaign was in 1993 in support of provincial tobacco control legislation to prohibit sales of cigarettes to minors, eliminate cigarette sales from pharmacies and vending machines, and make public places smoke-free throughout Ontario. With the exception of smoke-free public places, all of these objectives were achieved with the passage of Ontario's *Tobacco Control Act* in November 1994.

OCAT provides a variety of specialized memoranda, including legal opinions, on a variety of issues to do with smoke-free by-laws. These memoranda are prepared upon request and forwarded to health units which are in the process of implementing smoke-free by-laws, local interagency councils working on by-law campaigns, media, and other coalitions working on similar issues across Canada. OCAT's work involves a range of activities including presentations before municipal councils and to boards of health, local media interviews, preparation of strategic and factual memoranda and briefing to health unit staff.

Council for a Tobacco Free Ontario

- **Website:**
www.opc.on.ca/ctfo

- **Background**

The Council for a Tobacco-Free Ontario (CTFO) contributes to an increased understanding and implementation of effective tobacco control interventions through co-ordination, assistance, and the provision of resource materials to 56 local councils on smoking and health. CTFO is a volunteer-directed, not-for-profit organization, which was originally founded in 1975 by the Canadian Cancer Society — Ontario Division, the Heart and Stroke Foundation of Ontario, the Lung Association, and several other health and professional organizations. The Council supports local council activity for National Non-Smoking Week and World No Tobacco Day, as well as coalition-building activities.

National Clearinghouse on Tobacco and Health

- **Website:**
www.cctc.ca/ncth

- **Toll-Free Number**
1-800-267-5234

- **Background**

The National Clearinghouse on Tobacco and Health (NCTH) is a Canadian resource centre on tobacco and health-related issues. The NCTH identifies, collects, organizes, and disseminates tobacco and health information. For example, fact sheets that highlight selected topics such as

Second Hand Smoke and Sponsorship are produced and disseminated. One-page fact sheets, written in plain language, are used by many clients as handouts. It is a program of the Canadian Centre for Tobacco Control, funded by federal, provincial, and territorial governments, and is under the stewardship of the steering committee for the National Strategy to Reduce Tobacco Use in Canada. Although national, a majority of the NCTH clients are from Ontario. The NCTH provides a valuable link between the scientific, medical and health communities, the media, and the general public. Funding for at least another three years has been assured.

Program Training and Consultation Centre

- **Website:**

www.ptcc.on.ca

- **Background**

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 Ottawa-Carleton Health Department, 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.

Smoking and Health Action Foundation

- **Website:**

www.nsra-adnf.ca

- **Background**

The Smoking and Health Action Foundation (SHAF) plays a primary support role to the Ontario Tobacco Strategy by carrying out research and public education activities that help shape the development of healthy public policy in Ontario. SHAF also acts as an information resource centre on tobacco policy issues and assists in the development of national health policies that impact on the quality of health in Ontario. Areas of focus are ETS, tobacco taxation, economics of the tobacco industry, informed consent (packaging, labeling, warnings), tobacco advertising and sponsorship, alternative nicotine delivery, and monitoring and analysing current issues such as the recovery of tobacco-caused health care costs (B.C. and U.S.).

Ontario Tobacco Research Unit

- **Website:**

www.camh.net/otru

- **Background**

The Ontario Tobacco Research Unit (OTRU) was established by a grant from the Ontario Ministry of Health to the University of Toronto's Centre for Health Promotion in 1993. The original mandate was "to undertake a program of research, development and dissemination of knowledge about effective tobacco control programs and policies" and to ensure that existing knowledge was critically evaluated, summarized appropriately, and made available in the most useful form. OTRU also plays a role in monitoring the Ontario Tobacco

Strategy. Fundamental to this work are linkages and working partnerships with persons, groups and agencies interested in and committed to the reduction and elimination of tobacco use.

In April 2000, OTRU's mandate was revised to include:

- monitoring programs and activities conducted under the auspices of the Ontario Tobacco Strategy and providing advice and technical expertise on program evaluation and best practices;
- analysing and disseminating relevant scientific information for the research and public health communities;
- exercising leadership in the design and conduct of research projects;
- increasing Ontario's capacity to conduct research, monitoring and evaluation;
- strengthening and broadening OTRU's provincial, national and international network of researchers, programmers and policymakers;
- producing work that is collaborative, of the highest academic quality, and based on priorities established in concert with Ontario's public health practitioners and policy makers;
- remaining accountable to its funders, its institutions, and its partners in the Ontario Tobacco Strategy; and
- creating a body of knowledge that acts as a catalyst for the development and implementation of innovative public health policies and practices.

