Draft April 16, 2007
Position submission to health Canada
Chronic Hazards for Consumer Chemical Labeling
May 11, 2007

Submitted by Mae Burrows
Non-governmental public interest sector

Background

Health Canada has been managing a consultation process with various expert stakeholders from labour, public interest, and chemical manufacturers and distributors with a goal to find consensus on labeling chronic hazard chemicals in consumer products in Canada. This process has been called the Ad Hoc Expert Working Group: Chronic Hazard Implementation of Global Harmonization System: Chronic Hazards for Consumer Chemicals. The Labour Environmental Alliance Society (LEAS) through Mae Burrows has been representing the non-governmental public interest sector.

The group has arrived at consensus on the need to label products for chronic health hazards but could not arrive at consensus as to whether labeling would occur only when there was a *proven risk* to the consumer when exposed to the chemical in the product (*risk based management*) or if labeling was to occur if there was a *known hazardous chemical* (carcinogen, reproductive or developmental toxicant, or sensitizer) present in the product (*hazard based* labeling). The exception to this was consensus that germ cell mutagens would be labeled because safe thresholds of exposure cannot be determined.

Since the working group could not arrive at consensus on risk or hazard-based labeling, the sectors are submitting their views in a position paper. These position papers will be sent to Health Canada, as well as the Consumer Products Sectoral Working Group.

Public interest position

It is the view of the NGO public interest sector, as represented in the following signed organizations that products containing hazardous chemicals should have:

- Full ingredient disclosure and hazard labeling of hazardous chemicals contained in consumer domestic-use manufactured products
- Hazard labeling, using distinct symbols or letters for each hazard class, for all ingredients designated as carcinogens (labeled "C"), reproductive toxicants ("R) and mutagens ("M") according to IARC (Group 1, 2A, 2B), the OEHHA (P65), reproductive and developmental toxicants' ("D") list or the EU CMR list, as well as endocrine disrupting chemicals ("EDs) listed EU and EPA, and sensitizers as listed in the EU directives and other reviewed

lists acceptable to the international community. This would be in addition to current hazard labelling that indicates corrosive, flammable or explosive ingredients. In the alternative, Canada may consider adoption of the GHS standard symbols and hazard phrases for all these categories

- Plain English and French prescribed risk phrases to accompany hazard symbols, such as "the ingredient methylene chloride in this product has been designated as a possible human carcinogen."

The rationale

- Consumers should have the same rights as employees in the workplace when it comes to exposure to hazardous chemicals in products. In the workplace, employees have a right to see full disclosure of ingredients in products that contain hazardous chemicals. They also have the right to be informed if any of those ingredients are classified as carcinogens, reproductive or developmental toxicants or sensitizers. Consumers should have that same right. MSDS are not available to consumers, nor required. Further, there is no system in place to ensure MSDS accuracy, nor education and training in their use. Consumer label information needs to address these gaps through full disclosure of hazardous ingredients and clear symbols.
- Health Canada's priority should be to develop and enforce regulations to protect the health of Canadians. Ingredient and hazard labelling fulfills consumers' right to know what chemical ingredients they may be exposed to and the potential health hazards associated with using them; however Health Canada's obligation to protect Canadians does not end with labeling hazardous chemicals in products. Control and bans of hazardous chemicals would be the next direct and required step.
- Hazard-based labeling would follow the Precautionary Principle that states "when an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause-and-effect relationships are not fully established scientifically"
- Disclosure of potentially toxic ingredients allows for consumer education about ingredient safety and toxicity as well as environmental sustainability and helps encourage the market for safer, environmentally preferable products.
- A March 2007 Strategic Communications poll shows that over 93% of Canadians support the mandatory labeling of carcinogens and toxic chemicals in household and consumer products (poll +/-4.0%, 19 times out of 20, 606 respondents)

Signed by:

Mae Burrows, Labour Environmental Alliance (LEAS) and CancerSmart Consumer
And 5 or 6 other significant national Canadian groups

important priority risk factor to address in their 2010 Prevention Plan. The NCEOE and the Alberta Cancer Board hosted a "Symposium on Environmental and Occupational Carcinogens" in Calgary on March 31st, 2006. As part of its Cancer 2020 Plan, Cancer Care Ontario has launched an Environment and Cancer Initiative.

ii. **Input into a variety of other initiatives.** The National Committee on Environmental and Occupational Exposures has provided input into a number of Canadian Cancer Society position statements on environmental and occupational carcinogens. It has also provided advice to the federal government on their review of the Canadian Environmental Protection Act (CEPA), the Children's Health Surveillance Project, and the need for a national study on environmental influences on children's health.

D. CURRENT FUNDING

1. 2006 Federal Budget

In the 2006 Federal Budget, the Government of Canada noted that it is "*committed to doing (its) part to implement the Canadian Strategy for Cancer Control. We will invest $52 million per year over the next five years to improve screening, prevention, and research activities, and to help coordinate efforts with the provinces and with cancer care advocacy groups.*"

It is expected that the first of these funds will become available in January 2007.

2. CSCC Priority Areas for Action

Given this new funding, the CSCC has identified the following priorities for action:

Develop national systems

- Standards system and database
- Clinical practice guidelines system and database
- Prevention system and action in key areas of cancer risk
- Screening recommendations, guidelines and targets
- Human resources workforce planning and management system

Improve and upgrade

- Rebalance focus towards supportive, rehabilitative and palliative care
- Enhance surveillance system, including national cancer staging system and database
- Coordination of cancer research

Establish Canadian cancer leadership platform

- Networks of experts
- Information exchange platform

3. Allocation of CSCC Funds

On July 5th, 2006, the CSCC Council met and approved in principle the general allocation of the $260 million funding commitment to support the priority areas for action indicated below.

CSCC 5 Year Budget Allocations
(in Million$)

	$	%
Research	50.8	19.5
Surveillance and staging	50.2	19.3
Primary prevention	41.1	15.8
Standards	17.9	6.9
Rebalance focus	15.5	6.0
Human resources	11.9	4.6
Screening	10.3	4.0
Clinical practice guidelines	10.3	4.0
Pan-Canadian coordination	39.9	15.3
Quality / performance assurance	12.0	4.6
Total	**260.0**	**100.0**

Of the $260 million, $41.1 million, or 15.8% of the total, is to be allocated to primary prevention.

According to our current information, the first instalment of funds will likely be released in January of 2007 ($8.22 million for primary prevention), to be utilized in the current (2006/07) federal fiscal year.

While this funding is an important and very welcome start, it should be remembered that the annual dollar amount for the entire CSCC represents approximately a cup of coffee per Canadian ($1.59/year) whereas the amount allocated to prevention represents a local call on a pay phone ($0.25/year).

Direct health care expenditures related to cancer care in 2006 are estimated at $4.87 billion.[1] Five percent of this amount is $244 million, or $7.44 per capita. Ultimately, if a shift in paradigm with an increased emphasis on prevention is to take place, the amount of funding allocated

[1] P. Smetanin, *RiskAnalytica Life at Cancer Risk* (2005), personal communication.

to cancer prevention would need to be in the range of $7-8 per Canadian per year.

PP-AG is considering two principles to guide its budget allocations:

- Approximately 50% of the budget will be allocated to cancer-specific prevention issues (such as occupational/environmental exposures, sun/UV radiation, and infectious agents)
- The remainder of the budget will be allocated to risk areas that cancer shares with other chronic diseases (such as tobacco, overweight/obesity, poor nutrition and inactivity), but within these areas we will focus on the relevant cancer niche.

E. PRIMARY PREVENTION ACTION GROUP PLANNING PROCESS

August 15, 2006 - PP-AG Meeting

On August 15 the PP-AG met in Vancouver with key members of the Public Health Agency of Canada (PHAC) and Health Canada (HC). An important purpose of the planning day was to reassess the current PP-AG strategic plan in light of the recent increase in federal funding.

