Canadian Public Health Association Position Paper

The Winnable Battle

Ending Tobacco Use in Canada

December 2011

The Canadian Public Health Association is a national, independent, not-for-profit, voluntary association representing public health in Canada with links to the international public health community. CPHA's members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all Canadians.

CPHA's mission is to constitute a special national resource in Canada that advocates for the improvement and maintenance of personal and community health according to the public health principles of disease prevention, health promotion and protection and healthy public policy.

For more information, contact:
Canadian Public Health Association
300–1565 Carling Avenue, Ottawa, Ontario K1Z 8R1
Tel: 613-725-3769 Fax: 613-725-9826
E-mail: info@cpha.ca www.cpha.ca

CPHA ACSP

CANADA'S PUBLIC HEALTH LEADER
LE LEADER CANADIEN EN SANTÉ PUBLIQUE

Canadian Public Health Association
Position Paper

The Winnable Battle: Ending Tobacco Use in Canada

December 2011

Table of Contents

ACKNOWLEDGEMENT

The Canadian Public Health Association (CPHA) thanks the members of the Tobacco Control Position Working Group (Neil Collishaw, Roberta Ferrence, Charmaine Enns, Kathleen Brennan, Trish Hill and Zahra Hussein) as well as the many CPHA members and members of the Canadian tobacco control and public health communities for their input and advice to this document.

CPHA thanks la Coalition québécoise pour le contrôle du tabac (CQCT) and Johnson & Johnson for the French translation of this document.

Executive Summary

For more than five decades, the Canadian Public Health Association (CPHA) has consistently taken a strong stand against tobacco use and smoking in Canada and overseas. CPHA has called on international and domestic stakeholders time after time, including the federal, provincial/territorial and municipal governments in Canada, to put into place and follow through on effective, evidence-based public policies and actions to tackle the lethal tobacco epidemic head-on. Our goal is a tobacco-free Canada that is no longer characterized by tobacco-related disease, disability or death.

Despite the efforts of many stakeholders and practitioners, and the considerable progress made to date with fewer Canadians using tobacco products, the battle is not yet won. It is important to note that if tobacco products were being brought to market today, for the first time, public opinion would not tolerate their availability and governments would likely ban their commercialization and sale due to the clear evidence of tobacco's toxicity and profoundly adverse health effects. Unfortunately, this is not the case. The public demands and expects action on tobacco use. Yet, we continue to permit today the marketing, sale and use of products that have no redeeming social or economic value, and that take a tragic toll on the health, productivity and well-being of Canadians.

It is true that to date, a range of comprehensive, multi-pronged and multi-level (i.e., federal, provincial and territorial, and local/regional) tobacco control strategies and interventions has led to great reductions in overall smoking rates in Canada. However, progress has stalled—even with millions of smokers remaining and a new generation of tobacco users coming up. The only real hope is that future generations will reject the use of tobacco products entirely, and they will need information and effective programs and policies to support that choice.

Concerted action is required from local/regional, provincial/territorial and federal levels in order to pursue the eradication of the tobacco epidemic. CPHA believes that Canada has reached a critical juncture in its national tobacco control efforts. The Federal Tobacco Control Strategy (FTCS) is being reviewed while it is mere months away from termination. We are encouraged that the provinces, territories and municipal governments continue to create and support tobacco control policies, regulations and programs that address smoking cessation and prevention, and the protection of the public from tobacco-related health risks. Public health units and health practitioners across the country are actively involved in delivering a vast array of tobacco control-related services.

Given the clear evidence of tobacco's harm and the hard-won successes of tobacco control efforts over many decades, CPHA advocates that a tobacco-free Canada be achieved by the year 2035. We call on all levels of government, the non-governmental sector, citizens and the public health community to work together to achieve this goal. Accordingly, CPHA makes the following recommendations for action:

CPHA calls on the federal government:

- to implement all of the provisions of the Framework Convention on Tobacco Control (FCTC) and related guidelines to the highest degree possible, including fulfilling its obligations to global tobacco control, and
- to implement and fund fully on an annual and consistent basis an adequately-resourced, multi-year (10-year) Federal Tobacco Control Strategy (FTCS), which would include an endgame goal and milestone targets, to come into effect no later than April 1, 2012, to include:
  - nation-wide social marketing / social media campaigns to further de-normalize tobacco use, especially among youth
  - a ban on all remaining forms of tobacco advertising and promotion in movies, on the Internet and elsewhere
  - legislation to increase the graphic health warnings to 90% of the surface of cigarette packages
  - legislation governing plain packaging for tobacco products
  - adding menthol to the list of banned flavourings in tobacco products
  - expanding the current ban on flavourings in certain tobacco products to all smokeless tobacco products
  - a moratorium on all new tobacco products and all new packaging of existing tobacco products.

- to revitalize the First Nations and Inuit Tobacco Control Strategy (FNITCS) and engage in nation-to-nation dialogue with First Nations and other Aboriginal communities to develop community-led tobacco control strategies that will reduce the social disparities that contribute to poor health outcomes
- to work in partnership with and support of the efforts of Canadian stakeholders and their overseas partners to develop and implement effective tobacco control strategies and deter counter-tobacco control efforts by the tobacco industry in low- and middle-income countries and to put into place sustained and predictable funding and multi-year funding mechanisms for global tobacco control initiatives.

CPHA calls upon the federal, provincial and territorial governments:

- to include tobacco control (with time-specific targets and indicators) as components in future multi-year agreements on health and health care, such as the forthcoming federal/provincial/territorial health fund transfer agreement to begin in 2014
- to consider new fiscal mechanisms involving pricing and taxation to discourage the sale of cigarettes at reduced rates
- for the immediate adoption and support by the federal, provincial and territorial governments for a national quit-line and support to maximizing accessibility for all Canadians to cessation services and resources
- to support community-identified and led tobacco control initiatives for population-based approaches
- to reach and respond to the needs of disadvantaged and particularly vulnerable population groups with respect to smoking cessation and tobacco product use prevention
- to allocate government revenues from tobacco product taxes or tobacco industry sources (e.g., penalties resulting from regulatory or legal actions) to support tobacco control research and knowledge generation/exchange activities that produce evidence used to design effective tobacco control strategies and interventions.

CPHA calls on all provincial and territorial governments:

- to broaden the categories of outlets that are prohibited from selling tobacco products
- to cap the number of tobacco retail licenses at the current level, with the goal of significantly reducing the number of outlets in each province and territory within five years
- to develop and maintain an accurate database of retailers of tobacco products, require licencing of all wholesalers and retailers of tobacco products administered by the Ministry of Health, and implement as soon as possible a graduated penalty structure with substantial fines, licence suspension and permanent revocation of a retailer's licence to sell tobacco
- to enable municipalities to implement licencing fee systems for the retail sale of tobacco products as a means to reduce the number and density of retail outlets that sell tobacco products
- to apply and enforce a minimum age limit to retail outlets and establishments which sell tobacco products, similar to that in place for employees serving alcoholic beverages.

CPHA calls on municipalities to enact by-laws to ban smokeless tobacco, including hookahs, from public places including bars and restaurants.

CPHA encourages all jurisdictions:

- to ban the sale of tobacco products in retail outlets within 500 metres of registered child day-care centres, primary and secondary schools, and encourage all universities and colleges to ban the sale of tobacco products on campus
- to enact laws ensuring full protection from second-hand smoke in areas where young people gather, especially in school settings including post-secondary institutions.

CPHA calls upon the public health community:

- to promote the adoption and use of national cessation guidelines in clinical practice and population-based strategies (CAN-ADAPTT guidelines)
- to assess opportunities for systematically incorporating brief contact cessation interventions into their existing one-on-one programs and services
- to collaborate with the tobacco control and economic communities to explore innovative strategies for effective supply side responses for tobacco control.

CPHA calls on colleges, universities, professional associations, federal, provincial, regional and local governments to work together to build the capacity of health workers by ensuring that tobacco control principles are embedded within core curricula and continuing education offerings and by enhancing tobacco control learning opportunities for both public health and the allied health professions within their curricula. Additionally, the Public Health Agency of Canada should embed tobacco examples within the relevant Skills Enhancement for Public Health online modules.

CPHA should

- seek opportunities to cooperate and collaborate with the Canadian mental health community on issues related to tobacco control as it affects people with mental health issues
- in association with the Provincial/Territorial Public Health Associations, as appropriate, seek opportunities to cooperate and collaborate with Aboriginal peoples' organizations and communities on tobacco-related issues and strategies
- establish and facilitate a tobacco control community of practice within the Public Health KnowledgeCentre™ as a means of supporting greater horizontal knowledge exchange among researchers and local/regional public health organizations across provinces and territories to promote and improve the use of evidence to strengthen tobacco control
- address tobacco control during its annual conferences.