In fulfilling its revised mandate, OTRU's efforts will be allocated as follows:

- 60% to providing relevant products and services to programmers and policy-makers. These products and services will be designed to build capacity and to influence the way in which programmers and policy-makers carry out their business, e.g., mechanisms to integrate knowledge into practice. Where possible, OTRU will use existing mechanisms such as the Centre for Health Promotion's Best Practices Working Group to further this work.
- 30% to building and sustaining a researcher "network of networks" locally, regionally and provincially. This includes providing relevant products and services to existing researchers and building capacity for the "next generation" of tobacco researchers.
- 5% to building and sustaining a national researcher network.
- 5% to becoming an even more visible and credible player on the international scene, seeking international recognition for Ontario's researchers and their products.

Centre for Addiction and Mental Health

- **Website:**

www.camh.net

- **Toll-Free Number**:

1-800-INFO-CAMH

- **Background**

The Centre for Addiction and Mental Health (CAMH) represents the merging of the Addiction Research Foundation (ARF), the Donwood Institute, the Clarke Institute of Psychiatry, and the Queen Street Mental Health Centre. The goal of CAMH is to prevent and reduce the harm associated with alcohol, tobacco, and other drugs among Ontarians. The Centre conducts research on all aspects of tobacco use, from basic laboratory work to research on programs and policies. Ongoing work of scientific and program staff with expertise in the tobacco area provides science-based information to programmers and policy-makers across Ontario.

The Canadian Cancer Society - Ontario Division

- **Website:**

www.ontario.cancer.ca

- **Toll-Free Number**

1-888-939-3333

- **Background**

The Canadian Cancer Society — Ontario Division (CCS) is a national, community-based organization of volunteers whose mission is the eradication of cancer and the enhancement of the quality of life of people living with cancer. CCS, in collaboration with the National Cancer Institute of Canada, works toward these goals through research, education, patient services, and advocacy for healthy public policy. The CCS - Ontario Division is a major partner in OCAT and was a major player in the passage of the Ontario *Tobacco Control Act*. At the community level, both the public education components and the public policy activities are delivered by volunteers, either alone or as part of a coalition of agencies.

Heart and Stroke Foundation of Ontario

- **Website:**

www.hsf.on.ca

- **Toll-free Healthline**

1-888-473-4636

- **Background**

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 (OCAT) and continues to be a major partner in funding OCAT.

HeartSmart Family Fun Pack and *Heart Healthy Kids Toolbox, Vol. II* include materials to create awareness and provide information about healthy lifestyle choices, of which a smoke-free environment is a major component.

The Foundation is a member of CTFO and a partner in the Ontario Heart Health Network (OHHN), the Ministry of Health Initiative and OCAT (see above). As well, it is involved in the local community activities of these organizations.

The Ontario Lung Association

- **Website:**

www.on.lung.ca

- **Toll-Free Information Line:**

1-800-972-2636

- **Background**

The Ontario Lung Association, a division of the Canadian Lung Association, has 33 community offices throughout Ontario. The Lung Association is Canada's oldest not-for-profit health promotion organization and was first established in 1900 to stop the spread of tuberculosis. Now its mission is the improvement of respiratory health by providing a number of community services and supporting medical research. Since the early 1960s, the Lung Association has taken a leadership role in encouraging individuals to stop smoking.

The Association has a number of information resources such as print materials (brochures, fact sheets, and booklets) and a web site featuring a variety of tobacco-related topics such as the health effects of cigarette smoking and exposure, to statistics on smoking. The intended users range from clients, other agencies, the medical community, the education community and workplaces. The materials are obtained by calling The Lung Association Information Line or by dropping into a Lung Association community office or by visiting the website. The Lung Association receives about 12,000 calls each year on their information line and 5000 visits each day to the website. Lung Associations at the local and provincial levels continue to be members in the CTFO network. It is an active member of OCAT and Lung Association community offices are active participants in municipal smoking by-law work.

APPENDIX 4: TABLES

Table 4-1: Deaths Attributable to Tobacco Use by Sex and Major Smoking-Caused Diseases, Ontario 1992

	Males	Females	Total
Cancers	3502	1524	5026
Lung	2777	1237	4014
Oesophageal	172	37	209
Pancreatic	91	58	148
Lip and Oropharyngeal	104	41	145
Bladder	114	29	144
Renal Parenchymal	81	27	108
Laryngeal	97	10	107
Stomach	50	19	69
Lung (Spousal ETS)	8	28	36
Cervical	0	27	27
Other Cancers	8	11	19
Heart and Circulatory Diseases	2776	1355	4131
Ischaemic Heart	1754	673	2427
Arterial Disease	444	263	707
Stroke	395	298	693
Heart Failure, Ill-Defined	92	58	150
Cardiac Dysrhythmia	67	39	106
Pulmonary Circulatory	24	24	48
Respiratory Diseases	1545	770	2315
Chronic Obstructive Pulmonary Disease	1306	650	1956
Pneumonia and Influenza	239	120	359