Previously, PP-AG had pursued four strategic directions:

1. Ensure that all cancer control organizations advance a primary prevention agenda (monitoring)
2. Facilitate progress in communities of practice that require infrastructure and capacity building (incubation)
3. Support and add value to all primary prevention components (networking)
4. Assume a public and media communication/education role for primary prevention (communication/education)

The focus on August 15 was on an examination of current Key Results Areas (KRAs), and then modifying and/or adding new KRAs. KRAs represent priorities that help to identify the gaps between where the PP-AG is now and where it needs to be in order to succeed.

In addition to modifying and/or adding new KRAs at the August 15 meeting, the PP-AG also began the process of confirming strategic objectives. A strategic objective is a more precise formulation of a KRA, providing broad direction to achieve results within the area. If the KRA is complex, several objectives may be required. The KRAs and objectives identified at the August 15th meeting were discussed and further modified at the Integrated Cancer Primary Prevention Summit.

September 12-13, 2006 - Integrated Cancer Primary Prevention Summit

The Integrated Cancer Primary Prevention Summit, held September 12 -13 in Ottawa, was organized by the Primary Prevention Action Group (PP-AG) and the Public Health Agency of Canada (PHAC) in order to bring together cancer and chronic disease prevention leaders from across Canada.

More than 50 participants representing governmental and non-governmental sectors attended the Summit.

The objectives of the Summit were to:

- Improve the understanding of how cancer prevention links to chronic disease prevention;
- Achieve commitment to enhance collaboration between stakeholders involved in chronic disease prevention in Canada;
- Obtain feedback on the new PP-AG Strategic Plan; and
- Discuss specific ways to stay connected and work collaboratively.

F. KEY RESULTS AREAS

Based on feedback received at these two meetings, the following five KRAs (and the subsequent objectives) have been developed:

1. *Building Capacity*
2. *Policy Advice*
3. *Communication / Education*
4. *Leveraging Partnerships and Investments*
5. *Monitoring*

In addition, it was noted that *knowledge exchange, evaluation* and *management and administration* would be a component of each KRA.

Further consultation with members of the PP-AG resulted in a series of initiatives to support meeting each of the KRAs and the associated objectives. These 30 initiatives are detailed in a series of attachments at the end of the strategic plan. In the following section, the initiatives are briefly summarized below the objectives they support.

KRA.1 - Building Capacity: Identify, support and create (if necessary) communities of practice and assist in building their long-term capacity.

Objective #1.1 - To encourage and build long-term capacity within a national sun safety community of practice.

- Sun safety knowledge transfer and behaviour change (Attachment #19)
- Sun safety healthy settings (Attachment #20)
- Sun safety strengthen community capacity (Attachment #21)
- Sun safety policy development (Attachment #23)

Objective #1.2 - To encourage and build long-term capacity within a national environmental and occupational risk factors community of practice.

- Environmental and occupational carcinogen exposure unit (Attachment #13)
- O&E exposure community networks (Attachment #14)
- O&E exposure national symposia (Attachment #15)
- O&E patient history program (Attachment #16)
- O&E toxic use reduction strategy (Attachment #17)
- O&E policy development (Attachment #18)

Objective #1.3 - To encourage and build long-term capacity within a national infectious agents community of practice.

- Infectious agents national mobilization (Attachment #24)
- Infectious agents national symposia (Attachment #25)
- Infectious agents policy development (Attachment #26)
- Infectious agents literature review (Attachment #27)

Objective #1.4 - To identify our niche in the relationship between cancer prevention and chronic disease risk factors.

- Specific initiatives will be determined based on discussions with CDPAC and other NGOs

KRA.2 - Policy Advice: Work at the local, provincial, national and international levels to influence decision makers towards healthier public policies (e.g., supportive environments, including the areas of transportation, urban design, public education, etc.) that in turn move individuals towards healthier behaviours.

Objective #2.1 - To contribute advice towards public discourse and policy formulation.