Sommaire exécutif

Depuis plus de 50 ans, l'Association canadienne de santé publique (ACSP) prend systématiquement et vigoureusement position contre le tabagisme au Canada et à l'étranger. L'ACSP a exhorté à maintes reprises les acteurs internationaux et nationaux, y compris les administrations fédérale, provinciales/territoriales et municipales au Canada, à instaurer des politiques publiques et des mesures efficaces, fondées sur les preuves, pour s'attaquer de front à l'épidémie mortelle de tabagisme – et à donner suite à ces initiatives. Notre objectif : un Canada sans tabac qui ne soit plus caractérisé par les maladies, les invalidités et les décès liés au tabagisme.

Malgré les efforts de nombreux acteurs et praticiens, et malgré les progrès considérables réalisés jusqu'à maintenant (les Canadiens étant moins nombreux à utiliser les produits du tabac), la bataille n'est pas gagnée. Si les produits du tabac étaient mis en marché pour la première fois aujourd'hui, l'opinion publique ne tolérerait pas leur présence, et les gouvernements interdiraient sans doute leur commercialisation et leur vente en raison des preuves manifestes de la toxicité du tabac et de ses effets profondément défavorables sur la santé. Malheureusement, ce n'est pas le cas. Le public exige et attend des mesures contre le tabagisme. Pourtant, on continue de permettre aujourd'hui la commercialisation, la vente et la consommation de produits qui n'ont aucune valeur sociale ou économique compensatoire et qui imposent un lourd tribut à la population canadienne en termes de santé, de productivité et de bien-être.

Il est vrai que jusqu'à maintenant, grâce à un vaste ensemble de stratégies et de mesures menées sur plusieurs fronts et à plusieurs niveaux (fédéral, provincial et territorial, local/régional), on a beaucoup réduit les taux de tabagisme au Canada. Mais nos progrès semblent s'être arrêtés; or, il reste des millions de fumeurs et une nouvelle génération de consommateurs de produits du tabac qui entre en scène. Notre seul espoir est que les générations futures rejetteront massivement le tabagisme, mais elles auront besoin d'information, et de programmes et de politiques publiques efficaces, pour appuyer un tel choix.

Il faut une action concertée des autorités locales/régionales, provinciales/territoriales et fédérales afin de poursuivre l'éradication de l'épidémie de tabagisme. L'ACSP croit que le Canada est à la croisée des chemins dans ses efforts pour contrer le tabagisme au pays. On réexamine la Stratégie fédérale de lutte contre le tabagisme (SFLT) à quelques mois à peine de son lancement. Nous sommes encouragés de voir que les provinces, les territoires et les administrations municipales continuent de créer et de soutenir des politiques, des règlements et des programmes antitabac axés sur la prévention et l'arrêt du tabagisme et sur la protection du public contre les risques du tabac pour la santé. Les bureaux de santé publique et les professionnels de la santé de tout le pays s'impliquent activement dans la prestation d'une vaste gamme de services de lutte contre le tabagisme.

Étant donné les preuves manifestes des méfaits du tabac et les victoires et les avancées dans la lutte contre le tabagisme au cours des dix dernières années, l'ACSP propose qu'on en arrive à un Canada sans tabac d'ici 2035. Nous invitons tous les ordres de gouvernement, le secteur non gouvernemental, les citoyens et la communauté de la santé publique à travailler ensemble pour atteindre cet objectif. En conséquence, l'ACSP recommande que l'on prenne les mesures suivantes :

L'ACSP invite le gouvernement fédéral à :

- appliquer le plus strictement possible les dispositions de la *Convention-cadre pour la lutte antitabac* (CCLAT) et les lignes directrices connexes, notamment en respectant ses obligations dans la lutte internationale contre le tabagisme;
- appliquer et financer entièrement, sur une base annuelle et systématique, une Stratégie fédérale de lutte contre le tabagisme (SFLT) pluriannuelle (sur 10 ans) dotée de ressources adéquates, incluant un objectif final et des étapes critiques, qui entre en vigueur d'ici le 1er avril 2012 et qui comprenne :
  - des campagnes nationales de marketing social/dans les médias sociaux pour continuer à dénormaliser le tabagisme, surtout chez les jeunes,
  - l'interdiction de toutes les formes restantes de publicité et de promotion du tabac, que ce soit au cinéma, sur Internet ou ailleurs,

  - une loi qui étend à 90 % de la surface des paquets de cigarettes les illustrations explicites de mise en garde,
  - une loi imposant la banalisation de l'emballage des produits du tabac,
  - l'ajout du menthol à la liste des aromes interdits dans les produits du tabac,
  - l'élargissement de l'interdiction actuelle de l'aromatisation de certains produits du tabac à tous les produits de tabac sans fumée,
  - l'imposition d'un moratoire sur tous les nouveaux produits du tabac et tous les nouveaux emballages pour les produits du tabac existants;
- revitaliser la Stratégie de lutte contre le tabagisme chez les Premières nations et les Inuits (SLTPNI) et amorcer un dialogue de nation à nation avec les Premières nations et les autres communautés autochtones en vue d'élaborer des stratégies antitabac pilotées par les communautés, qui réduiront les disparités sociales contribuant aux mauvais résultats de santé;
- travailler en partenariat avec les acteurs canadiens et leurs partenaires étrangers, et appuyer leurs efforts a) pour élaborer et appliquer des stratégies antitabac efficaces et contrer la riposte de l'industrie du tabac dans les pays à faible revenu et à revenu intermédiaire et b) pour mettre en place un financement soutenu et prévisible, ainsi que des mécanismes de financement pluriannuels, à l'appui des initiatives internationales de lutte antitabac.

L'ACSP invite les gouvernements fédéral, provinciaux et territoriaux à :

- faire de la lutte antitabac (avec des cibles et des indicateurs assortis de délais précis) un élément des futurs accords pluriannuels sur la santé et les soins de santé, comme le prochain Transfert fédéral-provincial-territorial en matière de santé qui doit commencer en 2014;
- envisager de nouveaux mécanismes financiers axés sur l'établissement des prix et la fiscalité pour contrer la vente de cigarettes à prix réduit;
- instaurer immédiatement une ligne téléphonique nationale d'aide au renoncement au tabac et des mesures de soutien pour maximiser l'accessibilité des services et des ressources d'arrêt du tabagisme dans la population canadienne;
- appuyer les initiatives de lutte antitabac proposées et menées à l'échelon communautaire selon des approches populationnelles;
- joindre les populations défavorisées particulièrement vulnérables et répondre à leurs besoins en ce qui a trait à l'arrêt du tabac et à la prévention de l'utilisation des produits du tabac;
- répartir les recettes budgétaires provenant des taxes sur les produits du tabac ou d'autres sources dans l'industrie du tabac (p. ex., les sanctions résultant de procédures judiciaires ou réglementaires) pour soutenir la recherche et les activités de développement/d'échange de connaissances qui produisent des faits probants servant à informer des stratégies et des mesures efficaces de lutte contre le tabagisme.

L'ACSP invite les gouvernements provinciaux et territoriaux à :

- élargir les catégories de points de vente où il est interdit de vendre des produits du tabac;
- plafonner le nombre de permis de détaillants de tabac au niveau actuel, afin de réduire considérablement le nombre de points de vente dans chaque province et territoire d'ici cinq ans;
- créer et maintenir une base de données fidèles sur les détaillants de produits du tabac, exiger l'homologation de tous les grossistes et détaillants de ces produits sous l'administration du ministère de la Santé et instaurer le plus tôt possible un régime de sanctions graduelles (imposition d'amendes importantes, suspension du permis de détaillant de tabac, puis révocation permanente du permis);
- habiliter les municipalités à appliquer un système de redevances pour l'octroi de permis de détaillants de tabac afin de réduire le nombre et la densité des points de vente au détail des produits du tabac;
- appliquer et faire respecter la limite d'âge dans les points de vente au détail et les établissements qui vendent des produits du tabac, comme c'est le cas avec le système en vigueur pour les employés qui servent des boissons alcoolisées.

L'ACSP invite les municipalités à adopter des règlements interdisant le tabac sans fumée, y compris les houkas, dans les lieux publics, dont les bars et les restaurants.

L'ACSP encourage tous les paliers de gouvernement à :

- interdire la vente au détail de produits du tabac à moins de 500 mètres d'une garderie enregistrée ou d'une école primaire ou secondaire et encourager les universités et les collèges à interdire la vente de produits du tabac sur leurs campus;
- adopter des lois qui protègent entièrement contre la fumée secondaire dans les endroits où les jeunes s'assemblent, surtout en milieu scolaire, y compris dans les établissements postsecondaires.

L'ACSP invite la communauté de la santé publique à :

- promouvoir l'adoption et l'utilisation de lignes directrices nationales de cessation du tabagisme dans la pratique clinique et les stratégies à l'échelle de la population (les lignes directrices de CAN-ADAPTT);
- évaluer la possibilité d'intégrer systématiquement de brèves interventions de cessation du tabagisme dans les programmes et services individuels existants;
- collaborer avec les communautés de lutte antitabac et les communautés économiques afin d'explorer des stratégies novatrices et efficaces de lutte antitabac axées sur l'offre.

