NEW DIRECTIONS FOR TOBACCO CONTROL IN CANADA

A NATIONAL STRATEGY

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Steering Committee of the
National Strategy to Reduce Tobacco Use in Canada
in Partnership with
Advisory Committee on Population Health

Table of Contents

Executive Summary

Tobacco use is the most important cause of preventable illness, disability and premature death in Canada, with the deaths of 45,000 Canadians each year attributable to the use of tobacco products. The latest survey information, from the National Population Health Survey 1996/97 reports that 30% of Canadian men and 25% of women age 12 and over were daily or occasional smokers. However, there are specific populations, particularly First Nations, Metis and Inuit peoples and Francophones for which smoking rates remain significantly higher.

The health risks of smoking, for smokers and non-smokers, are well established and numerous. Other forms of tobacco, such as smokeless tobacco, are also harmful to health. The impact on Canadians reaches beyond health, to societal costs, including direct health care costs, lost productivity and foregone household income. Health Canada estimates that, in Canada, the societal costs attributable to smoking for 1993 were approximately $11 billion.

Tobacco is unlike other legally available consumer products. The nicotine in tobacco products makes the products inherently addictive. Other chemicals, released in tobacco smoke, or released in saliva in the case of chewing tobacco, makes tobacco hazardous. Increases in smoking since 1993, particularly among teens and young adults, are alarming given the fact that young people can develop an addiction with lifelong consequences.

Effective tobacco control requires partners to work together towards common goals and strategic directions. It requires integration, coordination and complementarity of a diverse array of strategies. The federal/provincial/territorial governments have a critical leadership role for achieving national action. A diverse array of strategies including research, policy and programmatic components developed and coordinated at the local, provincial/territorial, national and international levels are needed to successfully reduce tobacco consumption. Canadian governments and major voluntary health agencies have stated a commitment to reduce tobacco use and are engaged in a range of activities in this area. Canadians support such actions. In September 1998, the Provincial/Territorial Conference of Ministers of Health asked the Provincial/Territorial Conference of Deputy Ministers of Health to develop a national tobacco strategy.

This paper provides a framework for action. Building on the longstanding goals of prevention, cessation, and protection, the addition of a goal for denormalization[1] builds on recent evidence of effective interventions. The five strategic directions outlined are: policy and legislation; public education; industry accountability and product control; research; and, building and supporting capacity for action.

The strategic directions provide the basis for planning, implementing and evaluating collaborative action. The priorities for each strategic direction outline a comprehensive, long-term strategy based on practices and interventions known to be effective. It is hoped that all levels of government, organizations, community groups and individuals across Canada will develop plans of action based upon the framework provided in this paper.

When each jurisdiction and organization with an interest in tobacco control contributes to the overall action plan, Canada will be implementing an effective, comprehensive strategy.

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[1] Denormalization refers to activities undertaken specifically to reposition tobacco products and the tobacco industry consistent with the addictive and hazardous nature of tobacco products, the health, social and economic burden resulting from the use of tobacco, and practices undertaken by the industry to promote its products and create social goodwill towards the industry. See Appendix C.

1.0
Preface

The overall role of the Advisory Committee on Population Health is to advise the Conference of Deputy Ministers on national and interprovincial strategies that should be pursued to improve the health status of the Canadian population and to provide a more integrated approach to health.

The overall role of the Steering Committee of the National Strategy to Reduce Tobacco Use in Canada is to establish goals and strategic objectives for government and non-government organizations to collaborate on the national effort to reduce tobacco use.

The Steering Committee provided broad-based expertise in the area of tobacco control to support the development of the strategy.

2.0
The Health and Socioeconomic Issues

Tobacco use is the most important cause of preventable illness, disability and premature death in Canada.[1] The number of deaths attributable to smoking exceeds the combined total of those due to suicide, AIDS, vehicle collisions, and murder.

The deaths of 45,000 Canadians each year are attributable to the use of tobacco products. Between one third and one half of those Canadians, —over three million people, will die prematurely as a result of their long term tobacco use.[2] Others will suffer from years of reduced quality of life.

Unlike other legally available consumer products, tobacco is inherently hazardous and addictive.[3, 4] Because the nicotine in tobacco products is addictive, smokers find it difficult to quit even if they are aware of the hazards associated with smoking.[5] Increases in smoking since 1993, particularly among teens and young adults, are alarming given the fact that young people can develop an addiction with lifelong consequences.

The length of time between initial experimentation and the ultimate adverse health consequences is typically 20 to 30 years, resulting in a loss of the kind of immediacy generated by less threatening public health issues.[6] While the death toll will keep rising for some years because it is linked to past smoking prevalence, only by reducing demand for tobacco products in the present can the number who will die from addiction to smoking be reduced in future decades.

The consequences of tobacco use have become an issue of global concern far beyond the confines of national boundaries. The World Health Organization estimates that three million people die every year from tobacco-related diseases.[7]

2.1
Smoking Prevalence in Canada

The latest survey information, from the National Population Health Survey (1996/97) reports that 30% of Canadian men and 25% of women aged 12 and over were daily or occasional smokers. However, there are specific populations for which smoking rates remain significantly higher.