- Marketing campaign (Attachment #1)
- Public opinion poll (Attachment #8)

- Physician survey (Attachment #11)
- Knowledge translation re: physician survey (Attachment #12)
- Environmental and occupational carcinogen exposure unit (Attachment #13)
- O&E policy development (Attachment #18)
- Sun safety knowledge transfer and behaviour change (Attachment #19)
- Sun safety healthy settings (Attachment #20)
- Sun safety policy development (Attachment #23)
- Sun safety / skin cancer prevention best practices (Attachment #29)
- Infectious agents national mobilization (Attachment #24)
- Infectious agents policy development (Attachment #26)
- Infectious agents literature review (Attachment #27)
- National nutrition mobilization (Attachment #28)
- Systematic review of evidence on Vitamin D, ultraviolet radiation and health (Attachment #30)

Objective #2.2 - To create a policy forum as the platform for public debate and knowledge synthesis.

- O&E exposure national symposia (Attachment #15)
- O&E policy development (Attachment #18)
- Sun safety knowledge transfer and behaviour change (Attachment #19)
- Sun safety healthy settings (Attachment #20)
- Sun safety policy development (Attachment #23)
- Infectious agents national symposia (Attachment #25)
- Infectious agents policy development (Attachment #26)
- Systematic review of evidence on Vitamin D, ultraviolet radiation and health (Attachment #30)

KRA.3 - Communication/Education: Identify, create (if necessary) and promote key messages that encourage prevention through healthy living, plus information to be delivered through partners and strategic allies, in order to connect with stakeholders and the public at a local, provincial, national and international level.

Objective #3.1 - To communicate with stakeholders, addressing any gaps in knowledge concerning the importance of primary prevention in reducing the incidence and mortality of cancer.

- Marketing campaign (Attachment #1)
- Update on attributable risk (Attachment #4)
- Primary prevention newsletter (Attachment #5)
- Key messaging on cancer prevention (Attachment #7)

- Public opinion poll (Attachment #8)
- Environmental scan (Attachment #9)
- Physician survey (Attachment #11)
- Knowledge translation re: physician survey (Attachment #12)
- O&E exposure national symposia (Attachment #15)
- O&E patient history program (Attachment #16)
- Sun safety knowledge transfer and behaviour change (Attachment #19)
- Sun safety healthy settings (Attachment #20)
- Sun safety strengthen community capacity (Attachment #21)
- Sun safety / skin cancer prevention best practices (Attachment #29)
- Infectious agents national mobilization (Attachment #24)
- Infectious agents national symposia (Attachment #25)

Objective #3.2 - To create and enhance opportunities for engaging in collaboration and cooperation with the CDPAC.

- Planning for integrated chronic disease prevention (Attachment #6)
- National nutrition mobilization (Attachment #28)

Objective #3.3 - To deliver to the public knowledge about cancer prevention.

- Marketing campaign (Attachment #1)
- Primary prevention newsletter (Attachment #5)
- Key messaging on cancer prevention (Attachment #7)
- Public opinion poll (Attachment #8)
- Sun safety healthy settings (Attachment #20)
- Infectious agents literature review (Attachment #27)
- Sun safety / skin cancer prevention best practices (Attachment #29)
- Systematic review of evidence on Vitamin D, ultraviolet radiation and health (Attachment #30)

Objective #3.4 - To facilitate the creation/enhancement of ways and means to translate knowledge of primary prevention into action.

- Marketing campaign (Attachment #1)
- Primary prevention newsletter (Attachment #5)
- Key messaging on cancer prevention (Attachment #7)
- Public opinion poll (Attachment #8)
- Physician survey (Attachment #11)
- Knowledge translation re: physician survey (Attachment #12)
- O&E exposure community networks (Attachment #14)
- O&E exposure national symposia (Attachment #15)

- Sun safety knowledge transfer and behaviour change (Attachment #19)
- Sun safety healthy settings (Attachment #20)
- Infectious agents national mobilization (Attachment #24)
- Infectious agents national symposia (Attachment #25)
- National nutrition mobilization (Attachment #28)
- Sun safety / skin cancer prevention best practices (Attachment #29)
- Systematic review of evidence on Vitamin D, ultraviolet radiation and health (Attachment #30)

Objective #3.5 - To work with the media to monitor and influence how cancer risk factors and cross-cutting chronic diseases are portrayed in the media.

