



## The importance of a comprehensive, integrated, centralized, and distinct tobacco control program

(February 9<sup>th</sup>, 2004)

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The smoking epidemic requires a specific and distinct approach for many reasons, the main ones being the scope of damages caused by tobacco, the addictive nature of nicotine, and the paramount role played by the tobacco industry in the creation and maintenance of the tobacco epidemic.

In other words, tobacco is unique. The differences between the tobacco control efforts and those relating to lifestyle habits are far greater than their common traits:

- 1) **Smoking is an illness<sup>1</sup> and not a lifestyle choice such as obesity, physical activity/inactivity, or good/bad nutrition.** Nicotine in tobacco creates an extremely powerful addiction, as powerful as heroin or cocaine addiction.<sup>2</sup> Contrary to those who choose to eat well or be physically active, smokers do not have the same “freedom” in choosing or not to smoke.

Over 90% of children and teenagers who smoked their first 3 or 4 cigarettes will eventually become enslaved to a 30 to 40 year addiction.<sup>3</sup> The most young people who start smoking are convinced that they will stop within the next twelve months.<sup>4</sup> Three quarters of these will try to stop smoking at least once, but almost all (90%) will fail.<sup>5</sup> The same holds true for adults. The majority (82%) of smokers want to stop smoking, but most are incapable of doing so.<sup>6</sup>

Cigarette manufacturers discovered the biological slavery of nicotine addiction well before the scientific community, information they have kept secret and still continue to deny. Between 1965 and 1995, they increased the rate of nicotine in cigarettes by 53%, thus aggravating the problem of addiction.<sup>7</sup>

There is a strong distinction between tobacco and other narcotics: the effects of other drugs on users usually render them dysfunctional in society, which explains why the health care system tends to consider them (and treat them) as invalids. This is not the case with smokers. Smoking also cannot be compared to drinking: the harmful effects of alcohol stem from years of abuse, while smokers become addicted to cigarettes through “normal” consumption, meaning in accordance with the manufacturer’s intentions.

*[\*\* Translation provided by the Canadian Council for Tobacco Control]*

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<sup>1</sup> ICD-10 (International Classification of Diseases), World Health Organization (WHO)

<sup>2</sup> “The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General”, Rockville, MD: U.S. Department of Health and Human Services, 1988.

<sup>3</sup> M.A.H. Russell, The nicotine addiction trap: \$ 40-year sentence for four cigarettes, *British Journal of Addiction*, (1990) 85, 293-300.

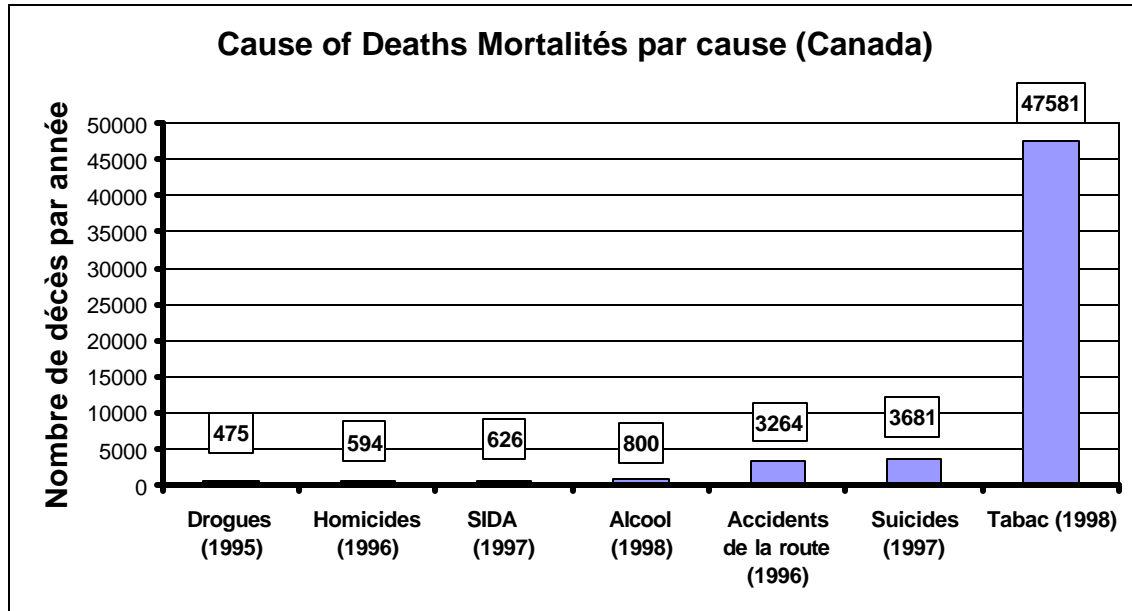
<sup>4</sup> *Recent Trends in Adolescent Smoking, Smoking-Uptake Correlations and Expectation about the Future*, Advance Data, No 221, 1992, U.S. Department of Health and Human Services.