Of particular concern is the rate of smoking among young women. While the rate of smoking among men exceeds the rate for women in every age group 18 years and over, the rate of smoking among girls age 12 to 14 (10%) and 15 to 17 (29%) is substantially higher than among young men of the same age (6% and 22% respectively).[8]

Smoking rates increase as income level decreases. Smoking rates among women and men in the highest income quintile were 13% and 16% respectively, in contrast to rates of 36% and 40% for the lowest income quintile.[9]

Smoking rates are also higher among Francophone populations.[10]

The highest rates of smoking in Canada are reported by Aboriginal peoples. The 1997 First Nations and Inuit Regional Health Surveys reported the smoking rates at 62% for the First Nations and 72% for the Inuit. This is more than twice the rate of the Canadian population as a whole. The average age for smoking uptake is also younger (at 10 years) for these populations.[11]

2.2
The Costs of Smoking

Health Canada estimates that, in Canada, the societal costs attributable to smoking for 1993 were approximately $11 billion, of which $3 billion was spent on direct health care costs such as hospitalization and physician time.[12] The remaining $8 billion was due to lost productivity, including foregone household income.[13] Labour Canada has estimated that a smoking employee costs $2,308 to $2,613 more a year to employ than a non-smoker as a result of absenteeism, increased health and life insurance premiums and lost productivity.[14] In comparison, it is estimated that in fiscal year 1993/94 federal excise taxes and duties totalled $2.6 billion.[15]

2.3
Health Effects of Tobacco Use

The health risks of smoking and smokeless tobacco use (chewing tobacco and snuff) are well established and numerous. Smoking is a major cause of heart disease, stroke and diseases of the blood vessels, and is responsible for many cancers, including those of the lung, oral cavity, urinary tract and cervix.

It causes respiratory diseases, and increases risks associated with pregnancy outcomes. Smokeless tobacco can lead to cancer of the oral cavity and other serious problems affecting the mouth, teeth and gums.[16]

The health consequences of smoking are not limited to smokers. The link between regular exposure to second hand smoke from other people's cigarettes and fatal disease is well established.[17] Children regularly exposed to second hand smoke at home or in child care are particularly vulnerable because of their small size and their physiological development.[18]

Quitting smoking is the single most effective thing that smokers can do to enhance the quality and length of their lives. For some conditions, such as ischemic heart disease, the benefits of quitting smoking are substantial, both immediately and in the long term. The risks of dying from tobacco-related diseases are reduced over time, in comparison with continuing smokers.

3.0 Evidence of Effective Action

Public education about the hazards of tobacco use reduced smoking rates among Canadians from the 1960s to the early 1990s. Further decreases were achieved during a period of considerable public health action that complemented public education. Canada is recognized for having taken an early and continuing international leadership role in combating smoking and in regulating the sale, marketing and labelling of tobacco products.[19]

The momentum toward reducing the prevalence of tobacco use has stalled because people who quit smoking (mostly adults) and people who die from smoking (also mostly adults) are being replaced with new recruits to smoking (mostly adolescents).[20] A similar trend has been seen in other developed countries (e.g., Great Britain and Australia) and is considered to be a result of aggressive marketing by tobacco companies. Increased pro-tobacco messaging occurred coincidentally with the reversal of some public health advances, notably tobacco taxation policy.

When a full range of regulatory and educational measures are deployed, tobacco use declines, as seen in Canada in the 1980s and more recently in California[21] and Massachusetts.[22,23]

The States of California and Massachusetts are pioneers in having launched long-term comprehensive public health programs to prevent and reduce tobacco use. These programs are funded with increases in their states' excise tax on tobacco products and have served as models for other jurisdictions. Per-capita consumption in both states has declined more rapidly than in the rest of the United States. Increase in tobacco use among youth in California and Massachusetts has also slowed in comparison to national trends.[24, 25]

While some may consider smoking to be an individual issue, healthier behaviours have an increased likelihood of being sustained by individuals if they are made in a context of societal behaviour change.

4.0
A National
Strategy

It is widely recognized that multiple approaches are required to effectively address tobacco use. No single approach has been shown to solve the problem of tobacco. Effective tobacco control requires a diverse array of strategies including research, policy and programmatic components. Strategies must be comprehensive, developed and coordinated to work together and compliment those implemented at the local, provincial/ territorial, national and international levels.

A coordinated approach to implementation of a comprehensive strategy, in addition to being more effective, means responsibility for action is shared among a number of governments and organizations. No jurisdiction or organization must do everything. Each jurisdiction and organization can make a contribution to the overall strategy.