L'ACSP invite les collèges, les universités, les associations professionnelles, les gouvernements fédéral/provinciaux, régionaux et locaux à travailler ensemble afin de renforcer les capacités des travailleurs de la santé en s'assurant que les principes de la lutte antitabac sont intégrés dans les programmes d'études à l'intention des professionnels de la santés et dans les activités de formation continue. De plus, l'Agence de la santé publique du Canada devrait intégrer des exemples sur le tabac dans les modules en ligne pertinents de l'Amélioration des compétences en santé publique.

L'ACSP devrait :

- chercher et saisir les opportunités de collaboration avec les milieux canadiens de la santé mentale dans les dossiers liés à la lutte antitabac et aux effets du tabagisme sur les gens qui ont des problèmes de santé mentale;
- avec la collaboration des associations provinciales et territoriales pour la santé publique, le cas échéant, établir des opportunités de collaboration avec les organismes et les communautés autochtones dans les dossiers et les stratégies liés au tabac;
- établir et animer une communauté de pratique sur la lutte antitabac au sein du Centre du savoir en santé publique[MC] pour favoriser l'échange des connaissances entre les chercheurs et les organismes de santé publique locaux/régionaux dans les provinces et les territoires, en vue de promouvoir et d'améliorer l'utilisation des preuves pour renforcer la lutte antitabac;
- aborder la lutte antitabac durant ses conférences annuelles.

I. Introduction

The evidence against tobacco use is clear and irrefutable; and so is the need for decisive and committed action to end tobacco-related deaths and suffering and improve the public's health. The decades-long work on tobacco control is one of public health's finest achievements of the last 100 years; but the task of eliminating tobacco is far from complete.

Tobacco control efforts must be renewed continuously if progress is to be made in, first, reducing the number of Canadians who smoke – a still staggering 21% of the population (5.9 million smokers) aged 15 years and older[1] – and, ultimately, ending the lethal tobacco epidemic. Approximately 37,000 preventable deaths are attributed to tobacco use annually in Canada in recent years.[2] Despite the decreasing trend in smoking among youth aged 12-19 years, 11.3%, approximately 375,000 youth, are current smokers.[3] Many of them, in the absence of strong, effective and fully applied tobacco control strategies, will likely keep smoking for many years to come. As the results of the Youth Smoking Survey indicate, a higher percentage of youth have progressed along the smoking continuum to become current smokers.[4] This is cause for concern.

In the 60 years since tobacco was unambiguously identified as a cause of lung cancer, knowledge of its broader health effects has grown. There is no safe level of exposure to tobacco. When consumed in any form, but particularly when smoked, it is carcinogenic – including second-hand smoke. More than 50 diseases and conditions are known or suspected to be caused by tobacco.[5] Any suggestion of a place for smokeless tobacco or other tobacco products in tobacco harm reduction strategies should be discouraged. The evidence indisputably finds all of these to be harmful to human health.*

In addition to its toll on health, tobacco use generates high economic costs in Canada. The economic burden of smoking has been estimated at $17 billion a year. The direct, attributable health care costs of tobacco use have been estimated at $4.4 billion annually.[6] The global economy is losing more than one trillion dollars annually to tobacco use.[7,8]

Tobacco control efforts deal not only with the highly addictive nature of tobacco, but also contend with the questionable marketing practices of the tobacco industry. Most people using tobacco daily do so because of their addiction to nicotine, tobacco's principal addictive element. Most users try to cut down or quit, but overcoming the addiction is difficult and requires a supportive environment. Effective tobacco control enforcement, protection and prevention initiatives, public policies and legislation are all necessary to prevent recidivism and counter the efforts of the tobacco industry to reinvent itself and its deadly products.

From a multi-decade perspective, the considerable reductions in overall smoking rates among Canadians are largely attributable to comprehensive, multi-pronged and multi-level (i.e., federal, provincial and territorial, and local/regional) tobacco control strategies. These strategies have employed a variety of interventions, including high prices and taxes, bans on smoking in public places, restrictions on advertising and sponsorship of tobacco products, and social marketing programs to de-normalize tobacco use. However, at this time, overall progress has stalled – there remain millions of smokers in Canada, and a new generation of tobacco users is emerging. The only real hope is that future generations will reject the use of tobacco products entirely. They will need information and effective programs and policies to support that choice. No other undertaking could save as many lives as sustained tobacco control efforts.

The Canadian Public Health Association (CPHA) has been involved in tobacco control since 1959. That year CPHA passed a pioneering resolution urging health agencies to support anti-tobacco educational campaigns to prevent tobacco addiction among youth. Since then, we have actively supported the regulation of tobacco products and the reduction or elimination of tobacco use through many resolutions, position papers, knowledge generation and exchange activities, policy development and programs. CPHA last released a position paper on tobacco and smoking in 1988. This updated position paper is a forceful call to action for all who care about public health to commit to the steady reduction and ultimate eradication of tobacco use so that, in the near future, we can truly say the battle has been won.

* The International Agency for Research on Cancer (2007) classifies smokeless tobacco products as Group 1 carcinogens, and sufficient evidence demonstrates that these products cause cancers of the oral cavity and pancreas in humans. Moreover, smokeless tobacco products deliver nicotine in quantities and at rates that cause psychoactive effects, which eventually lead to tolerance and addiction.

II. A Public Health Approach to Tobacco Control

The fundamental mission of public health is to protect and promote the health of the public. Public health has played a key role in the dramatic reduction of tobacco consumption through policy development, and prevention, cessation and enforcement activities, both in this country and around the world. Continued effective responses to tobacco use in Canada are needed from local/regional, provincial/territorial and federal levels to avoid a reversal of decades of progress in decreasing tobacco-related disease and death.

A public health approach to tobacco control should strive to accomplish the following seven goals, to:

1. Effectively control the vector of disease – the tobacco industry;
2. Create social environments that support a tobacco-free life;
3. Prevent the uptake of smoking;
4. Eliminate harmful exposure to tobacco smoke among non-smokers;
5. Encourage and assist as many tobacco-users to quit as soon as possible;
6. Reduce harm and disadvantages/disparities associated with and caused by the continuing use of and dependence on tobacco and nicotine; and,
7. Ultimately create tobacco-free societies.

Tobacco control cannot be reduced to promoting healthy behaviour at the individual level. A population-based approach to tobacco control addresses a range of factors (social, economic, environmental, political, among others) that affect an individual's decision-making and capacity to avoid smoking. It facilitates and supports population-oriented tobacco control interventions, while at the same time focuses needed efforts on vulnerable populations.

Tobacco control is a part of a broader, comprehensive effort to build and improve the social, economic, cultural/racialized and environmental contexts and resources within communities through an inter-sectoral and multi-stakeholder approach.[9,10] It is predicated on political commitment at all levels, community participation (including from vulnerable populations) and working in different settings. The future success of tobacco control will depend on both how well public health collaborates with all of these partners and on progressively greater control over the tobacco industry.

III. Setting the Agenda

CPHA proposes the goal of a tobacco-free Canada by the year 2035.* This goal would be achieved through an array of strategies, policy and programs/services. Appreciating the challenges in the near-term to reach this goal, CPHA calls on all levels of government, communities, public health practitioners and citizens to work aggressively to achieve the specific intermediate targets of:

- Reaching a 50% reduction in the number of smokers by the year 2020 (equivalent to approximately three million smokers); and
- A further 50% reduction in the number of youth aged 12-19 years who smoke by the year 2020 (equivalent to approximately 180,000 smokers).

The goal and intermediate targets are achievable. To attain them, the number of smokers in Canada must be reduced by 400,000 annually. It has been done before; the number of smokers was reduced by 600,000 people in one year between 2000 and 2001.[11] It is an ambitious objective, but with the right mix of policies, programs and services, along with firm commitment and follow-through by all levels of government and citizenry, it can be reached. It will require collective effort on the part of all stakeholders to put public health and the health of our communities ahead of corporate interests.

Achieving a smoke-free Canada by 2035 will take a constant renewal of efforts and sustained dedication of resources. This is not the time to drop our guard, which would inevitably result in higher smoking rates.

* The term "tobacco-free" denotes a situation wherein by the year 2035 there would be a pan-Canadian smoking prevalence rate of less than 1%, equivalent to approximately 250,000 smokers.

IV. Priority Areas for Action

A. FEDERAL LEADERSHIP

Framework Convention on Tobacco Control (FCTC)

Canada is one of 174 Parties to the Framework Convention on Tobacco Control (FCTC), the world's first global public health treaty.[12] The FCTC is a legally binding commitment for signatory countries that specifies tobacco demand reduction measures and interventions to cut supply to protect public health. Full implementation of the FCTC – with its integration of a 'social determinants of health' approach – is viewed as a 'leveling force' that enables countries to focus on and affect the root causes of tobacco use.