<sup>5</sup> Fiore, M.C., Trends in Cigarette Smoking in the United States: The Epidemiology of Tobacco Use, *Med Clin North Am* 1992; 76: 289-303.

<sup>6</sup> Canadian Cancer Society, Press release citing an Environics survey (conducted between December 11 and 29, 2003 on 2,002 Canadians), January 16<sup>th</sup>, 2004.

<sup>7</sup> W.S. Rickert, Nicotine in whole tobacco and tobacco smoke, A Study Funded Under Contract With Health Canada, March 1995.

- 2) **Tobacco industry products are the most important cause of premature loss of life in our society, representing about one in every four deaths.**<sup>8</sup> The figures are so astronomical that their reach is difficult to fully comprehend. Every year over 47,000 Canadians die due to tobacco. In Quebec, the estimated figure has now reached 13,295.<sup>9</sup> In fact, tobacco<sup>10</sup> kills more Quebecers than alcohol<sup>11</sup>, suicide<sup>12</sup>, AIDS<sup>13</sup>, drugs<sup>14</sup>, murder<sup>15</sup>, and road accidents<sup>16</sup> combined.



With regards to tobacco costs incurred by society, it is estimated that the total amount attributable to smoking is approximately \$15.8 billion for Canada and \$4.3 billion for Quebec.<sup>17</sup>

- 3) **The smoking phenomenon is fabricated entirely by the tobacco industry, through sophisticated marketing strategies developed throughout the 20<sup>th</sup> century as well as product engineering (to maximize addiction).** Tobacco provides no benefit whatsoever, other than to feed the addiction that it created. It does not answer to normal desires or basic needs such as hunger or thirst. A totally useless product, it causes considerable harm not only to smokers but to non-smokers as well, including millions of children. Cigarettes exist and are consumed solely because there is an

<sup>8</sup> Makomaski, I., Kaiserman, M.J., « Mortality Attributable to Tobacco Use in Canada and its Regions, 1998 », Canadian Public Health Review, Vol. 95, No 1, Jan.-Feb., 2004.

<sup>9</sup> Makomaski, I., Kaiserman, M.J., « Mortality Attributable to Tobacco Use in Canada and its Regions, 1998 », Canadian Public Health Review, Vol. 95, No 1, Jan.-Feb., 2004.

<sup>10</sup> Makomaski, I., Kaiserman, M.J., « Mortality Attributable to Tobacco Use in Canada and its Regions, 1998 », Canadian Public Health Review, Vol. 95, No 1, Jan.-Feb., 2004.

<sup>11</sup> Statistics Canada, Health Statistics Division, «Deaths for all provinces from each cause by sex and age, 1998», National Mortality Database [non-catalogued tabulation], Ottawa (cited in Makomaski, I., Kaiserman, M.J., « Mortality Attributable to Tobacco Use in Canada and its Regions, 1998 », Canadian Public Health Review, Vol. 95, No 1, Jan.-Feb., 2004.

<sup>12</sup> Statistics Canada, «Principal Causes of Deaths Selected According to Gender, 1997» Web site.

<sup>13</sup> Statistics Canada, «Principal Causes of Deaths Selected According to Gender, 1997» Web site.

<sup>14</sup> Canadian Centre for Alcoholism and Drug Addictions, «Canadian Profile 1999», 1999 [total of 804 deaths – 329 suicides linked to drugs].

<sup>15</sup> Statistics Canada, «Standardized Mortality Rate According to Age, 1996»; Statistics Canada, Population and Demographic Growth Component, Census from 1851 to 2001 [Canada's population in 1996 of 29,672,000].