The National Strategy for Tobacco Control is based on a population health approach and addresses a range of factors that determine health such as social, economic and physical environments, personal health practices, individual capacity and coping skills, and health services. The strategy is intented to affect the entire population and create opportunities for the integration of tobacco issues within population health initiatives.[26]

Reaching all Canadians does not mean, however, that everyone in the community receives exactly the same program. Interventions directed to the community at large should be balanced with interventions for groups and individuals with particular risks and needs. Smoking rates within the Canadian population help identify groups needing specific approaches. For example, due to the high smoking rates and unique needs and requirements[2] of First Nations peoples, Metis and Inuit, it is recognized that separate strategies, that build on the National Strategy, must be developed for these groups. All strategies would need to be developed in conjunction with local leadership using collaborative, community based mechanisms.

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[2]   Unique needs and requirements include factors such as the traditional use of tobacco in some aboriginal cultures and the governance and cultural differences of Nunavut (e.g. in Nunavut, 85% of the population are Inuit and the smoking rate is 72%).

Implementation of a National Strategy must include partnerships between governments, non-governmental organizations and other partners, and use of collaborative mechanisms, such as the Steering Committee of the National Strategy to Reduce Tobacco Use, the Advisory Committee on Population Health, and the Canadian Tobacco Research Initiative.[27] An outline of key partners and their potential roles are provided in Appendix B.

Canadian governments and major voluntary health agencies have stated a commitment to reduce tobacco use and are engaged in a range of activities to support this aim. There is strong evidence that the public supports these initiatives and is demanding further action. The federal/provincial/territorial governments have a critical leadership role for achieving national action.

A long term, sustained and comprehensive commitment to tobacco control is essential to achieve continued progress in reducing tobacco use.

5.0
A Framework for Action

Tobacco control initiatives over the past three decades have been directed primarily, although not exclusively, to the creation of social environments that support smoke-free living, and to influencing individual decisions about smoking and smoking behaviours. Action has been taken at the national, provincial/territorial, regional and community levels, through many governments and non-governmental organizations. Having shared responsibility for tobacco control has provided Canada with a history of different jurisdictions leap-frogging forward to provide leadership and models for action.

Some major activities to date have included:

▸ Informing Canadians about the health effects of smoking and second hand smoke;

▸ Providing programs to support those who choose to quit smoking;

▸ Reducing access to tobacco products by minors (through federal and provincial laws);

▸ Deterring smokers by increasing product pricing through taxation (at the federal and provincial/territorial level);

▸ Placing restrictions on where smoking may occur (through federal and provincial/territorial laws and municipal bylaws; and through organizational policy);

▸ Restricting tobacco product advertising and promotion;

▸ Encouraging Canadians to become involved in creating social environments that support smoke-free living;

▸ Educating and building skills among school-age Canadians;

▸ Requiring tobacco companies to release information on the composition of cigarettes and cigarette smoke; and

▸ British Columbia challenged the tobacco industry to recover the costs due to tobacco related illnesses.

All of these initiatives have had a measure of success and should be continued, although the focus may shift to reflect the current learnings. For example, Canadians have high levels of awareness that smoking is bad for their health, but have limited understanding of the specific risks of smoking and second hand smoke and smokeless tobacco.

There is an emerging interest in taking actions directed specifically at the tobacco industry. Recent access to thousands of tobacco industry documents has created public awareness about the strategies and tactics of the tobacco industry. In the United States, for example, specifically questions arise as to how young smokers are recruited. Accordingly, it is appropriate to examine how the tobacco industry has dealt with Canadians and whether they have exhibited fair play or responsible corporate conduct. This examination is a necessary exercise because, unlike other legally available consumer products, tobacco is inherently hazardous and addictive.[28, 29]

5.1 Goals for a Renewed Tobacco Control Strategy

The epidemic of death and disease among Canadians resulting from tobacco use, can only be stopped by ending the use of tobacco products. It is recognized it will take several decades to achieve the vision of a smoke-free society.[30] However, taking collaborative action can lead to significant progress toward that objective. The four goals and five strategic directions presented in this paper provide a framework for continuous and increasing efforts by governments and non-governmental organizations, individuals, health intermediaries and communities.

The four goals are:

Prevention:	Preventing tobacco use among young people.
Cessation:	Persuading and helping smokers to stop using tobacco products.
Protection:	Protecting Canadians by eliminating exposure to second hand smoke.
Denormalization:	Educating Canadians about the marketing strategies and tactics of the tobacco industry and the effects the industry's products have on the health of Canadians in order that social attitudes are consistent with the hazardous, addictive nature of tobacco and industry products.[3] (See also Appendix C).

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[3]   This includes a broad understanding of the health, social and economic burden resulting from the use of tobacco, and practices undertaken by the industry to promote its products and create social goodwill towards the industry.

5.2
Strategic Directions

Recognized effective tobacco control interventions and actions rarely address only one of the prevention, cessation, protection, or denormalization goals. An intervention that primarily addresses one goal also contributes to achieving other goals, or the action may be broad based and support three or four goals. An example of the former is restrictions on smoke-free places. Such policies or legislation primarily address protection from second hand smoke. However, such restrictions also support prevention by reducing role modelling of smoking as socially acceptable behaviour, encourage smokers to reduce smoking, and are an environmental support for those who are trying to, or have quit smoking. Other activities, such as researching the relationship between smoking and other determinants of health, or building community coalitions, support all four goals.

