THE ONTARIO TOBACCO RESEARCH UNIT
UNITÉ DE RECHERCHE SUR LE TABAC DE L'ONTARIO
Generating knowledge for public health

EVALUATION UPDATE

March 2017

Smoke-Free Ontario Strategy Monitoring Report Executive Summary

The Smoke-Free Ontario Strategy is a comprehensive tobacco control program involving a broad coalition of partners including provincial and local governments, boards of health, voluntary health organizations, hospitals, and universities. Primary funding for the Strategy comes from the Ontario Ministry of Health and Long-Term Care, with direct and in-kind funding from other Strategy partners. This year's Smoke-Free Ontario Monitoring Report includes assessments of Ontario's progress relative to the World Health Organization's MPOWER standards,[1] and the recommendations of the 2010 Smoke-Free Ontario Scientific Advisory Committee (SAC).[2]

The Ontario Government continues to take noteworthy steps to strengthen tobacco control. Recent initiatives include smoking bans on restaurant and bar patios, playgrounds, and publically-owned sports fields and surfaces; bans on the sale of flavoured tobacco, now including menthol cigarettes. These activities complement recent ongoing initiatives including smoking bans in indoor public and workplaces, free access to smoking cessation medications and pharmacist counselling for Ontario Drug Benefit beneficiaries, limited access to free nicotine replacement therapy (NRT), and cessation support through a variety of channels.

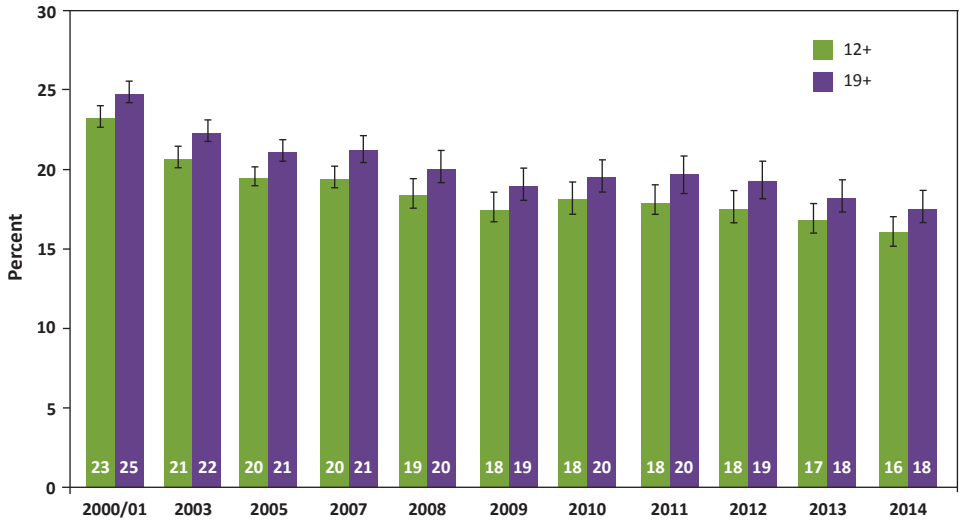
Overall Tobacco Use

- In 2014, 19.6% of Ontarians aged 12 years or over reported past 30-day use of various tobacco products (including cigarettes, cigars, pipes, snuff or chewing tobacco, but excluding waterpipe and electronic cigarettes). This represents 2,268,300 tobacco users (CCHS 2014).[3]
- This is statistically lower from the 2010, rate of 22.1% (or 2,465,400 users).

Cigarette Use

- In 2014, 16% of Ontarians aged 12 years and over and 18% of those aged 19 and over were current smokers (had smoked cigarettes in the past 30 days and had smoked at least 100 cigarettes in their lifetime), (CCHS 2014; Figure 1 here; Figure 2-1 and Table 2A-1 in the full report), statistically lower from 2010 (18.2% and 20% respectively).
- In 2014, 20% (or 1,167,800) of males aged 12 years or over currently smoked, whereas 12% (or 721,200) of females smoked.
- In 2014, current smoking was highest among workers in processing, manufacturing and utilities (33%); trades, transport and equipment operators (32%); and primary industry (29%M[4]), representing a combined total of 461,400 (or 37%) of the 1,253,900 employed smokers in Ontario aged 15 to 75 years (CCHS 2014).
- In recent years, Ontarians with a university degree were 2 to 3 times less likely to be current smokers than those with less education (CAMH Monitor 2015).

Figure 1: Current Smoking (Past 30 Days), Ages 12+ and 19+, Ontario, 2000/01 to 2014



Note: Vertical lines represent 95% confidence intervals. X-axis scale (Year) is not uniform—interpret with caution.
Source: Canadian Community Health Survey 2000/01, 2003, 2005, 2007-2014.