<sup>16</sup> Statistics Canada, «Standardized Mortality Rate According to Age, 1996»; Statistics Canada, Population and Demographic Growth Component, Census from 1851 to 2001 [Canada's population in 1996 of 29,672,000].

<sup>17</sup> Groupe d'Analyse, «Update on Smoking Costs to Society», January 15, 2004.

industry which profits from their sale and which can pass off their considerable social and health costs to the societies that harbor them.

- 4) The tobacco industry spends vast fortunes to block any measure that will reduce the consumption of its products. It has maintained this behavior of corporate delinquency for decades.** This is not the case with most other health problems relating to lifestyle choices or health protection measures: one cannot imagine a multi-billion dollar industry sabotaging programs that encourage physical activity, promote risk-free sexual relationships (AIDS) or even force cleanliness in restaurant kitchens.

Among the tobacco industry's many tactics, one finds:

- 40 years of deceit, obscurantism and systematic denials concerning health issues, addiction, and toxic effects of second-hand smoke;
- manipulation of its products in order to increase addiction to nicotine;
- aggressive marketing systematically aimed at children and teenagers;
- public relations and litigation aimed at sabotaging government policies on health issues;
- organization of front groups, secret financing of so-called research, conspiracy to corrupt major international health organizations<sup>18</sup>;
- smuggling of cigarettes, mainly to lower taxes but also to introduce illegal brands into a restricted jurisdiction.

- 5) Smoking also affects non-smokers.** In private and public areas, second-hand smoke is harmful to non-smokers' health, including children. In Quebec, an estimated 300 people die each year due to the pollution caused by second-hand smoke<sup>19</sup>. This is a very complex societal problem that continues to be a major public debate, with opponents raising questions of freedom of choice for smokers, of business economic interests, and of dubious scientific studies that falsely minimize the secondhand smoke effects on health and promote ventilation as a solution. This specific issue requires important changes in social norms combined with global legislation.

### **Comprehensive Approach**

For quite some time, tobacco control efforts consisted of conducting public awareness campaigns aimed at changing individual behavior. These campaigns were treated as isolated initiatives and either announced through the media or sent to local public health workers who were ill prepared to tackle this epidemic.

In fact, when smoking is treated as an issue related to individual free will or behavior, it follows that one may think that convincing smokers to stop, or teenagers not to start, will solve the problem. However, ongoing misinformation and marketing strategies, as well as addiction to nicotine, ensures a continuous influx of new smokers for the industry: almost always youths, they replace those who have managed to quit or who have died from using these products.

The main lesson learnt over the past three decades is that the smoking issue cannot be solved without the implementation of comprehensive set of policies that change social norms and fundamentally change the

<sup>18</sup> Experts Committee on the Tobacco Industry's documents, named by the Director General of the World Health Organization 'Strategies used by the tobacco industry to counter tobacco control efforts at the World Health Organization'; July 2000.

<sup>19</sup> According to the Quebec/Canada smoker ratio, based on Makomaski, I., Kaiserman, M.J., 'Mortality Attributable to Tobacco Use in Canada and its Regions, 1998', Canadian Public Health Review, Vol. 95, No 1, Jan.-Feb. 2004.

commercial practices of cigarette manufacturers. (It is only in such an environment that education and cessation programmes can be really effective.)

Today, public health experts, anti-tobacco groups, and other health organizations maintain that effective tobacco control begins by introducing regulatory and fiscal measures, supported by solid public funding, and containing the following elements<sup>20</sup>:

- Cease all forms of direct and indirect advertising, including sponsorship;
- Make tobacco less accessible by increasing taxes and controlling smuggling;
- Protect non smokers from all exposure to tobacco smoke;
- Promote cessation and make nicotine replacement therapies available to those who want to quit;
- Inform the public of the content and effects of tobacco industry products.

Based on recommendations from the *Centers for Disease Control and Prevention*, the budget for tobacco control should be between \$64 M and \$178 M<sup>21</sup> per year for a population the size of Quebec's. (For years, health groups in Quebec have requested a sum of \$75 M.)

Of course, the adoption and rigorous implementation of these measures (with appropriate budgets) are far from having been achieved in most countries throughout the world, including Canada. However, these objectives are generally recognized and recommended by the most prominent international organizations, such as the World Health Organization, the Centers for Disease Control and Prevention, and the World Bank.