Although Canada is in compliance with most of the provisions of the FCTC, significant room for improvement remains.[13] In November 2010, the Canadian Global Tobacco Control Forum (CGTCF), of which CPHA is a founding member, released its report card on Canada's FCTC implementation.[14] It noted some movement forward and many areas where Canada falls short of its obligations as evidenced by:

- High levels of illicit tobacco sales;
- Absence of enforcement of public health laws in many First Nations communities;
- Extremely slow pace of regulatory developments at the national level;
- No increases in federal tobacco taxes;
- No response to the increased market presence of discount cigarette brands;
- Reductions of over $20 million in tobacco control grants and contributions; and
- Uncertainty about the federally-led tobacco control strategy that expires in March 2012.

Federal Tobacco Control Strategy (FTCS)

The Federal Tobacco Control Strategy (FTCS) expired on March 31, 2011. Although extended by one year, the lack of an ongoing and adequately resourced federal strategy gravely affects the vision and actions it purports to support. It is imperative that the federal government return to its leadership role in tobacco control as more work is urgently needed.

Research demonstrates that increases in tobacco control expenditures are independently associated with declines in adult smoking prevalence. When tobacco control was absent or quiescent in Canada (1908-1981, 1993-1996 and 2006-2010), tobacco consumption increased or was stable. During periods when new and effective tobacco control measures were implemented (1982-92 and 1997-2005), tobacco consumption declined.[15] With respect to youth, Ontario has consistently made one of the highest per capita investments in tobacco control, and the results are telling: smoking rates for young Ontarians (aged 15-19 years) decreased from 14% to 9% between 2003 and 2009.[16]

Public health authorities in Canada indicated through a recent survey conducted by CPHA that more adequate and sustainable funding for programs and hiring dedicated staff are key factors in implementing effective tobacco control measures.[17] Despite the decade-long FTCS, health authorities still experience a lack of adequate funding across many of the tobacco control areas, especially in prevention and cessation. Indeed, a substantial amount of federal government funds transferred to Health Canada for the FTCS has not been spent on tobacco control.[18,19] For the fiscal years 2002-2003 to 2007-2008, funding to Health Canada for tobacco control was repeatedly under-spent, and a significant proportion of these funds were diverted to other Health Canada initiatives unrelated to tobacco control.[20]

A renewed adequately-resourced, multi-year FTCS (at least 10 years' duration) should include an endgame goal and annual milestone targets to reduce tobacco use through the following strategies:

- Implement price and tax measures to reduce the demand for tobacco;
- Implement a broad spectrum of non-price measures to reduce the demand for tobacco, including the initiation of tobacco use among children, adolescents and young adults;
- Protect all Canadians from exposure to tobacco smoke;
- Motivate, assist and provide a supportive environment to every smoker to quit and increase their successful cessation attempts, including enhancing the capacity of health professionals to integrate tobacco use prevention/cessation at all levels;
- Adopt a broad-based determinants of health approach for tobacco control, especially for particularly at-risk/vulnerable populations;
- Support research and knowledge exchange for the application of healthy public policies and best practices;

- Reduce the supply of tobacco products in Canada, including instituting a moratorium on new tobacco products, reducing and limiting the number of retail outlets of tobacco products, deterring the illicit trade in tobacco products, and implementing innovative measures to make tobacco companies accountable for annual targeted reductions in smoking prevalence; and,
- Support global tobacco control efforts.

A renewed FTCS should also be linked to any future federal/provincial/territorial agreement on health and health care. Innovative funding mechanisms to award provinces and territories for reaching agreed-upon health goals related to tobacco and smoking should be explored and instituted. Future health agreements, including the future federal/provincial/territorial health fund transfer agreement to begin in 2014, could include a requirement to collect and report data on smoking and tobacco use, as well as setting goals and targets for specific vulnerable populations. The federal government has a critical role to play in Canada's efforts to achieve the aforementioned goals and intermediate targets.

RECOMMENDATIONS

CPHA calls on the federal government to implement all of the provisions of the Framework Convention on Tobacco Control (FCTC) and related guidelines to the highest degree possible, including fulfilling its obligations to global tobacco control, and to implement and fund fully on an annual and consistent basis an adequately-resourced, multi-year (10-year) Federal Tobacco Control Strategy (FTCS), which would include an endgame goal and milestone targets, to come into effect no later than April 1, 2012.

CPHA calls upon the federal, provincial and territorial governments to include tobacco control (with time-specific targets and indicators) as components in future multi-year agreements on health and health care, such as the forthcoming federal/provincial/territorial health fund transfer agreement to begin in 2014.

B. REDUCING THE DEMAND FOR TOBACCO

Price and tax measures to reduce the demand for tobacco

High prices are one of the most effective measures to reduce tobacco use, especially among youth who are particularly price-sensitive.[21] Taxes imposed on tobacco products are one means of maintaining a high price. For every 10% increase in the real price of tobacco products, the consumption of those products will drop by about 8%, with the greatest decrease seen among youth.[22]

RECOMMENDATION

CPHA calls upon the federal, provincial and territorial governments to consider new fiscal mechanisms involving pricing and taxation to discourage the sale of cigarettes at reduced rates.

Non-price measures to reduce the demand for tobacco

De-glamorize smoking

The 'don't start/quit' messages must be promoted and the tobacco industry's seductive messaging that still pervades media favoured by youth must be eliminated. This can be done in three ways:

1. Reducing the visibility of tobacco advertising and promotion in movies and on the Internet to support healthy decision-making for young people;
2. De-glamorizing smoking through well-designed and delivered social marketing campaigns that complement comprehensive tobacco control policies and programs. De-normalization campaigns help young people shun/quit tobacco use when they involve youth and their communities in them.
3. Obliging tobacco companies to achieve public health goals, no longer permitting them to mitigate the effects of public health measures. Canada has made progress here, recently through the adoption of new and larger graphic health warnings on cigarette and small cigarillo packages. But more remains to be done, including the objective of a 90% coverage of all tobacco products with health warnings and the adoption of plain packaging.

RECOMMENDATION

CPHA recommends that the FTCS include:

- *nation-wide social marketing / social media campaigns to further de-normalize tobacco use, especially among youth*
- *a ban on all remaining forms of tobacco advertising and promotion in movies, on the Internet and elsewhere*
- *legislation to increase the graphic health warnings to 90% of the surface of cigarette packages*
- *legislation governing plain packaging for tobacco products.*

Prohibit flavourings, including menthol

Menthol has been called the 'ultimate tobacco flavour' as menthol smokers are 29% less likely to quit smoking and 89% more likely to relapse when they do attempt to quit.[23] Mentholated tobacco products also promote initiation in youth smoking.[24] Banning menthol will make tobacco less enjoyable for many users, which can greatly help cessation attempts and deter initiation.[25] Closing the loopholes in the current *Cracking Down on Tobacco Marketing to Youth Act* and expanding its reach to cover all tobacco products are also vital to this effort.

RECOMMENDATION

CPHA recommends that the FTCS include:

- *adding menthol to the list of banned flavourings in tobacco products*
- *expanding the current ban on flavourings in certain tobacco products to all smokeless tobacco products.*

Smokeless tobacco is not an acceptable substitute

Although the evidence suggests that the overall health risk of smokeless tobacco is roughly 5% of that of cigarettes, the International Agency for Research on Cancer continues to classify smokeless tobacco products as Group 1 carcinogens; these products cause cancers of the oral cavity and pancreas in humans.[26] Moreover, they deliver nicotine in quantities and at rates that cause psychoactive effects, which eventually lead to tolerance and addiction. Several new products and delivery agents are being produced and marketed as smoking substitutes. These include the electronic cigarette, which is promoted as a non-tobacco alternative nicotine-delivery device. The use of hookahs, or water pipes, creates great challenges for the enforcement of smoke-free places due to the difficulty of differentiating between tobacco and herbal products. Any suggestion that there is a place for smokeless tobacco or other contentious products that manage to evade current legislative parameters should be discouraged. The state of the evidence indisputably finds all of these to be harmful to human health.

RECOMMENDATION

CPHA calls on municipalities to enact by-laws to ban smokeless tobacco, including hookahs, from public places including bars and restaurants.

C. PROTECT CANADIANS FROM EXPOSURE TO TOBACCO SMOKE

Smoke-free areas support people's efforts to stay smoke-free. Created through a blend of provincial/territorial legislation and local by-laws, smoke-free area policies help prevent smoking initiation, support individuals' decisions to quit, reinforce the de-normalization of tobacco use, and encourage recent quitters – all factors having a particular resonance with youth and young smokers. Public health organizations have taken a leadership role in advocating for and enforcing such laws about smoke-free places and second-hand smoke. Outdoor workplaces and public places, such as construction sites, bar and restaurant patios, parks and beaches, should all be made smoke-free.