Similarly, actions specifically directed at youth have not been singled out as these are not necessarily the most effective approaches to reduce tobacco uptake and use among young people. Tobacco control initiatives that have proven to be effective, focus not only on youth but all aspects of society in which young people live. There are actions that affect all people but have greater impact on young people. An example is increasing the price of tobacco through taxation, which affects the smoking patterns of all smokers, but youth significantly more than adults.

For this reason, actions are presented by strategic directions which help identify the type of intervention needed.

This section identifies five strategic directions to achieve the goals of prevention, cessation, protection and denormalization :

Policy and Legislation: To ensure coordination of tobacco policy across sectors, and implementation of organizational policies and legislation across sectors that support reducing tobacco use.

Public Education: To make available and accessible information, services and programs about tobacco and tobacco related issues, which address prevention, cessation, protection and denormalization.

Industry Accountability and Product Control: To regulate the manufacturing, marketing, and sale of tobacco products to reduce addiction and disease.

Research: To increase knowledge of tobacco and tobacco use, the tobacco industry, effective interventions for tobacco control and health and socioeconomic impacts of tobacco use.

Building and Supporting Capacity for Action: To increase the ability of individuals, health intermediaries and communities at the national, provincial/territorial and local levels to take action.

5.3
Priorities for Action Under Each Strategic Direction

The priorities for action outline a comprehensive, long-term strategy based on practices, and interventions known to be effective. While some of these actions have been implemented, the scope and depth varies across Canada.

No one type of organization could, on their own, undertake all these activities. Effective tobacco prevention control requires integration, coordination and complementarity of a diverse array of strategies at the local, provincial/territorial, national and international levels, with the participation of a range of organizations.

The strategic directions provide the basis for planning, implementation and evaluation of collaborative action on tobacco control at the local, provincial/territorial and national levels by governments and non-governmental organizations to achieve the goals. Strategic directions should be reviewed periodically to determine what changes should be made to reflect socioeconomic, health promotion, research, and industry developments.

Specific detailed plans from partners need to ensure that program activities are based on best practices, acknowledge the needs of Canadians (such as addressing gender-sensitive issues) and integrate evaluation of interventions as an ongoing part of their activity. While each partner will make a contribution to the overall strategy, there needs to be a co-ordinating mechanism to ensure that collective action is addressing all the priorities for action.

Policy and Legislation[4]

- ▸ Recognizing that higher prices are a deterrent for tobacco use, contribute to a long-term joint federal-provincial-territorial strategy for increasing taxation for tobacco products across Canada.

- ▸ Enforce tobacco control legislation by adopting a comprehensive approach which includes traditional enforcement measures, as well as citizen engagement to influence community practices.

- ▸ Develop legislation and policies to support protection from second hand smoke in public places, the workplace and schools.

- ▸ Encourage and support pro-health policies on tobacco among all media in order to influence editorial and advertising policies to be supportive of smoke-free living.

- ▸ Support the development of the World Health Organization (WHO) Framework Convention on Tobacco Control. (See Appendix D for information about the Framework).

- ▸ Participate in international policy initiatives to coordinate control of the transnational tobacco industry.

- ▸ Develop policies to provide adequate funding for tobacco control initiatives.

- ▸ Align policies across relevant departments/ministries such as health, finance, agriculture, trade, justice and education to support the health agenda related to tobacco control.

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

- ▸ Develop public education campaigns that denormalize the tobacco industry and tobacco products, and the consumption of tobacco products, exposing the strategies and tactics of the industry, and informing the public of the true costs and the health impact of tobacco use.

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[4] Additional policy and legislative initiatives are placed under the strategic directions of "Industry Accountability" and "Product Control".

▸ Identify gaps in existing programs, relevant to specific populations, e.g., First Nations, Metis and Inuit peoples, Francophones, youth, ethnic groups, pregnant women and develop and implement evidence-based programs involving these populations.

▸ Provide Canadians with relevant information concerning tobacco products, such as ingredients, constituents of smoke, etc.

▸ Provide Canadians who want to stop smoking, including lower income groups, with access to appropriate smoking cessation programs, supports, and nicotine replacement therapy when appropriate and explore the feasibility of establishing a national 1-800 counselling line.

▸ Reach and involve youth in a range of programs and activities in a variety of settings, including school based prevention programs. Youth can also be reached through a range of other settings such as youth groups, teen wellness centres, community centres, youth at risk programs, cultural centres, detention centres, group homes, etc.

Industry Accountability and Product Control

▸ Establish comprehensive restrictions on brand name advertising of tobacco products, and related promotion and sponsorship.

▸ Encourage the development of enabling legislation to recover from tobacco companies the health care costs resulting from tobacco product use.