Fortunately, both the Federal and Quebec governments respect this golden rule of effective tobacco control: they both address the tobacco epidemic through a comprehensive and integrated approach. Activities in Health Canada's **Tobacco Control Programme** and the Quebec Ministry of Health and Social Services' *Service de la lutte contre le tabagisme* include regulatory reform, public information and education, cessation, protection against second-hand smoke, and networking with stakeholders. (Added to these are tax increases by the respective Finance Ministries.)

### **Potential Problem: The Integration of Tobacco in Lifestyle Choices**

If tobacco were to be integrated with other lifestyle choices, the emphasis on broad environmental measures to reduce smoking would be at risk. A case in point is France. Bertrand Dautzenberg, President of *l'Office français de prévention du tabagisme* and professor of respirology at *Hôpital Pitié-Salpêtrière*, Paris, and Gérard Dubois, professor of Public Health at *Université Jules Verne* and President of *l'Alliance Française Contre le Tabagisme*, explain the impacts of a comprehensive approach to tobacco ("product policy") compared to the individual approach ("individual responsibility"), the latter having resulted for several years in a three-part integrated narcotic's programme (tobacco, alcohol, and cannabis) under a single "all addiction policy":

*"The so-called 'product policy' deals with offer, image, and the perception of the product in society (price, advertising, availability) without neglecting cessation aides for a product like, which is highly addictive. The 'all addiction' policy stems from the higher frequency of use of*

<sup>20</sup> First International Francophone Conference on Tobacco Control, "Declaration of Montreal", September 2002.

<sup>21</sup> Conversion based on the Bank of Canada of figures for North Carolina, with a population comparable to that of Québec (Total upper estimate = \$ US 118 626 000, total lower estimate = \$ US 42 591 000) ; Centers for Disease Control and Prev ention, "Best Practices for Tobacco Control Programs", August 1999.

*these types of products and deals exclusively with the addicted person who consumes them (care, weaning, and reintegration)...*"

*"The 'all addiction' [policy] is a major error, committed from 1998 to 2002, that has in France had catastrophic results with respect to tobacco and cannabis consumption. From 1991 to 1997, tobacco control efforts concentrated on prohibiting advertising, protecting non-smokers from tobacco smoke, and product taxing. The drop in tobacco sales was 11%, and that of cigarettes alone was 14%. Between 1998 and 2002, the anti-tobacco programme was integrated in the inter-ministerial mission on drug and drug addiction control (MILDT), which resulted in an approach that was essentially centered on care services. One had to talk about consumer behavior, and not longer about the 'product'. Despite having reinforced access to cessation aides, this approach, associated with non-dissuasive price hikes, resulted in a stagnant consumption from 1998 to 2001."*<sup>22</sup>

### **Different Messages**

Messages to support the fight against tobacco must necessarily take into consideration the very specific nature of tobacco, for example: the generally underestimated risks of death caused by tobacco, nicotine's addictive nature, the impacts of second-hand smoke, and the tobacco industry's marketing strategies that associate smoking with independent adult behaviour, glamour and seduction, and healthy physical vigor. In fact, messages that expose the tobacco industry immoral behavior as well as the dangers of secondhand smoke are the most effective themes to reach youth<sup>23</sup> – two themes have absolutely no relevance to other public education efforts that promote better lifestyle choices such as physical activity.

In a school environment, where several health messages are often simultaneously communicated, it is dangerous to associate smoking with other lifestyle choices. For example, it becomes easy to minimize the consequences of smoking, which kills half of smokers – a disproportionately enormous mortality rate in comparison to even that of suicide or other causes of adolescent death. Associating tobacco use to individual lifestyle choices also diminishes the role of the tobacco industry as the promoter of the epidemic and delays public awareness regarding the extraordinary anomaly of promoting nicotine addiction as a socially accepted form of pleasure and relaxation.

Many studies have shown the counter-productive effects generated by anti-tobacco messages that are intermingled with other lifestyle behaviours. For example, a Montreal study demonstrated that a programme encouraging healthy lifestyles had beneficial effects when it came to nutrition and physical activity, but had the opposite effect with regards to smoking – with boys three times more likely to smoke, and five times more likely for girls.<sup>24</sup>

### **The tobacco industry supports the integration of tobacco control with lifestyle choices**

It is important to note that the tobacco industry *supports* the integration of tobacco with other lifestyle choices. According to Stanton Glantz, Professor at the University of California and author of several books on the tobacco industry, the latter systematically works to submerge tobacco in broader programs<sup>25</sup>. The main benefits for the industry are that it shifts the focus away from the industry and its business practices to the individual, and that it minimizes the magnitude of the tobacco problem.