- Marketing campaign (Attachment #1)
- Key messaging on cancer prevention (Attachment #7)
- Public opinion poll (Attachment #8)

Objective #3.6 - To create an awareness and understanding of the importance of primary prevention programming and concentrated investment for the long-term benefits of reducing cancer incidence.

- Marketing campaign (Attachment #1)
- Key messaging on cancer prevention (Attachment #7)
- Public opinion poll (Attachment #8)
- Physician survey (Attachment #11)
- Knowledge translation re: physician survey (Attachment #12)
- Sun safety knowledge transfer and behaviour change (Attachment #19)
- Sun safety healthy settings (Attachment #20)
- Infectious agents national mobilization (Attachment #24)

Objective #3.7 - To develop strategies and the body of knowledge that support a paradigm shift toward adopting an increased preventative emphasis in cancer control.

- Advocate for healthy living (Attachment #2)
- Status report on cancer prevention (Attachment #3)
- Update on attributable risk (Attachment #4)
- Primary prevention newsletter (Attachment #5)
- Physician survey (Attachment #11)
- Knowledge translation re: physician survey (Attachment #12)
- O&E exposure community networks (Attachment #14)
- O&E exposure national symposia (Attachment #15)
- O&E patient history program (Attachment #16)
- Infectious agents national symposia (Attachment #25)

KRA.4 - Leveraging Partnerships and Investments: Networking across the PP-AG community and other chronic disease communities of practice in order to guard against redundancy, create strategic linkages and synergies, share information, optimize resources and collaborate in order to get things done.

Objective #4.1 - To link with existing systems through increased collaboration and cooperation to maximize PP-AG impact and avoid working in isolation.

- Planning for integrated chronic disease prevention (Attachment #6)
- Environmental scan (Attachment #9)
- Physician survey (Attachment #11)
- Knowledge translation re: physician survey (Attachment #12)
- O&E exposure community networks (Attachment #14)
- O&E toxic use reduction strategy (Attachment #17)
- Sun safety strengthen community capacity (Attachment #21)
- Infectious agents national mobilization (Attachment #24)
- National nutrition mobilization (Attachment #28)

KRA.5 – Monitoring: The on-going monitoring of primary prevention initiatives in order to document them for analysis and commentary upon risk factor implications, up-take, results and overall success.

Monitoring supports evaluation activities and is a necessary first step in the evaluation process.

Objective #5.1 - To support the development of a system that will monitor progress related to cancer prevention in order to ensure timely analysis and dissemination of results.

- Advocate for healthy living (Attachment #2)
- Status report on cancer prevention (Attachment #3)
- Environmental and occupational carcinogen exposure unit (Attachment #13)
- Sun safety strengthening informed decision making (Attachment #22)
- National nutrition mobilization (Attachment #28)

Objective #5.2 - To advocate for appropriate primary prevention research.

- Update on attributable risk (Attachment #4)
- Environmental and occupational carcinogen exposure unit (Attachment #13)

- Sun safety strengthening informed decision making (Attachment #22)
- Sun safety / skin cancer prevention best practices (Attachment #29)

Objective #5.3 - To survey and assess/analyse/synthesize the current cancer prevention activities of stakeholders and disseminate results.

- Environmental scan (Attachment #9)
- Sun safety strengthening informed decision making (Attachment #22)
- Sun safety / skin cancer prevention best practices (Attachment #29)

G. FIVE YEAR BUDGET

The following table summarises the estimated financial needs required to achieve each of the 30 proposed initiatives. Note that this is still a work in progress and will no doubt be refined; however, it is meant to provide a sense of the overall priority areas and major initiatives.