Alternative Products: Cigars, E-Cigarettes and Waterpipes

- In 2014, 3.8% of Ontarians aged 12 years and over (444,200 people) had smoked cigars in the past 30 days, making cigars the second-most prevalent form of tobacco use after cigarettes. In 2015, 83% of cigars sold in Ontario were flavoured, with menthol comprising 4.2% of all cigar sales.
- In 2015, past 30-day use of electronic cigarettes was 3%M among adults 18 years and older. Past-year use of electronic cigarettes was 11% among adults 18 years and over, with young adults aged 18 to 24 three times as likely to have used in the past year compared to 25 to 44 year olds (33% vs. 11%) and more than four times more likely than adults aged 45 to 65 (33% vs. 7%; CAMH Monitor 2015).
- Among all students in grades 7 to 12 in 2015, 23% reported ever using an e-cigarette (OSDUHS 2015); significantly more male than female students had ever used an e-cigarette in their lifetime (27% vs. 18%).
- Among students in grades 7 to 12, 14% had ever used a waterpipe, with use significantly increasing with grade, peaking at 26% in grade 12 (OSDUHS 2015).
- Past-year use of a waterpipe in 2015 among students in grades 7 to 12 was 12% (or 113,100 youth).

Prevention

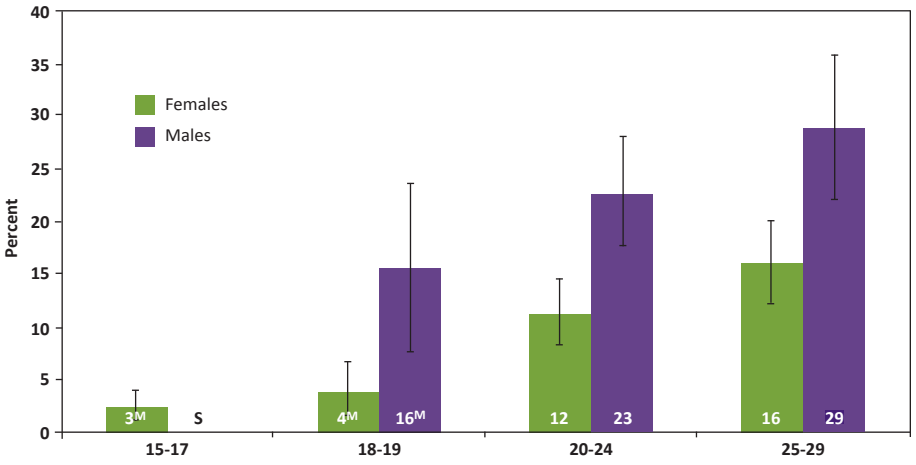
The Smoke-Free Ontario Strategy includes a number of programs, services, and policies focused on prevention and reduction of tobacco use among youth and young adults. These initiatives are centred on increasing knowledge of the harmful effects of tobacco use; increasing youth resiliency to make healthy choices and resist tobacco use initiation; limiting social exposure to tobacco use; and decreasing access and availability of tobacco products.

Policies and programs to prevent initiation—including taxation, restrictions on youth access, smoking bans, advertising bans, youth engagement initiatives, and school-based programming—have had some success in the general youth population.

- Reporting of past 30-day current smoking is 2%M in Grades 9 and 10 (combined) and has remained relatively constant at 5% for Grade 11 and 12 since 2011 (OSDUHS 2015).
- Over the period 2010 to 2014, there has been a significant decline in current smoking among young adults aged 20 to24—from 24% to 17%; this decline has yet to be mirrored in smoking rates of older young adults aged 25 to 29, which remain at 23%.
- Despite improvements in recent years, in 2014, current smoking was still firmly established among 18- to 19-year olds (10%M), young adults aged 20 to 24 (17%) and those aged 25-29 (23%; CCHS 2014).
- Males aged 18 to 19, 20 to 24 and 25 to 29 were significantly more likely to smoke in the past-30 days compared to females of the same age (Figure 2 here, Figure 3-7 and Table 3A-6 in the full report)

Work remains to fulfill several of the 2010 Scientific Advisory Committee recommendations for preventing tobacco use among youth and young adults including: addressing tobacco use in movies that are rated for youth viewing; requiring advertisements preceding movies and video games that contain tobacco imagery; enhancing the protocols for compliance of tobacco and e-cigarette retailers with restrictions on sales to minors; and focusing prevention efforts on high-risk schools, colleges and workplaces where youth and young adults are at greatest risk for tobacco use.