RECOMMENDATION

CPHA encourages all jurisdictions:

- *to ban the sale of tobacco products in retail outlets within 500 metres of registered child day-care centres, primary and secondary schools, and encourage all universities and colleges to ban the sale of tobacco products on campus*
- *to enact laws ensuring full protection from second-hand smoke in areas where young people gather, especially in school settings including post-secondary institutions.*

D. MOTIVATE, ASSIST AND PROVIDE A SUPPORTIVE ENVIRONMENT TO EVERY SMOKER FOR THEIR CESSATION EFFORTS

Although the proportion of smokers has decreased significantly over the past five decades (from the 50% rate of the 1960s to the 21% rate recorded in the 2010 Canadian Community Health Survey), the real number of smokers in Canada remains the same, roughly 5.9 million smokers in Canada, putting their lives and others at risk. This fact cannot be ignored. The literature clearly shows that quitting early can effectively minimize nearly all excess risks associated with smoking, and smokers who quit before age 50 cut in half their risk of dying by age 65.[27,28] However, tobacco is highly addictive, which means quitting is not easy requiring repeated and sustained effort. The most common cessation method used by former smokers is unaided quitting.[29] However, pharmacotherapies may increase the chances of quitting successfully in certain cases.

The tobacco industry is compelled to maintain and even enhance the addictiveness of tobacco. The industry also works diligently to stall or defeat effective tobacco control measures. It rarely opposes tobacco education or smoking cessation programs as it deems them the least effective tobacco control measures. Unfortunately, the industry is not entirely wrong in its assessment. At the population level, the rate of relapse among former smokers is very high. While relapse is rarely tracked by public health agencies, tobacco companies do collect such information. Analysis of Imperial Tobacco Canada data by an independent scholar revealed the net annual rate of smoking cessation to be about two percent.[30]

The key to making smoking cessation programs more successful is to broaden the scope of our approach; the overall social environment in which such programs are offered to become much more supportive of individuals trying to quit has to be transformed. As tobacco control becomes more comprehensive in its approach, smoking cessation will increase.[31] At this time, great variation exists in the availability and accessibility to smoking cessation programs in Canada. CPHA's 2010 survey of public health units* found that although many health authorities reported an increase in cessation activities in the past three years, only 7% reported addressing smoking cessation "very well". About 10% of respondents reported a decrease in cessation activities mainly due to funding cuts and a low uptake of services.[32]

Promoting tobacco cessation and providing effective treatment and a supportive environment for smokers trying to quit are essential parts of a comprehensive public health approach to tobacco control. In order to ensure that comprehensive approach however, coordination and consistency in tobacco cessation and treatment *at the national level* are urgently needed. Sustainable funding for cessation help should be established and ideally be derived from new levies on the tobacco industry. When considering cessation approaches, all users of tobacco products who need pharmacotherapy should have access to it. In addition, tobacco use assessment and cessation interventions should be integrated into the training and practice of all allied health professionals.

RECOMMENDATIONS

CPHA calls for the immediate adoption and support by the federal, provincial and territorial governments for a national quitline and support to maximizing accessibility for all Canadians to cessation services and resources.

CPHA calls upon the public health community:

- *to promote the adoption and use of national cessation guidelines in clinical practice and population-based strategies (CAN-ADAPTT guidelines)*
- *to assess opportunities for systematically incorporating brief contact cessation interventions into their existing one-on-one programs and services.*

E. ADOPT A DETERMINANTS OF HEALTH APPROACH TO FOCUS ON VULNERABLE POPULATIONS

Tobacco use is a barometer for social inequities and by extension health disparities. Poverty, inadequate housing, welfare policies and general disadvantage lead to and link to tobacco use. For instance, smoking prevalence is two times higher in the lowest family income bracket than in the highest income category,[33] and tobacco users at greater socio-economic disadvantage are less likely to access treat-

* This, and other surveys, were conducted through The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks project [http://www.cpha.ca/en/programs/substance-use.aspx], a Health Canada funded initiative implemented by CPHA between December 2009 and March 2011 to engage Canada's public health community in knowledge exchange activities and identify evidence-informed, practice-based strategies and inform the "next generation" of tobacco control policy in Canada.

ment and succeed at quitting.[34,35] Given that smoking-related disparities (e.g., prevalence, frequency, consumption, quit intentions and attempts, quit ratios) between socio-economic groups based on income, education, racialization and other socio-cultural factors have changed very little over time,[36,37] it is clear that the underlying causes of tobacco use have not yet been addressed through current policies.

The public health community calls for greater attention to vulnerable populations carrying a disproportionate burden of use and dependence that include youth, low-income adults, those with mental illness or substance abuse disorders, Aboriginal Peoples, prison inmates, and homeless individuals and for a social justice and health equity lens to be applied when formulating such policies to better address the psychological and socio-economic dynamics of smoking. For example, a high percentage of people with mental health issues are smokers. Many suffer from co-morbidities such as substance abuse and need sustained support as it may take longer for them to quit. Interventions should be tailored to this population and learning shared with public health and mental health practitioners. Smoke-free mental treatment facilities may help encourage quit attempts and prevent relapse, as well as protect others from second-hand smoke.[38] In addition, taxation has been shown to be an effective tobacco control tool. However, emerging work in the area of tobacco taxes and health points to psychological and other concerns such as weight gain and food insecurity for low-income households with smokers.[39] Following a tax increase, households that fail to reduce their tobacco consumption will have less income available for other goods, such as nourishing and balanced food. Using an equity lens will help integrate measures to address the additional challenges that low-income households have in order to support successful smoking cessation.

The smoking behaviour and prevalence rates among vulnerable populations should be monitored and their specific needs identified before addressing their needs through a general population-based strategy. Vulnerable populations should be actively engaged in initiatives designed to help determine what works best for them. Gaining commitment from interested and willing communities will lead to innovations in tobacco control.[40] Stakeholders across all sectors and levels of government have a role to play in helping communities implement programs and policies to support cessation interventions and tobacco-free living.

RECOMMENDATIONS

CPHA calls upon the federal, provincial and territorial governments:

- *to support community-identified and led tobacco control initiatives for population-based approaches*
- *to reach and respond to the needs of disadvantaged and particularly vulnerable population groups with respect to smoking cessation and tobacco product use prevention.*

CPHA should seek opportunities to cooperate and collaborate with the Canadian mental health community on issues related to tobacco control as it affects people with mental health issues.

Aboriginal Peoples

In this country, the First Nations, Inuit and Métis communities bear a disproportionate burden of tobacco use and tobacco-related illnesses. Current data indicate that smoking rates among the Aboriginal Peoples are approximately triple the Canadian average with 59% of First Nations and 58% of Inuit smoking.[41]

Aboriginal Peoples whether on or off reserve deserve separate and special tobacco control focus due to the lack of efforts made to date and the need for collaborative, nation-to-nation solutions that address the unique social, cultural, political and economic circumstances of these populations. A social determinants of health approach that tackles factors that contribute to poor health outcomes and social inequities within these communities should be utilized. In addition, greater participation by Aboriginal communities in Canada's FCTC management and implementation should be instituted and could be achieved by:

- Exploring options for effective community-led tobacco control in Aboriginal communities;
- Addressing the relationships among sovereignty, Aboriginal rights, the tobacco trade and economic development;
- Developing alternative models of tobacco regulation to be community-led and keeping tobacco taxation revenues in First Nations communities to support social and economic development; and
- Updating the *Indian Act* to respect traditional Aboriginal rights while providing a more appropriate framework for public health protection, tobacco control and social and economic development.

RECOMMENDATIONS

CPHA urge the federal government to revitalize the First Nations and Inuit Tobacco Control Strategy (FNITCS) and engage in nation-to-nation dialogue with First Nations and other Aboriginal communities to develop community-led tobacco control strategies that will reduce the social disparities that contribute to poor health outcomes.

CPHA should, in association with the Provincial/Territorial Public Health Associations, as appropriate, seek opportunities to cooperate and collaborate with Aboriginal peoples' organizations and communities on tobacco-related issues and strategies.

F. Support research and knowledge exchange

Research and the exchange of knowledge are vital to the development of effective policy and program interventions in tobacco control. Knowledge exchange fosters interaction between research and practice communities that is essential to measure and assess the effectiveness of innovative measures. Considerable experience and evidence already exist about comprehensive tobacco control and universal-type approaches, such as taxation, mass media and smoke-free space policies, but gaps remain.

According to the results of the 2010 CPHA survey, most health authorities can easily access published scientific research, provincial and federal tobacco control documents and smoking cessation guidelines, but lack access to grey literature and information about other jurisdictions' experiences and activities.[42] Specifically, they lack information on best and emerging/promising practices in tobacco control, public education and tobacco counter-marketing campaigns; successful tobacco control initiatives across jurisdictions; programs for youth and young adults; regional/local data on tobacco use; design, implementation and assessment of tobacco control programs; and, networking opportunities.