PP-AG 5 Year Strategic Plan - Overview

Resource Allocation

	Fiscal Year 2006/07	2007/08	2008/09	2009/10	2010/11	5 Year Total $	Attach. #
Chronic Disease							
General							
Marketing Campaign	$ 1,247,450	$ 825,000	$ 825,000	$ 825,000	$ 825,000	$ 4,547,450	1
Key Messaging on Cancer Prevention	$ 100,000	$ -	$ -	$ -	$ -	$ 100,000	7
Public Opinion Poll	$ 125,000	$ -	$ -	$ -	$ -	$ 125,000	8
Advocate for Healthy Living	$ 68,750	$ 1,075,000	$ 1,075,000	$ 1,075,000	$ 1,075,000	$ 4,368,750	2
Status Report on Cancer Prevention	$ 30,000	$ 70,000	$ -	$ -	$ 150,000	$ 250,000	3
Attributable Risk	$ 250,000	$ -	$ -	$ -	$ -	$ 250,000	4
Newsletter	$ 10,000	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 170,000	5
Planning for Integrated Chronic Disease Prevention	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 500,000	6
Environmental Scan	$ 25,000	$ 50,000	$ -	$ -	$ -	$ 75,000	9
Infrastructure Support	$ 100,000	$ 280,000	$ 280,000	$ 280,000	$ 280,000	$ 1,220,000	10
General Subtotal	**$ 2,056,200**	**$ 2,440,000**	**$ 2,320,000**	**$ 2,320,000**	**$ 2,470,000**	**$ 11,606,200**	
Primary Care							
Family Physician Survey	$ 25,000	$ 50,000	$ -	$ -	$ -	$ 75,000	11
Knowledge Translation	$ 59,375	$ 377,500	$ 302,500	$ 100,000	$ 100,000	$ 939,375	12
Primary Care Subtotal	**$ 84,375**	**$ 427,500**	**$ 302,500**	**$ 100,000**	**$ 100,000**	**$ 1,014,375**	
Nutrition / Physical Activity / Tobacco							
National Nutrition Mobilization	$ 118,125	$ 272,500	$ 272,500	$ 272,500	$ 272,500	$ 1,208,125	28
Response to Emerging Issues	$ 4,210,500	$ 1,001,450	$ 968,818	$ 905,461	$ 491,676	$ 7,577,905	
Nutrition Subtotal	**$ 4,328,625**	**$ 1,273,950**	**$ 1,241,318**	**$ 1,177,961**	**$ 764,176**	**$ 8,786,030**	
Chronic Disease Total	**$ 6,469,200**	**$ 4,141,450**	**$ 3,863,818**	**$ 3,597,961**	**$ 3,334,176**	**$ 21,406,605**	
Cancer Specific							
Occupational / Environmental Exposures							
O & E Carcinogen Exposure Unit (CAREX)	$ 421,300	$ 716,800	$ 734,932	$ 750,789	$ 764,574	$ 3,388,395	13
Community Networks	$ 48,750	$ 355,000	$ 605,000	$ 855,000	$ 1,105,000	$ 2,968,750	14
National Symposia	$ 38,750	$ 337,500	$ 337,500	$ 337,500	$ 337,500	$ 1,388,750	15
O & E Patient History Program	$ 37,500	$ 275,000	$ 275,000	$ 275,000	$ 275,000	$ 1,137,500	16
Toxic Use Reduction Strategy	$ 68,750	$ 118,750	$ 118,750	$ 118,750	$ 118,750	$ 543,750	17
Policy Development	$ 58,750	$ 117,500	$ 117,500	$ 117,500	$ 117,500	$ 528,750	18
O & E Subtotal	**$ 673,800**	**$ 1,920,550**	**$ 2,188,682**	**$ 2,454,539**	**$ 2,718,324**	**$ 9,955,895**	
Sun Safety							
Knowledge Transfer and Behaviour Change	$ 187,500	$ 450,000	$ 450,000	$ 450,000	$ 450,000	$ 1,987,500	19
Healthy Settings	$ 137,500	$ 350,000	$ 450,000	$ 450,000	$ 450,000	$ 1,837,500	20
Strengthen Community Capacity	$ 137,500	$ 350,000	$ 450,000	$ 450,000	$ 450,000	$ 1,837,500	21
Strengthen Informed Decision Making	$ 100,000	$ 200,000	$ 200,000	$ 200,000	$ 200,000	$ 900,000	22
Policy Development	$ 58,750	$ 117,500	$ 117,500	$ 117,500	$ 117,500	$ 528,750	23
Sun Safety/Skin Cancer Prevention Best Practices	$ 50,000	$ 150,000	$ -	$ -	$ -	$ 200,000	29
Systematic Review - Vitamin D	$ 39,500	$ 40,500	$ -	$ -	$ -	$ 80,000	30
Sun Safety Subtotal	**$ 710,750**	**$ 1,658,000**	**$ 1,667,500**	**$ 1,667,500**	**$ 1,667,500**	**$ 7,371,250**	
Infectious Agents							
National Infectious Agents Mobilization	$ 88,750	$ 215,000	$ 215,000	$ 215,000	$ 215,000	$ 948,750	24
National Symposia	$ 38,750	$ 187,500	$ 187,500	$ 187,500	$ 187,500	$ 788,750	25
Policy Development	$ 38,750	$ 97,500	$ 97,500	$ 97,500	$ 97,500	$ 428,750	26
Literature Review	$ 200,000	$ -	$ -	$ -	$ -	$ 200,000	27
Infectious Agents Subtotal	**$ 366,250**	**$ 500,000**	**$ 500,000**	**$ 500,000**	**$ 500,000**	**$ 2,366,250**	
Cancer Specific Total	**$ 1,750,800**	**$ 4,078,550**	**$ 4,356,182**	**$ 4,622,039**	**$ 4,885,824**	**$ 19,693,395**	
Overall Total	**$ 8,220,000**	**$ 8,220,000**	**$ 8,220,000**	**$ 8,220,000**	**$ 8,220,000**	**$ 41,100,000**	