Figure 2: Current Smokers (Past 30 Days), Youth and Young Adults, by Sex, Ontario, 2014



Note: Vertical lines represent 95% confidence intervals. M=Marginal. Interpret with caution: subject to moderate sampling variability. S = data suppressed due to small sample sizes.
Source: Canadian Community Health Survey 2014.

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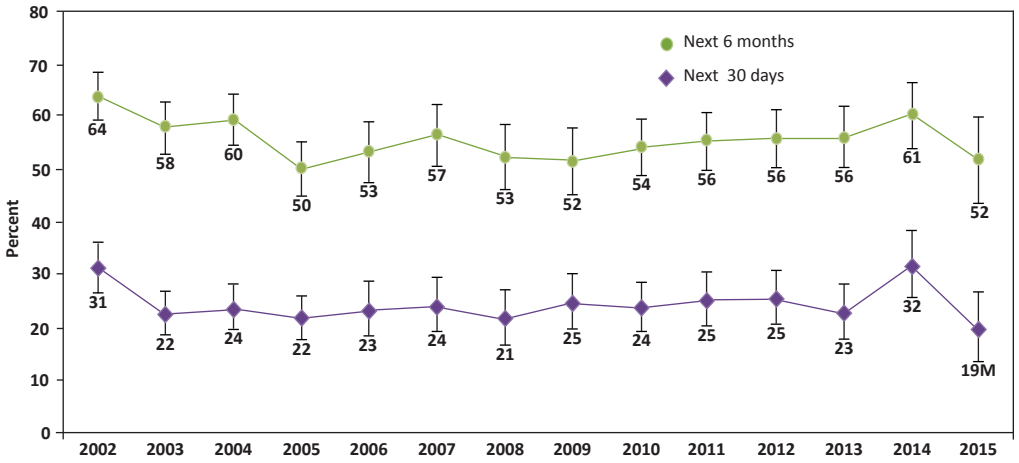
Cessation

A main objective of tobacco control efforts is to increase the proportion of smokers who successfully quit smoking.

- In 2015, five in ten Ontario smokers (52%) intended to quit in the next six months; 19%M in the next 30 days. Both estimates are not statistically different to that reported in 2014 (61% and 32%, respectively; CAMH Monitor; Figure 3 here; Figure 4-7 and Tables 4A-7 and 4A-8 in the full report).
- The proportion of Ontario's smokers who successfully quit each year is estimated to be 1.7%. In order to achieve a five percentage-point decrease in the prevalence of smoking over five years, the proportion of smokers who successfully quit needs to at least double.

Figure 3: Intentions to Quit Smoking in the Next Six Months and Next 30 Days, Ages 18+, Ontario, 2002 to 2015



Note: Vertical lines represent 95% confidence intervals. M = Interpret with caution: subject to moderate sampling variability.
Source: Centre for Addiction and Mental Health Monitor 2002–2015.

Ontario's cessation system builds capacity, provides technical assistance, and offers research and evaluation support to key stakeholders. This infrastructure is delivered by several key organizations including: the Ontario Tobacco Research Unit, University of Ottawa Heart Institute's Ottawa Model for Smoking Cessation, Program Training and Consultation Centre, Public Health Units and Tobacco Control Area Networks, Registered Nurses' Association of Ontario's Nursing Best Practice Smoking Cessation Initiative, Training Enhancement in Applied Cessation Counselling and Health Project, You Can Make It Happen, and Youth Advocacy Training Institute.

Local Boards of Health are mandated to ensure the provision of tobacco use cessation programs and services for priority populations. Public health units may provide cessation services or refer smokers to community and provincial partners. Provincial cessation support services (Leave The Pack Behind, Ottawa Model for Smoking Cessation, the Ontario Drug Benefit program, OHIP billing, Smokers' Helpline, the STOP Program and YATI's Not-On-Tobacco program) reach approximately 17% of smokers annually, with only a small proportion of these participants likely to succeed in quitting in the long term. This is consistent with existing evidence that smokers make multiple quit attempts, and only a few of them go on to successfully quit, with relapse being a typical outcome in a quit attempt.

Progress is being made on some key 2010 SAC directions for cessation including:

- Developments to support an integrated support system
- Direct support to smokers from a variety of program initiatives
- Provision of free NRT or prescription medications and counselling to some high-risk populations and in a variety of settings
- Ongoing cessation training

Opportunities still exist to enhance the cessation system in line with additional 2010 SAC recommendations: universal provision of free NRT and stop-smoking medications; mechanisms to ensure that smokers are asked, advised and assisted to quit at every point of contact with the health care system; creation of a Tobacco-User Support System to ensure that there is "no wrong door" for access to cessation support services; further integration of cessation support services; and tie in with a cessation mass media campaign.