To help close this gap, CPHA launched an online Public Health KnowledgeCentre™ in mid 2011 to foster communication and knowledge exchange among local/regional public health organizations across the country. The Public Health KnowledgeCentre™ includes an online Tobacco Control Community with a links to key resource centres such as the Canadian Council for Tobacco Control and CAN-ADAPTT. Public health practitioners are already submitting their products, initiatives, publications, and findings to the KnowledgeCentre's™ library of public health resources, which is easily browsed through a user-centred web interface. The resource collection exceeds 10,000 items, and subscribers add their own resources using an online form. The KnowledgeCentre™ intends to showcase new and promising approaches that will form the next generation of tobacco policies.

RECOMMENDATIONS

CPHA calls upon the federal, provincial and territorial governments to allocate government revenues from tobacco product taxes or tobacco industry sources (e.g., penalties resulting from regulatory or legal actions) to support tobacco control research and knowledge generation/exchange activities that produce evidence used to design effective tobacco control strategies and interventions.

CPHA should establish and facilitate a tobacco control community of practice within the Public Health KnowledgeCentre™ as a means of supporting greater horizontal knowledge exchange among researchers and local/regional public health organizations across provinces and territories to promote and improve the use of evidence to strengthen tobacco control.

CPHA should address tobacco control during its annual conferences.

Build capacity at local and regional levels

Tobacco control is one of many areas of responsibility for the public health workforce. Recent research has found that tobacco control within public health is currently a mid-level priority with limited capacity to address it. The majority of local/regional public health staff are public health nurses and public health inspectors, with dedicated tobacco control staff representing only 2% of the workforce. Moreover, any new tobacco control staff need specific tobacco control training and orientation when they enter these positions.[43] Making tobacco control a public health priority at the provincial/territorial and federal levels with the associated provision of dedicated resources is essential to eliminate the threat to the health of current and future generations.

Enhance education and professional development

A study commissioned by CPHA on the state of tobacco control training in Canadian universities found that very little training is being provided to undergraduates in the faculties of medicine, nursing, pharmacy and dentistry.[44] The situation has improved somewhat in recent years. A graduate course in tobacco control already exists.* A complementary approach would be to embed tobacco control principles and examples throughout the core curriculum of health sciences faculties and in programs/schools of public health in Canada. When this has been attempted in the U.S., institutional leadership and faculty buy-in have been critical success factors. Comprehensive approaches have also incorporated financial incentives to students.[45] In addition, continuing professional education should be another core strategy for addressing tobacco-related competencies. For its part, CPHA has invited Canadian schools and programs of public health to establish a tobacco control working group that will pursue a coordinated approach to comprehensively integrate tobacco control concepts and examples throughout the public health graduate curricula in Canada.

RECOMMENDATION

CPHA calls on colleges, universities, professional associations, federal, provincial, regional and local governments to work together to build the capacity of health workers by ensuring that tobacco control principles are embedded within core curricula and continuing education offerings and by enhancing tobacco control learning opportunities for both public health and the allied health professions within their curricula. Additionally, the Public Health Agency of Canada to embed tobacco examples within the relevant Skills Enhancement for Public Health online modules.

* The Ontario Tobacco Research Unit (OTRU) offers two courses: (i) an on-line course *Tobacco and Public Health: From Theory to Practice* is aimed at the public health community. Over 7000 people have already completed this course; and (ii) a graduate level course *Tobacco and Health: From Cells to Society* has been taught since 1998 and is videoconferences and webcast across Canada. It covers the full spectrum of tobacco-related issues, from genetics to clinical issues to global policy.

G. REDUCE THE SUPPLY OF TOBACCO PRODUCTS IN CANADA

Institute a moratorium on new products

Tobacco manufacturers never cease developing new marketing strategies and products to evade the laws and regulations in force in Canada. New products touted to be less harmful than cigarettes represent a 'bait and switch' approach, giving the industry new and renewed addicted customers. Introducing a moratorium on new tobacco products is an effective way to counter the industry's business strategy and put a stop to the pretence of safety claimed by new alternative products—all of which remain a clear threat to public health. The moratorium should extend to all new packaging of existing products and apply retroactively to all flavoured cigars introduced into the marketplace since the adoption of the federal ban on flavourings in certain tobacco products.

RECOMMENDATION

CPHA recommends that the FTCS include a moratorium on all new tobacco products and all new packaging of existing tobacco products.

Reduce the availability of tobacco products at retail outlets

Reducing the number and type of retail locations for the sale of tobacco products will help defeat tobacco's social acceptability, make access to such products less convenient, and enhance law enforcement. Today, the retail outlets for tobacco products are widely varied across the country. The precise number of tobacco points-of-sale in Canada is not known because not all governments require tobacco retailers to register and document their activities.[46] We do know that the density of those vendors remains high. One study in Ontario in 2009 showed that there are four times more vendors of tobacco per consumer than vendors of alcohol per consumer – and this greater vendor density is for a psychoactive product that causes four times more deaths, 75% more hospital days and 30% more direct health care costs than alcohol.[47]

The Ontario Tobacco Strategy Advisory Group (TSAG) identified the pervasive availability of tobacco products in retail outlets as a major issue for tobacco control. TSAG has made two important recommendations in this regard:

1. That a system of designated sales outlets be adopted, using methods such as licensing strategies and zoning laws to

reduce the number of tobacco retailers and locations permitted to sell tobacco products, and

2. That the number of specific places prohibited from selling tobacco products be increased.[48]

Support is high for limiting the type of establishments permitted to sell tobacco especially as a means of prohibiting sales in places where minors have access and in outlets within 500 metres of schools.[49] Evidence also exists that distance from a retail outlet selling tobacco affects cessation attempts, wherein smokers who live less than 500 metres from an outlet are less likely to stay abstinent during a quit attempt.[50]

A retail licensing fee should be applied universally across Canada. Municipalities in Ontario, Nova Scotia and Alberta have the ability to require municipal licences for tobacco retailers and to increase licence fees. Not only is licensing a means to generate revenue for municipalities and support tobacco control initiatives, it also ensures compliance with tobacco control laws and regulations, and serves to limit and eventually decrease the number of retail outlets selling tobacco products. In addition, a minimum age requirement for store employees in retail outlets selling tobacco products should be established, much like the minimum age requirement for serving and selling serving alcoholic beverages.

RECOMMENDATION

CPHA calls on all provincial and territorial governments:

- *to broaden the categories of outlets that are prohibited from selling tobacco products*
- *to cap the number of tobacco retail licenses at the current level, with the goal of significantly reducing the number of outlets in each province and territory within five years*
- *to develop and maintain an accurate database of retailers of tobacco products, require licencing of all wholesalers and retailers of tobacco products administered by the Ministry of Health, and implement as soon as possible a graduated penalty structure with substantial fines, licence suspension and permanent revocation of a retailer's licence to sell tobacco*
- *to enable municipalities to implement licencing fee systems for the retail sale of tobacco products as a means to reduce the number and density of retail outlets that sell tobacco products.*
- *to apply and enforce a minimum age limit to retail outlets and establishments which sell tobacco products, similar to that in place for employees serving alcoholic beverages.*

Deter illegal tobacco products

Contraband tobacco products have the potential to undermine much of the work done by the tobacco control community and the federal government to date, especially with respect to youth. For example, the Centre for Addiction and Mental Health and the University of Toronto noted in October 2010 that 43% of the cigarettes consumed by teenage smokers in Ontario were contraband, up from an estimated 25% in the 2006/07 Canadian Youth Smoking Survey.[51] Contraband tobacco is most prominent in Ontario and Quebec, where the density of the population and location of Aboriginal reserves along the US border make manufacturing and distribution easier, but it is an issue that reaches across the country.

Canada's Implementation of the Framework Convention on Tobacco Control: A Civil Society 'Shadow Report' prepared by the Canadian Global Tobacco Control Forum (CGTCF) in 2010 indicates that many countries have a contraband tobacco problem, and that Canada is lagging behind in addressing the issue. Other countries have demonstrated that adopting enhanced enforcement strategies does lead to a very substantial reduction in contraband sales.[52] Results from the 2010 CPHA survey of public health units identified two significant barriers to implementing contraband prevention activities in this country: jurisdictional conflicts and a lack of effective legislation. Respondents indicated that they do not have the authority to address issues relating to contraband, believing instead that these issues fall under provincial and federal jurisdictions. Consequently, as public health units are not the enforcement agencies for contraband, any education about contraband that they provide is limited. Respondents also cited a lack of effective and enforced provincial and federal legislation regarding the selling, purchasing and possession of contraband as a significant barrier to implementing contraband prevention activities.[53]

Implement innovative measures to make industry accountable

Most of the tobacco control measures taken anywhere in the world, whether directed towards individual behaviour change or placing requirements on tobacco companies, are 'demand control' measures. It is doubtful that the tobacco epidemic can be eliminated if efforts are restricted to demand control strategies alone; 'supply control' approaches must be fully incorporated as well. All stakeholders must begin to examine and implement strategies for reducing

and, ultimately, removing tobacco products from the marketplace. One option is for governments to apply performance-based regulation[54] to ensure that the tobacco industry is held accountable for achieving public health goals, by way of obligatory annual smoking reduction targets that combine supply and demand reduction measures. This is a genuinely new direction for tobacco control, which CPHA endorses and calls on governments to explore and implement.