** Note: the 2006/07 fiscal year is from January to March of 2007.*

An important goal of the planning process was to allocate approximately half of the budget to risk areas that cancer shares with other chronic diseases and half to cancer-specific prevention issues.

Of the total $41.1 million, $21.4 million (52%) are allocated to the broader risk factors areas that cancer shares (such as tobacco, overweight/obesity, poor nutrition and inactivity) while $19.7 million are allocated to cancer-specific prevention issues such as occupational/environmental exposures ($9.9 million), sun/UV radiation ($7.4 million), and infectious agents ($2.4 million).

Of the $21.4 million allocated to the broader risk factors, a substantial amount ($7.4 million) has been set aside to respond to emerging issues. This component of the plan will be refined based on further consultation with partners addressing the common risk factors (currently being referred to as "the cube"). A key step forward in this area will be the CDPAC conference in November of 2006 and the integrated chronic disease planning process associated with that conference.

Of the total $41.1 million, $7.5 million are allocated to staffing to support an estimated 24.25 FTEs during the five-year period, $22.1 million to operating costs, $4.1 million to grants and $7.4 million to respond to emerging issues.

As noted earlier, a long-term perspective is essential when addressing the prevention of cancer. Within this long-term perspective, however, there is also the desire for shorter term successes. While these successes may not be in the arena of ultimate goals (a reduced incidence of cancer), they could be in the arena of intermediate outcomes (e.g., reduced smoking, increased physical activity, and healthier eating, and an increased prevalence of healthy body weight) or even process outcomes (e.g., co-ordinated prevention messages, disease-specific agencies working in concert to address key risk factors, greater public knowledge or increased participation in programs).

H. CONCLUDING REMARKS

For the Primary Prevention Action Group of the Canadian Strategy for Cancer Control, the completion of this five year plan cannot be the end. The importance of primary prevention will need to become "institutionalized" within the cancer control and general health care sectors.

It does, however, constitute a good start.