▸ Require the tobacco industry to report on: marketing research, financial statements, sales volumes, toxic constituents of tobacco smoke from each of its products, activities and expenditures on marketing, promotion and sponsorship, etc.

▸ Develop a strategy for the implementation of product standards to reduce addiction and disease from tobacco products.

▸ Continue to introduce measures to make tobacco packaging more informative.

Research (Research, Evaluation, Monitoring)

▸ Analyze and disseminate research findings to support the development and adoption of best practices.

▸ Examine a range of tobacco use cessation strategies, including comprehensive strategies that match clients to appropriate interventions, and recruitment strategies to increase the number of tobacco users who access cessation supports. This includes research to develop effective cessation programs for youth. Programs should also identify when nicotine replacement therapy (NRT) is appropriate.

▸ Research to better understand interactiveness among interventions, with a view to developing guidelines for the best mix of interventions for optimal impact for prevention, cessation, protection, and denormalization.

▸ Research the "world" (culture) in which youth live, to understand the multiple and varied factors and influences that contribute to youth uptake of tobacco use.

▸ Research to better understand the impact of health determinants on tobacco use.

▸ Research to better understand the potential for use and abuse of nicotine available in products other than tobacco products, e.g., nicotine replacement therapy.

▸ Research how product modification (in nicotine/tar, content, delivery systems, additives, taste, size, etc.), including the examination of unintended negative effects, can change use patterns and reduce addiction and disease.

▸ Monitor knowledge, attitudes and behaviour about smoking and second hand smoke among children, youth and adults on an ongoing basis.

▸ Monitor and evaluate intervention activities and outcomes on an ongoing basis. In some cases, it may be necessary to establish a baseline.

▸ Monitor emerging issues, such as changing tobacco industry marketing practices, availability and use of nicotine replacement products, etc.

Building and Supporting Capacity for Action

▸ Build capacity of communities by providing training, resources, and technical expertise in areas such as best practices, social marketing, communications, partnerships, advocacy, research and evaluation.

▸ Ensure access to information on tobacco, including through the National Clearinghouse on Tobacco and Health.

▸ Assist Canadians to acquire the knowledge and skills necessary for action on tobacco control.

▸ Support coalition development, including those specifically for Francophones, Aboriginal peoples, and minority ethnic groups.

▸ Hold regular tobacco conferences or workshops nationally/regionally to promote knowledge development and networking.

▸ Involve youth as advisors, activists and peer models.

▸ Involve people who are role models for children and youth, including parents and other care givers, school teachers and sports leaders, visitors to the family home, and older siblings.

▸ Ensure the curriculum for health and other relevant professionals includes tobacco issues and relevant professional practices.

▸ Promote the implementation of practice guidelines for health professionals to identify, counsel and monitor patients who use tobacco.

6.0

Closing Comment

The potential for positively affecting the health of Canadians with an effective tobacco control strategy is enormous. This paper provides a framework and strategic priorities for action. Canadians at the national, provincial/ territorial and community levels are encouraged to use this framework to develop and implement action plans, consistent with their organizational mandate, that will contribute to effective action to reduce tobacco use in Canada.

Canada has provided international leadership on tobacco control in the past. Action based on this framework, with a strong commitment to moving towards a smoke-free society, will keep Canada in the forefront. The greatest benefits of all will be to the individuals whose health is affected by tobacco products, and to the society as a whole, who no longer has to bear the burden of the costs of tobacco harm.

Appendix A

About the F/P/T Advisory Committee on Population Health (ACPH)

The F/P/T Advisory Committee on Population Health was established by the Conference of Deputy Ministers of Health in 1992, with a mandate to address major issues that affect the health and well-being of Canada's population as a whole, as well as groups with less favourable health status. The Committee makes recommendations based on analysis of population health data, as well as factors which influence health, in the context of finite resources.

The Committee's role is to advise the F/P/T Conference of Deputy Ministers of Health on national and international strategies that should be pursued to improve the health status of the Canadian population and significant sub-populations, and to provide a more integrated approach to health.

ACPH is used as a forum to discuss and facilitate strategy development regarding a number of other population health related issues.

About the Steering Committee of the National Strategy to Reduce Tobacco Use in Canada (NSTRTU)

In May of 1985, the federal, provincial and territorial Ministers of Health from across Canada agreed that the movement to reduce tobacco use could only succeed by taking a comprehensive and collaborative approach. A Steering Committee was formed from representatives from these governments, as well as national health organizations. The Steering Committee has since grown to include additional non-government partners.

The role of the Steering Committee is to provide a forum for government and non-government organizations to collaborate on the national effort to reduce tobacco use. The functions of the Steering Committee are planning, monitoring, networking and supporting the National Strategy.

The Steering Committee members participate in the establishment of goals and objectives for the National Strategy. They support and encourage the comprehensive, collaborative and integrated approach needed throughout Canada to ensure the success of the Strategy.