Other measures for applying economic supply-side principles to regulate the tobacco industry warrant further study as well. Canadian tobacco control researchers have identified the legal obligation of tobacco corporations to continue to make profits as a significant barrier to tobacco control. They propose that the business of tobacco supply no longer be the sole domain of for-profit corporations. Instead, tobacco product sales would be transferred to non-profit enterprises working in the public interest with a central purpose of phasing out tobacco.[55] The same researchers have also proposed that existing profit-making tobacco companies be obliged to achieve a phase-out of tobacco while continuing to meet their fiduciary obligations to earn profit.[56] In Australia, a researcher has proposed a similar approach whereby all tobacco products are required to pass through a government monopoly distribution agency, helping to control tobacco demand and supply.[57] Researchers in New Zealand have proposed progressively lower ceilings on the supply of tobacco products (the concept of the 'sinking lid') until tobacco use is considerably reduced or phased out completely, again complemented by increasingly stringent demand control measures.[58] Tobacco companies would seek to maximize their sales, but be more constrained by a progressively lower supply ceiling. The bottom line is that the public health community should support research and implementation of effective innovative strategies that use both demand and supply control measures in concerted efforts to phase out tobacco.

RECOMMENDATION

CPHA calls on the public health community to collaborate with the tobacco control and economic communities to explore innovative strategies for effective supply side responses for tobacco control.

H. Support global tobacco control efforts

Globally, there are over one billion smokers and over five million tobacco-caused deaths every year, accounting for one in 10 adult deaths annually.[59] Tobacco is also implicated as a risk factor for six of the eight leading causes of death worldwide. There is no time to waste. Continued efforts and support for a sound and comprehensive mix of interventions – including population-level interventions, targeted interventions for specific disadvantaged groups and a social determinants of health lens – in global tobacco control programs are vitally important.

CPHA has since 1996 been actively involved in supporting the efforts of public health associations in 20 low and middle-income countries to advocate for the signature, ratification and application of the FCTC in their respective countries, and to implement effective tobacco control measures, specifically promoting the implementation of FCTC Articles 6, 8, 11 and 12.[60] For several years, CPHA collaborated in the WHO/CDC-led Global Tobacco Surveillance System management committee and supported the implementation of the Global Youth Tobacco Survey, the Global School Personnel Survey and the Global Health Professions Students Survey in several countries in Africa and Eastern Europe. CPHA has also championed tobacco control as a priority issue for the World Federation of Public Health Associations (WFPHA).

The Canadian Global Tobacco Control Forum (CGTCF), of which CPHA is a founding member, is a network of Canadian non-governmental organizations working to strengthen global tobacco control capacity and progress. It has informed the Government of Canada that its lack of sustained and predictable funding over the last few years in support of global tobacco control efforts, as prescribed through FCTC, has had a grave impact on the capacity of CGTCF's partners to implement their programs. In several cases, proposed projects have been shelved due to decisions by Health Canada to renege on its allocation to global tobacco control; in other cases, project timelines and activities have been cut to fit Health Canada's requirements. The absence of both a predictable and sustained funding base and a multi-year project funding mechanism are issues that concern CPHA and the CGTCF.

CPHA strongly supports a revitalized role for Canada in facilitating international consensus on tobacco reduction and

control issues under the purview of the FCTC as well as be a role model for action on how to protect populations from the harms of tobacco use.

RECOMMENDATION

CPHA calls on the federal government to work in partnership with and support of the efforts of Canadian stakeholders and their overseas partners to develop and implement effective tobacco control strategies and deter counter-tobacco control efforts by the tobacco industry in low- and middle-income countries and to put into place sustained and predictable funding and multi-year funding mechanisms for global tobacco control initiatives.

REFERENCES

1. Physicians for a Smoke-Free Canada. (2011). *Smoking rates by province, 2000-2010*.
2. Rehm J, Baliunas D, Brochu S, et al. (2006). *The Costs of Substance Abuse in Canada 2002*. Canadian Centre on Substance Abuse.
3. Physicians for a Smoke-Free Canada. (2011). *Smoking among young Canadians by province, 2000-2010*.
4. Health Canada. *Summary of Results of the 2008-2009 Youth Smoking Survey* [Accessed at: http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/_survey-sondage_2008-2009/result-eng.php].
5. US Department of Health and Human Services. (2004). *The health consequences of smoking: A report of the Surgeon General*. Atlanta: U.S Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health.
6. Rehm J, *Op cit*.
7. Industrial Economics Incorporated. (2009). *Economic evaluation of Health Canada's proposal to amend the tobacco product information regulations: Final report*. Regulations Division, Office of Regulations and Compliance, Controlled Substances and Tobacco Directorate. Healthy Environments and Consumer Safety Branch, Health Canada.
8. Collishaw N. (2011) *Phasing out tobacco*. Presented at the European Conference on Tobacco or Health 2011. Amsterdam (February). [Accessed at: http://ectoh.org/documents/Neil%20Collishaw%202011%20Phasing%20out% 20tobacco-7%20-%20v11.pdf].
9. Government of Nova Scotia. (2011). *Moving toward a tobacco-free Nova Scotia: Comprehensive tobacco control strategy for Nova Scotia*. [Accessed at: http://www.gov.ns.ca/hpp/publications/Moving-toward-Tobacco-Free-NS-Strategy.pdf].
10. Canadian Public Health Association. (2010). *Synthesis of findings from the Next Stage Project*.
11. Physicians for a Smoke-Free Canada. (2011). *Questions and answers about prohibiting new and rarely used tobacco products and phasing out cigarettes, cigars and smoking tobacco in Canada*.
12. World Health Organization (WHO). (2005). *WHO Framework Convention on Tobacco Control (WHO FCTC)*. [Accessed at: http://www.who.int/fctc/text_download/en/index.html].
13. World Health Organization (WHO). (2010). *Canada's 2010 report on progress in FCTC implementation*. [Accessed at: http://www.who.int/fctc/reporting/can/en/index.html].
14. Global Tobacco Control Forum. (2010). *Canada's implementation of the Framework Convention on Tobacco Control: A civil society 'shadow report'*. [Accessed at: http://www.smoke-free.ca/pdf_1/FCTC-Shadow-2010-Canada.pdf].
15. Collishaw N. (2009). *History of tobacco control in Canada*. [Accessed at: http://www.smoke-free.ca/pdf_1/2009/History%20of%20tobacco%20control%20in%20Canada.pdf].
16. Health Canada. *CTUMS Smoking Prevalence 1999 – 2010*. Canadian Tobacco Use Monitoring Survey (CTUMS). [Accessed at: http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/_ctums-esutc_prevalence/prevalence-eng.php].
17. Babayan A, Srikandarajah A, Duncan A, Schwartz R. (2010). *Survey on tobacco control in Canada's public health units and health regions: Survey results report*. Commissioned by the Canadian Public Health Association. [Accessed at: http://www.cpha.ca/uploads/progs/substance/tobacco/cpha_survey.pdf].
18. Health Canada. (1999). *Federal Tobacco Control Strategy*. [Accessed at: http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/tobac-tabac-eng.php].
19. Doucas F. (March 15, 2011). *A letter from Flory Doucas, Co-director of the Coalition québécoise pour le contrôle du tabac, to The Honourable Leona Aglukkaq, Minister of Health, Government of Canada*.
20. Tobacco Control Program financial information (unaudited), Branch and Departmental Financial Data (SAP), and Health Canada. (2008). *Final Audit Report – Tobacco Control Directorate: Audit of Management Systems and Practices*. [Accessed at: http://www.hc-sc.gc.ca/ahc-asc/pubs/_audit-verif/2008-12/index-eng.Php]. Cited in Doucas F.
21. World Bank. (1999). *Curbing the epidemic : Governments and the economics of tobacco control*. Washington, DC [Accessed at: http://go.worldbank.org/N4BBVYY9V0].
22. Pan American Health Organization. (2003). *'Greatest hits' of tobacco control opponents: Suggested responses to common queries*. [Accessed at: www.paho.org/English/AD/SDE/RA/toh_greatest_hits.doc].
23. Pletcher MJ, et al. (2006). Menthol cigarettes, smoking cessation, atherosclerosis, and pulmonary function. *Arch Intern Med,* 166:1915-1922.
24. Kreslake JM, et al. (2008).Tobacco industry control of menthol in cigarettes and targeting of adolescents and young adults. *American Journal of Public Health, 98*(9): 1685.