Source: Xie et al., 1996

Table 4-2: Students Reporting Use of >1 Cigarette During the Past Year, by Sex and Grade, Ontario 1981-1999

Year		1981	1983	1985	1987	1989	1991	1993	1995	1997	1999	
(N)		(3270)	(4737)	(4154)	(4267)	(3915)	(3945)	(3571)	(3870)	(3990)	(2868)	(4894)
		% Reporting >1 Cigarette During the Past Year (95% Confidence Interval)										
											G7,9,11,13	G7-13
Total		30 (27-34)	29 (26-32)	25 (23-27)	24 (23-26)	23 (22-25)	22 (20-23)	24 (21-26)	28 (26-30)	28 (26-29)	28 (25-32)	29 (27-32)
Sex	Male	26 (24-29)	28 (24-32)	23 (20-25)	23 (20-25)	22 (20-24)	22 (20-23)	23 (20-25)	28 (26-31)	26 (24-29)	28 (24-33)	30 (27-33)
	Female	35 (29-41)	30 (27-33)	26 (23-29)	25 (23-27)	25 (21-28)	22 (19-25)	25 (22-29)	28 (25-30)	29 (28-30)	28 (24-33)	29 (26-32)
Grade	7	9 (8-11)	15 (8-21)	11 (7-14)	10 (7-13)	7 (4-10)	6 (5-7)	9 (8-11)	10 (7-14)	10 (8-12)	7 (5-10)	7 (5-10)
	8	—	—	—	—	—	—	—	—	—	—	18 (14-22)
	9	32 (27-38)	33 (31-34)	25 (20-29)	25 (22-28)	28 (26-30)	21 (19-24)	24 (19-29)	28 (26-29)	26 (24-28)	28 (24-33)	28 (24-33)
	10	—	—	—	—	—	—	—	—	—	—	37 (32-43)
	11	43 (38-49)	45 (39-50)	35 (31-39)	32 (29-36)	30 (27-34)	32 (29-34)	35 (29-41)	42 (37-46)	43 (40-47)	42 (35-48)	42 (35-48)
	12	—	—	—	—	—	—	—	—	—	—	39 (33-44)
	13 (OAC)	23 (13-33)	30 (27-33)	29 (26-33)	32 (29-34)	30 (27-34)	31 (29-32)	28 (22-33)	31 (28-34)	31 (29-33)	38 (25-53)	38 (25-53)

Refer to Appendix 2 for survey descriptions.
Source: Adlaf et al., 1999b

Table 4-3: Current Smoking by Age and Sex, Age 18+, Ontario 1992-1999

	1992	1993	1994	1995	1996	1997	1998	1999
	% Smokers (95% Confidence Interval)							
Age 18+								
Total	26 (23-29)	23 (20-26)	25 (23-27)	29 (26-32)	27 (25-29)	27 (25-29)	26 (24-28)	25 (23-27)
Male	30 (26-34)	28 (24-32)	27 (24-30)	30 (26-34)	29 (26-32)	30 (27-33)	28 (25-31)	28 (25-31)
Female	23 (19-27)	19 (16-22)	24 (21-27)	27 (23-31)	26 (24-29)	25 (23-28)	24 (21-26)	23 (20-25)
Ages 18-34								
Total	31 (26-36)	28 (23-33)	34 (30-37)	33 (28-38)	30 (27-34)	35 (31-38)	33 (29-37)	33 (29-37)
Male	33 (26-40)	31 (24-38)	35 (29-41)	31 (23-39)	31 (26-37)	39 (34-45)	37 (31-43)	38 (32-44
Female	28 (21-35)	24 (18-30)	34 (29-39)	35 (27-43)	30 (25-35)	30 (26-35)	29 (24-34)	28 (23-33)
Ages 35-54								
Total	27 (23-31)	25 (21-29)	23 (20-26)	29 (24-34)	30 (27-33)	28 (25-31)	27 (24-30)	26 (23-29)
Male	35 (28-42)	30 (23-37)	24 (19-29)	35 (28-42)	32 (28-37)	30 (26-35)	27 (23-32)	27 (23-32)
Female	22 (16-28)	20 (14-26)	22 (18-26)	23 (16-30)	27 (23-31)	26 (22-30)	26 (23-31)	26 (22-30)
Age 55+								
Total	14 (9-19)	12 (7-17)	15 (11-19)	19 (13-25)	19 (16-22)	14 (12-17)	17 (14-20)	15 (12-19)
Male	12 (6-18)	16 (8-24)	18 (12-24)	17 (9-24)	17 (13-23)	14 (11-19)	18 (13-24)	18 (13-24)
Female	15 (8-22)	9 (4-14)	12 (8-16)	21 (13-29)	20 (16-25)	14 (11-18)	15 (12-20)	13 (10-17)

Source: CAMH surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor 1996-1998; CAMH Monitor 1999.
Refer to Appendix 2 for definitions of smoking status and survey descriptions.