Appendix B

Partnership Roles in Implementing a National Strategy

Effective tobacco prevention control requires partners to work together towards common goals and strategic directions. It requires integration, coordination and complementarity of a diverse array of strategies at the local, provincial/territorial, national and international levels. This section identifies some of the critical roles of various partner organizations.

Federal Government

▸ Provide leadership and resources to support tobacco control.

▸ Use the National Strategy as a Blueprint for action.

▸ Enact and enforce legislation within the federal jurisdiction.

▸ Provide support for the NSTRTU Steering Committee as a collaborative mechanism among governments and national NGO's.

▸ Support research into effective interventions.

▸ Take a leadership role for national public education programs.

▸ Take a leadership role in development of national approaches to building and supporting capacity for action, by coordinating activities with provincial/territorial governments.

▸ Take a leadership role on Canada's participation in international tobacco control activities.

Provincial/Territorial Governments

▸ Provide leadership and resources to support tobacco control.

▸ Use the National Strategy as a Blueprint for action.

▸ Enact and enforce legislation within the provincial/territorial jurisdiction.

▸ Enact enabling legislation for municipal by-laws

▸ Take a leadership role in coordinating provincial activities.

▸ Ensure the curriculum for health and other relevant professionals includes tobacco issues and relevant professional practices.

▸ Provide support for the NSTRTU Steering Committee as a collaborative mechanism among governments and national NGO's.

▸ Provide support for provincial/territorial programs.

▸ Provide public education programs.

▸ Provide supports for building and maintaining capacity for action.

National NGO's

▸ Provide direction to provincial and regional level offices on tobacco control priorities.

▸ Use the National Strategy as a Blueprint for action.

▸ Provide information and materials to support national/regional and local tobacco control activities.

▸ Advocate to support national government tobacco control activities.

Provincial/Territorial NGO's

▸ Develop tobacco control activities that fit with the organizational mandate, using the National Strategy as a Blueprint for action.

▸ Provide direction to provincial/territorial and regional level offices on tobacco control priorities.

▸ Deliver provincial/territorial programs.

▸ Provide information, materials and training to community groups to support tobacco control activities.

▸ Provide information and materials to private sector organizations.

▸ Advocate to support provincial /territorial and national government tobacco control activities.

Regional Health Authorities

▸ Provide leadership and resources to support tobacco control.

▸ Use the National Strategy as a Blueprint for action.

▸ Enforce legislation within the provincial/territorial jurisdiction.

▸ Deliver programs through appropriate health service agencies.

Community/Local Groups

▸ Provide leadership and support in community activities.

▸ Take the initiative in developing community/municipal tobacco control policies.

▸ Initiate and support tobacco control activities in local businesses and organizations.

▸ Deliver community programs.

▸ Provide advocacy support for national, provincial/territorial and regional level initiatives on tobacco control.

Individuals

▸ Volunteer to work with local tobacco coalitions.

▸ Develop steps to smoke free environments at home, at work and in the community.

▸ Parents and other caregivers to implement smoke-free policies for their home.

▸ Provide support to business and organizations that are moving to create smoke-free living.

▸ Lobby local, provincial, federal politicians.

Private Sector

▸ Promote leadership and role modelling behaviour for implementing policies that support tobacco control, such as smoke-free places, anti-tobacco media policies, etc.

▸ Support non-governmental and government organizations by providing access to relevant research, providing services in kind, or grants, to support collaborative projects.

Collaborative Mechanisms

▸ Partnering organizations should seek to participate in appropriate collaborative mechanisms. These include: Steering Committee of the NSTRTU; ACPH; Canadian Tobacco Research Initiative; and national, provincial/territorial and community coalitions.

Appendix C

Denormalization of Tobacco Industry Products

Definition

Normalize – to make normal or regular

Normalization – the process of making normal or regular

Denormalization – to remove, or steer away from, what seems to be normal

What is encompassed by denormalization?

Traditionally, anti-smoking social marketing efforts have been directed at making smoking a less socially acceptable behaviour without blaming the victim. Denormalization, in the context of social behaviour, aims to change attitudes toward what is generally regarded as normal or acceptable behaviour, including through social marketing. When attitudes change, behaviour will also change because humans generally want to act in ways that are acceptable to others.

There are many examples of how social behaviour has been "denormalized", for example:

▸   Failure to use safety belts and child restraints;

▸   Drinking and driving;

▸   Poop and scoop laws for dogs; and

▸   The shift away from corporal punishment for children.

There is clearly scope to consider further behavioural denormalization, particularly where it focuses on the consequences for others, rather than just the person smoking:

▸   Working to discourage smoking in enclosed public or private spaces where others could be affected by second hand smoke, including children in the home;

▸   Working to discourage smoking by and around pregnant women.

However, consideration can be given to approaches to denormalization that go beyond the individual. Another possibility is promoting greater awareness of the effects of second hand smoke on non-smokers' health, and to provide appropriate support for increased smoke-free areas. Additional

possibilities lie in creating greater awareness of the extent of criminal sales to children (50 million criminal sales per year), and the role the retail sector plays in displaying, promoting and selling cigarettes to children.