25. Clark P, et al. (2008). *Menthol cigarettes: What do we know?* Background paper presented to the World Health Organization, University of Maryland (November).
26. Phillips CV, Rabiu D, Rodu B. (2006). Calculating the comparative mortality risk from smokeless tobacco versus smoking. *Am J Epidemiol*, 163:S189.
27. Harris J. Cigarette advertising and promotion in Canada: Effects on cigarette smoking and public health. [Online]; 1989 [Accessed at: http://legacy.library.ucsf.edu/tid/rpk70g00/pdf].
28. Callard C, Thompson D, Collishaw N. (2005). *Curing the addiction to profits: A supply-side approach to phasing out tobacco*. Ottawa: Canadian Centre for Policy Alternatives.
29. Chapman S. (2011). Tar wars over smoking cessation. *British Medical Journal*, 342: d5008 doi: 10.1136/bmj.d5008.
30. Harris J. (1989). *Cigarette advertising and promotion in Canada: Effects on cigarette smoking and public health*. [Accessed at: http://www.legacy.library.ucsf.edu/tid/rpk70g00/pdf].
31. See:
    Chapman S, et al. (1999). The impact of smoke-free workplaces on declining cigarette consumption in Australia and the United States. *AJPH,* Jul;89(7): 1018-23.
    Pizacani BA, et al. (2004). A prospective study of household smoking bans and subsequent cessation related behaviour: The role of stage of change. *Tobacco Control*, March; 13(1): 23–28.
    Gilpin EA, et al. (2006). Population effectiveness of pharmaceutical aids for smoking cessation: What is associated with increased success? *Nicotine and Tobacco Research*, Oct;8(5): 661-9
    Shields M. (2004). A step forward, a step back: Smoking cessation and relapse. Statistics Canada. 82-618.
    Health Canada. (2011). *Econometric evaluation of tobacco control initiatives in Canada, 1999-2009*. (Gagne L., author).
32. Babayan A, Srikandarajah A, Duncan A, Schwartz R. (2010). *Survey on tobacco control in Canada's public health units and health regions: Survey results report*. Commissioned by the Canadian Public Health Association. [Accessed at: http://www.cpha.ca/uploads/progs/substance/tobacco/cpha_survey.pdf].
33. Physicians for a Smoke-Free Canada. (2010). *Smoking rates in Canada by age 2000-2009*. [Accessed at: http://www.smoke-free.ca/factsheets/pdf/cchs/Canada-2009-smokingratesbyage.pdf].
34. Blas E, Kurup AS (Eds.).*Equity, Social Determinants and Public Health Programmes*. World Health Organization (WHO): Geneva, 2010, p. 214.
35. Frohlich KL, Potvin L. (2008). The inequality paradox: The population approach and vulnerable populations. *American Journal Public Health,* 98: 216-221.
36. Reid JL, Hammond D, Drizen P. (2010). Socio-economic status and smoking in Canada, 1999-2006: Has there been any progress on disparities in tobacco use? *Canadian Journal of Public Health*, *101*(1): 73-78.
37. Greaves L, Jategaonkar N. (2006) Tobacco policies and vulnerable girls and women: toward a framework for gender sensitive policy development. *J Epidemiol Community Health*. 60(Suppl 2): ii57–ii65.
    World Health Organization/International Development Research Centre. (2007) Gender and tobacco control: a policy brief. [Accessed at: http://www.who.int/tobacco/resources/publications/general/policy_brief.pdf].
38. Nevala J, Forsythe J. (2010) *The Next Stage: Delivering Tobacco Prevention and Cessation Knowledge through Public Health Networks*. *Findings from Key Informant Interviews*. Commissioned by the Canadian Public Health Association.
39. Hamilton VD, Levington C, St-Pierre Y, Grimard F. (1997). The effect of tobacco tax cuts on cigarette smoking in Canada. *Canadian Medical Association Journal*, *156*(2): 187-191.
40. Nevala and Forsythe, *Op cit*.
41. Statistics Canada. (2005) Canadian Community Health Survey [Accessed at: http://www.statcan.gc.ca/cgi-bin/imdb/p2SV.pl?Function=getSurvey&SurvId=3226&SurvVer=0&InstaId=15282&InstaVer=3&SDDS=3226&lang=en&db=imdb&adm=8&dis=2]
    Statistics Canada. (2006) Aboriginal Peoples Survey, 2006: Inuit Health and Social Conditions [Accessed at: http://www.statcan.gc.ca/pub/89-637-x/89-637-x2008001-eng.pdf]
    Canadian Paediatric Society. (2010). Use and misuse of tobacco among Aboriginal peoples. Paediatr Child Health 2006;11(10):681-5 [Accessed at: http://www.cps.ca/english/statements/II/FNIH06-01.htm].
42. Babayan A, Srikandarajah A, Duncan A, Schwartz R. (2010). *Op cit*.
43. Moloughney BW. (2010). *The Next Stage: Delivering tobacco prevention and cessation knowledge through public health networks – DRAFT Report*. Tobacco control education - Project area 3. Canadian Public Health Association.
44. Boily M, Lovato C, Murphy C. (2006). Training in tobacco cessation counseling for medical, nursing, dentistry and pharmacy students: Environmental scan and recommendations. Report prepared for the Canadian Public Health Association. [Accessed at: http://www.cpha.ca/uploads/progs/substance/tobacco/chpscstudyfinal.pdf].
45. Moloughney BW. (2010). *Op cit*.
46. Tilson M. (2011). *Reducing the availability of tobacco products at retail: Policy analysis*. Non-Smokers' Rights Association.
47. Corporate Research Associates Inc. (2005). *National baseline survey on the tobacco retail environment: Final report, POR-04-48*. Prepared for Health Canada. [Accessed at: http://www.smoke-free.ca/filtertips-5/POR-05-48%20FINAL%20(2).doc]. Cited in Tilson, p. 37.
48. Ontario Tobacco Research Unit. (2011). Prohibition of tobacco sales in specific places: Monitoring update. *OTRU Update*. (February 19).
49. Nevala and Forsythe, *Op cit*.
50. Reitzel LR, Cromley EK, Li Y, Cao Y, Dela Mater R, Mazas CA, Cofta-Woerpel L, Cinciripini P, Wetter DW. (2010). The effect of tobacco outlet density and proximity on smoking cessation. *Am J Public Health, 101*(2):315-20. [Accessed at: http://ajph.aphapublications.org/cgi/reprint/AJPH.2010.191676v1].
51. Callaghan RC, Veldhuizen S, Ip D. (2010) Letter: Contraband cigarette consumption among adolescent daily smokers in Ontario, Canada. *Tob Control* 2011;20:173-174. Published Online First: 21 October 2010
52. Global Tobacco Control Forum. (2010). *Canada's implementation of the Framework Convention on Tobacco Control: A civil society 'shadow report'*. [Accessed at: http://www.smoke-free.ca/pdf_1/FCTC-Shadow-2010-Canada.pdf].
53. Babayan A, Srikandarajah A, Duncan A, Schwartz R. (2010). *Op cit*.
54. Physicians for Smoke-Free Canada. (2010). *Future options for tobacco control: Performance-based regulation of tobacco*. [Accessed at: http://www.smoke-free.ca/eng_home/news_whatsnew.htm].
55. Callard C, Thompson D, Collishaw N. (2005). *Curing the addiction to profits: A supply-side approach to phasing out tobacco*. Ottawa: Canadian Centre for Policy Alternatives.
56. Collishaw N. (2011) *Phasing out tobacco*. Presented at the European Conference on Tobacco or Health 2011. Amsterdam (February). [Accessed at: http://ectoh.org/documents/Neil%20Collishaw%202011%20Phasing% 20out%20tobacco-7%20-%20v11.pdf].
57. Borland R. (2003). A strategy for controlling the marketing of tobacco products: a regulated market model. *Tobacco Control,* Dec;12: 374-82.
58. Thomson G, Wilson N, Blakely T, Edwards R. (2010). Ending appreciable tobacco use in a nation: Using a sinking lid on supply. *Tob Control*,*19*:431-435. [Accessed at: http://tobaccocontrol.bmj.com/content/19/5/431.abstract].
59. World Health Organization. (2010). *Tobacco fact sheet*. N°339. [Accessed at: http://www.who.int/mediacentre/factsheets/fs339/en/index.html].
60. Canadian Public Health Association. (2009) Where there is smoke: CPHA's involvement in international tobacco control. [Accessed at: http://www.cpha.ca/uploads/progs/substance/tobacco/wherenosmoke2009.pdf].

Founded in 1910, the Canadian Public Health Association (CPHA) is the independent voice for public health in Canada with links to the international community. As the only Canadian non-governmental organization focused exclusively on public health, CPHA is uniquely positioned to advise decision-makers about public health system reform and to guide initiatives to help safeguard the personal and community health of Canadians and people around the world. With a diverse membership representing more than 25 professions, a track record of success, a collaborative approach and national reach, CPHA is Canada's Public Health Leader.

www.cpha.ca