Table 4-4: Daily Smoking by Sex, Age 18+, Ontario 1992-1999

	1992	1993	1994	1995	1996	1997	1998	1999
	% Daily Smokers (95% Confidence Interval)							
Age 18+								
Total	25 (22-28)	22 (19-25)	24 (22-26)	27 (24-30)	23 (21-25)	23 (21-25)	21 (20-23)	21 (19-23)
Male	29 (25-33)	26 (22-30)	25 (22-28)	29 (25-33)	24 (21-26)	26 (23-29)	24 (21-27)	23 (21-26)
Female	22 (19-25)	19 (16-22)	23 (20-26)	25 (21-29)	23 (20-25)	20 (18-23)	19 (17-22)	18 (16-21)

Source: CAMH surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor 1996-1998; CAMH Monitor 1999

Table 4-5: Mean Number of Cigarettes Smoked Daily by Sex, Daily Smokers, Age 18+, Ontario 1992-1999

	1992	1993	1994	1995	1996	1997	1998	1999
	Mean # cigarettes smoked daily (95% Confidence Interval)							
Age 18+								
Total	17.5 (16.2-18.7)	16.5 (15.1-17.6)	16.1 (15.1-17.1)	17.6 (16.2-19.0)	17.7 (17.0-18.5)	17.1 (16.2-17.9)	17.6 (16.8-18.5)	17.6 (16.7-18.5)
Men	18.4 (16.5-20.2)	18.7 (16.7-20.6)	16.7 (15.0-18.3)	19.4 (17.7-21.2)	19.6 (18.5-20.8)	18.1 (16.9-19.2)	19.7 (18.4-20.9)	19.3 (17.9-20.6)
Women	16.4 (14.7-18.1)	16.3 (14.5-18.0)	15.5 (14.3-16.8)	15.4 (13.3-17.6)	16.0 (15.0-16.9)	15.9 (14.7-17.0)	15.4 (14.4-16.4)	15.6 (14.5-16.7)

Source: CAMH surveys: Ontario Alcohol and Other Drug Opinion Survey 1992-1995; Ontario Drug Monitor 1996-1998; CAMH Monitor 1999.

Table 4-6: Support for Smoke-Free Public Places, by Smoking Status, Age, and Sex, Age 18+, Ontario 1999

ATTITUDES TOWARD SMOKING IN PUBLIC PLACES	Percent Support	SMOKING STATUS			AGE			SEX	
		Current	Former	Never	18-34	35-54	55+	Men	Women
Workplaces									
• Smoking should NOT be allowed in any section of a workplace	**47**	25	50	56	38	51	52	39	54
• Smoking should be allowed ONLY in enclosed sections that are separately ventilated to the outdoors	**30**	35	32	26	31	31	26	31	29
Restaurants									
• Smoking should NOT be allowed in any section in restaurants	**32**	11	31	43	25	35	37	27	36
• Smoking should be allowed ONLY in enclosed sections that are separately ventilated to the outdoors	**38**	37	40	38	41	38	33	36	40
Bars/Taverns									
• Smoking should NOT be allowed in any section of a bar or tavern	**15**	4**	15	22	10*	17	21	13	18
• Smoking should be allowed ONLY in enclosed sections that are separately ventilated to the outdoors	**31**	17	35	36	24	35	32	27	35

* Small cell size (<30). **Very low cell count (n≤15) Interpret data with caution.

Source: CAMH Monitor, 1999

Table 4-7: Support for Various Tobacco Policies, by Smoking Status, Age, and Sex, Ontario 1999

ATTITUDES TOWARD VARIOUS TOBACCO POLICIES	Percent Support	SMOKING STATUS			AGE			SEX	
		Current	Former	Never	18-34	35-54	55+	Men	Women
Sponsorship									
• The government should not allow cigarette companies to sponsor sporting or cultural events*	**44**	27	50	49	39	47	44	38	49
Taxes									
• Taxes on cigarettes should be increased*	**43**	16	46	55	41	46	38	38	47

* responses for “strongly agree” and “somewhat agree” are combined
Source: CAMH Monitor, 1999

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