Secondly, rather than "smoking", increased focus can be placed on use of "tobacco products" and their effects.

Finally, denormalization activity can help draw attention to the way the tobacco industry operates. As the Federal Minister for Health stated in his speech of January 18, 1999, we need to look at "ideas that might help us in our work in the Canadian context to counterbalance the steady flow of images that make smoking seem natural and desirable when it is anything but. It's also going to be about informing Canadians of the marketing tactics used by the tobacco industry to recruit new smokers."

Denormalization could help build public support for tobacco control measures and public concern about the tobacco industry.

This type of denormalization activity can include:

▸ Deglamorizing the use of tobacco products;

▸ Combatting myths about tobacco products (for example, that light and mild products are safer or can help you quit);

▸ Drawing attention to the size and impact of tobacco industry advertising budgets, and the nature of their promotional activities.

▸ Drawing attention to the role of other industries and organizations in supporting the promotion and sale of tobacco.

Benefits of denormalization

Denormalization activities are important because they may help develop a set of values and behaviours that bring the whole community together to reinforce desirable behaviour and attitudes. It can help make tobacco use an issue of community concern, rather than just an issue for those using the products. Secondly, it can help ensure that people behave in appropriate ways—including making efforts to quit—without the need for a lot of policing or enforcement. Thirdly, it can help generate support for Government and broader defence of public health

policy in the face of industry challenges.

Examples of possible benefits of denormalization in the context of tobacco, could include:

▸ Any attempt to sell cigarettes to minors would be discouraged by attention from other shoppers;

▸ People using tobacco products in places where others were affected by smoke would attract adverse attention;

▸ Canadians would accept health advice relating to tobacco use and cessation from credible sources only; and

▸ Canadians would be sensitized to promotional techniques, particularly where they influence children.

▸ Corporations currently engaged in partnerships with tobacco companies (i.e., Banks, newspapers, advertisers, governments and other co-sponsors) would disengage from supporting tobacco promotion and sales.

▸ Governments would gradually cease their promotion and support of tobacco-promoting events (i.e., Co-sponsored festivals) and the promotion of tobacco production and sale (i.e., Trade missions which encourage tobacco exports).

Appendix D

International Framework Convention on Tobacco Control (FCTC)

In May 1996, the 49th World Health Assembly (WHA)—the highest governing body of the World Health Organization (WHO) composed at that time of the representatives of 190 Member States—adopted a resolution calling on the Director-General to initiate the development of an international framework convention for tobacco control in accordance with Article 19 of the WHO Constitution. It would be the first international convention adopted by WHO.

Canada has been a leading supporter of the development of a framework convention for tobacco control. We hosted the first (Halifax, 1997) and second (Vancouver, 1998) WHO meetings of public health and legal experts on the development of the framework convention, and continue to be a leading source of funds for the initiative.

What is an international framework convention?

It is a legal instrument in the form of an international treaty in which the signatory states agree to pursue broadly stated goals, and possible protocols, in this case, on tobacco control. The framework convention on tobacco control will represent a collective international response to common concerns related to tobacco.

How does a framework convention work?

Unlike other more detailed kinds of treaties, a framework convention does not try to resolve all substantive issues in a single document. Rather, Member States first adopt a convention that calls for cooperation in achieving broadly stated goals. Parties to the convention then negotiate separate protocols containing specific measures concerning each of the goals stated in the framework convention.

What could be the content of a framework convention on tobacco control?

The final answer to this question would be highly dependent on what the signatories would choose to include. Nevertheless, one broadly stated goal could be to move progressively towards implementation of comprehensive tobacco control strategies that include the measures referred to in previous WHA resolutions, as well as other appropriate measures. Separate protocol agreements would be more detailed in nature, focusing on specific elements, and developing separate plans and

timetables for implementation. Member States could then choose to become signatories to those protocols, which if they agree, could be implemented in their country.

Member States can do most of these things on their own. So why is an international framework convention needed?

In practice, only a few Member States have actually implemented comprehensive tobacco control measures. The planning, scheduling and international information sharing that would accompany the development of an international convention would facilitate and encourage Member States to strengthen their own national tobacco control policies.

In addition, a framework convention is a useful tool for promoting international cooperation and coordination of international aspects of tobacco control. Because many elements of national tobacco control programmes can be affected by what is going on in other countries, international instruments can be used to move towards better international control—and greater public health effectiveness—with respect to a number of areas that are transboundary in nature. WHO has identified the following as possible areas for Protocols:

▶ **Tobacco smuggling:** Currently, recorded world cigarette exports exceed imports by about 400 million cigarettes, implying that over seven per cent of world cigarette production is smuggled from one country to another to avoid cigarette taxes. It has been estimated that cigarette smuggling results in global losses of tax revenue totaling US $16 thousand million annually.

▶ **Tobacco advertising:** Bans or restrictions on tobacco advertising in one country can be undermined by advertising spillover from other countries.