Protection

The US Surgeon General's review of scientific evidence concluded that there is no risk-free level of exposure to secondhand smoke.[5] In addition to the adverse health effects of SHS, exposure to other people smoking results in social exposure to tobacco use with ensuing

normalization of tobacco use, triggering of initiation in youth and young adults through processes of social influence and modeling, and encouragement of the continued use of tobacco among smokers and relapse among quitters.

Ontario meets all of the minimum standards for protection that are included in MPOWER standards in that smoking tobacco is prohibited in all indoor public places and compliance is high. Moreover, Ontario's recent legislation now offers protection in select outdoor settings (restaurant/bar patios, playgrounds and playing fields). Yet, too many Ontarians continue to be exposed to secondhand smoke in a variety of settings:

- In 2015, 13% of workers aged 18 years or older were exposed to secondhand smoke in the past week indoors at work or inside a workplace vehicle, similar to 2014 estimates (9%M) and recent years (CAMH Monitor).
- In 2014, 15% of Ontarians aged 12 years and older were exposed to SHS in public places (restaurants, bars, shopping malls and arenas); a significantly greater proportion of 12 to 18 year olds were exposed (25%; CCHS 2014).
- 6% of nonsmoking Ontarians aged 12 years and older were exposed to SHS in vehicles over the past month compared to 5%M of youth aged 12 to 15 (CCHS 2014).
- 3% of nonsmoking Ontarians aged 12 years and older were exposed to SHS in their home, whereas 8% of 12 to 18 year olds were exposed (CCHS 2014).

The 2010 Scientific Advisory Committee recommended possible next steps to offer further protection for Ontarians including eliminating smoking in priority settings specifically unenclosed bar and restaurant patios, not-for-profit multi-unit housing and selected outdoor public settings (e.g., beaches, playgrounds, outdoor sports facilities, parks, transit shelters, doorways, etc.). Recent regulatory changes implemented by the Government of Ontario closed some of these gaps in protection. Select municipalities have closed other gaps.

Concluding Note

Ontario aspires to become the Canadian jurisdiction with the lowest smoking rate. The province continues to work diligently toward achieving this objective, and progress is being made across the comprehensive goals of protection, cessation, and prevention. Smoke-Free Ontario partners are supporting positive changes in the physical and social climates both to prevent and reduce tobacco use, which helps to create environments conducive to decreased initiation, increased cessation, and, ultimately, reduced smoking in Ontario.

Tobacco control efforts resulted in a 2.1 percentage point (statistically significant) decrease in the prevalence of smoking over the five-year period starting in 2010 and ending in 2014. This falls short of the five percentage point decrease over five years called for in 2010 by the Tobacco Strategy Advisory Group. And the gap between Ontario and British Columbia–the Canadian jurisdiction with the lowest cigarette smoking rate–is still a significant four percentage points.

Given what is known about tobacco caused morbidity and mortality, this rate of decline is viewed by many as unsatisfactory. In some occupations, one in every three people still smokes cigarettes. And university educated people are 2 to 3 times less likely to smoke cigarettes than people with no post-secondary education. With one in every five adult Ontarians currently using tobacco, it is clear that tobacco is far from done.

To accelerate the rate of reduction in tobacco use, there is a need to adopt more far-reaching policies such as those recommended by the 2016 SAC and those being adopted in other leading jurisdictions.

References and Notes

[1] World Health Organization. *WHO Report on the Global Tobacco Epidemic, 2008: The MPOWER Package*. Geneva, Switzerland: WHO, 2008.
[2] Smoke-Free Ontario – Scientific Advisory Committee. *Evidence to Guide Action: Comprehensive Tobacco Control in Ontario*. Toronto, ON: Ontario Agency for Health Protection and Promotion, 2010.
[3] The 2015 Canadian Community Health Survey was unexpectedly delayed and was not available when this report was released.
[4] M = Marginal estimate. Interpret with caution: subject to moderate sampling variability.
[5] US Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
[6] Ontario Ministry of Health and Long-Term Care. *Ontario's Action Plan for Health Care.* Toronto, ON: Queen's Printer for Ontario, 2012.

Since 1994, the Smoke-Free Ontario Evaluation/ Monitoring Reports have presented evaluative information about the activities and results of the provincial tobacco control strategy. Drawing on information from population-level surveys, program evaluations, performance reports and administrative data, this year's report describes Strategy infrastructure and Interventions, (policies, programs and social marketing), analyzes population-level changes, and explores the contributions of the various interventions, as of December 2016.

Key authors of the report are: Robert Schwartz, Shawn O'Connor and Jolene Dubray. The full report is available on our website at www.otru.org.