▶ **Duty-free sales of tobacco:** Current international agreements on duty-free sales should be reconsidered in the light of the serious health consequences of tobacco use.

▶ **Tobacco pricing and taxation:** International harmonization of tobacco prices and taxes at high levels would do much to discourage tobacco use and to ensure that high-price policies for tobacco products are not undermined by smuggling from nearby low-price jurisdictions.

▸ **Reporting of production, sales, imports and exports of tobacco products:** Improved standards of international reporting of tobacco production and sales would facilitate international monitoring of this epidemic.

▸ **Testing and reporting of toxic constituents:** Improved and more effective international standards for the testing and reporting of toxic constituents in tobacco products and tobacco smoke would facilitate the monitoring of the degree of hazards of tobacco products.

▸ **Policy and programme information sharing:** More effective sharing of information among nations about the state of their national tobacco control legislation and programmes would help improve both national and international tobacco control.

Endnotes

[1]   National Clearinghouse on Tobacco or Health. *Health effects of tobacco use.*

[2]   Peto, R., Lopez, A.D., Boreham, J., Thun, M., Health Jr., C. *Mortality from Smoking in Developed Countries, 1950 - 2000* (1994) Oxford University Press, Oxford, U.K.; as cited in : Health Canada (1995) *Tobacco Control : A Blueprint to Protect the Health of Canadians.*

[3]   U.S. Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General.* (1989) Rockville, MD: Public Health Service, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. DHHS Pub. No. (CDC) 89-8411, 1989.

[4]   The Royal Society of Canada. *Tobacco, Nicotine and Addiction.* (1989) Ottawa.

[5]   Health Canada (1995) *Tobacco Control: A Blueprint to Protect the Health of Canadians*

[6]   U.S. Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General.* (1989) Rockville, MD: Public Health Service, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. DHHS Pub. No. (CDC) 89-8411, 1989; as cited in Health Canada (1995) *Tobacco control : a Blueprint to Protect the Health of Canadians.*

[7]   Ibid.

[8]   National Population Health Survey 1996/97.

[9]   Ibid.

[10]   Health Canada, *Survey on Smoking in Canada, Cycle 4, June 1995.*

[11]   First Nations and Inuit Regional Health Surveys, 1997.

[12]   Health Canada (1995) *Tobacco Control: A Blueprint to Protect the Health of Canadians*.

[13]   Ibid.

[14]   Ibid.

[15]   Minister of National Revenue. Part III, Main Estimates. 1995-1996, as cited in Health Canada (1995) *Tobacco Control: A Blueprint to Protect the Health of Canadians*.

[16]   National Clearinghouse on Tobacco and Health. *Health Effects of Tobacco Use.*

[17]   U.S. Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General.* (1989) Rockville, MD: Public Health Service, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. DHHS Pub. No. (CDC) 89-8411, 1989.

[18]   Stephens, T., and d'Avernas, J. (1997) *The need for tobacco research. Appendix 3 of "Proposal for a Tobacco Research Initiative"*, October 8, 1997. Presented to NCIC Board of Directors.

[19]   Health Canada (1995) *Tobacco Control: A Blueprint to Protect the Health of Canadians*.

[20]   *Stephens, T., and d'Avernas, J. (1997) The need for tobacco research.*

[21]   Breslow, L., and Johnson, M. (1993) California's Proposition 99 on tobacco and its impact. *Annual Review of Public Health,* 14: 585-604.

[22]   Morbidity and Mortality Weekly Report (1996) Cigarette smoking before and after an excise tax and an anti-smoking campaign – Massachusetts, 1990-1996. *Morbidity and Mortality Weekly Report,* 45.

[23]   Stephens, T., and d'Avernas, J. (1997) *The need for tobacco research.*

[24]   Connolly, G., Robbins, H. (1998) Designing an Effective Statewide Tobacco Control Program –Massachusetts. *American Cancer Society.*

[25]   Tobacco Education and Research Oversight Committee. (1997) *Toward a Tobacco-free California: Renewing the Commitment 1997-2000.*

[26]   *Strategies for Population Health–Investing in the Health of Canadians*. Prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health for the Meeting of the Ministers of Health, September 14-15, 1994.

[27]   The Canadian Tobacco Research Initiative (CTRI) is a collaboration among a group of Canadian agencies and governments with the aim to support and develop a closer relationship between researchers, those responsible for program/policy development, and those who implement program/policy changes.

[28]   U.S. Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General* (1989) Rockville, MD., Public Health Services, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, DHHS Pub. No. (CDC) 89-8411, 1989.

[29]   The Royal Society of Canada. *Tobacco, Nicotine and Addiction.* (1989) Ottawa.

[30]   A vision for a "smoke-free" Canada must recognize traditional aboriginal uses of tobacco in sacred ceremonies, which are clearly different from smoking "abuse" throughout Canadian society. Restrictions on tobacco use must exempt traditional aboriginal use of tobacco.