<sup>22</sup> Bertrand Dautzenberg and Gérald Dubois, « Point de vue : Contre le tabac, pas de faiblesse », Le Monde, January 6, 2004.

<sup>23</sup> Goldman, L. and S. Glantz. "Evaluation of Antismoking Advertising Campaigns", *Journal of the American Medical Association*, vol. 279, n° 10 (March 1998).  
Dufour, V. "Anti-Tobacco Paradox: A Programme Intended for Young Montrealers had a reverse effect than that researched", *Le Devoir*, April 22, 2000. [Article citing Lise Renaud of Montreal-Centre's Health Management and Social Services]

<sup>25</sup> Stanton Glantz, written communication, January 7, 2004.

Integrating tobacco control under a broader umbrella also increases the risk of losing precious funds allocated to tobacco control. Senior officials may find themselves in a position that forces them to dip into a larger budget for tobacco control in order to finance other lesser-funded sectors in their department. In fact, this is a favourite tactic of the tobacco industry which has, for example, succeeded in diverting California's anti-tobacco budget towards other public health problems — until the courts forced the government to restore the will of the legislator<sup>26</sup>.

This strategic position greatly benefits the industry. Indeed, it applies it to its own “prevention programs” which, we are now aware, are mere public relations ploys. Thus, *Wise Decisions*, a school-based programme sponsored by the Canadian tobacco industry and intended for students in grades 6 to 8, addresses a whole range of lifestyle habits, including physical exercise, amount of sleep, and nutrition. The programme is similar to the American school-based programme called *Lifeskills Training*, promoted and funded by *Philip Morris USA* (now *Altria*), which purports to help students “resist peer pressure to smoke, drink alcohol, and use drugs”<sup>27</sup>.

Experts in the public health sector condemn tobacco industry's prevention programs as ineffective in reducing smoking and being designed (or funded) by the tobacco companies with the sole purpose of enhancing its image, thereby helping it block effective anti-tobacco measures.

### **A distinct governmental service is more effective**

The various fronts in the fight against tobacco are not only complex but also interdependent. It is therefore essential for all governmental teams working on the tobacco issue to share their knowledge on the numerous aspects of tobacco control and to coordinate their tobacco reduction efforts. A comprehensive programme that concentrates solely on tobacco, that incorporates all the research, monitoring, evaluation, education, programming, inspection, and regulation components, will necessarily be better coordinated and more efficient.

Such an organization will result with strategic priorities being more likely based on what is *effective* and on what optimizes the *synergy* of the different tobacco control efforts, rather than on competing needs and their ensuing arbitrations within different public health sectors.

### **Tobacco in Health Canada before and after the Tobacco Control Program**

In 1999, following a request from Canadian health groups, the Federal Health Minister, the Honorable Allan Rock, recommended a far-reaching reorganization of Health Canada. Hence, all staff members working on the tobacco issue and located in different Health Canada departments (policy, promotion, regulation, research, monitoring, etc.) would be regrouped under one management.

Health Canada's experience before and after restructuring<sup>28</sup> reflects the opinion of many health organizations on this issue. Prior to reorganization, priorities relating to tobacco in different departments were determined mostly in relation to the forces that existed within these structures, especially when political will had no decisive role. Priorities depended not only on the availability (and sharing) of funds for all projects, but also on the knowledge or preferences of decision-makers along various levels of authority.

<sup>26</sup> Stanton Glanz, “Tobacco War”, University of California Press, 2003. [<http://texts.cdlib.org/dynaxml/servlet/dynaXML?docId=ft167nb0vq&chunk.id=d0e7313>]

<sup>27</sup> Philip Morris USA, “Policies, Practices & Position”, Web site, January 2004.

<sup>28</sup> Private Communication with Hélène Goulet, General Director of Health Canada's Tobacco Control Programme, January 2004.

Each department had a manager who handled the tobacco file and who reported to a departmental director<sup>29</sup>. The latter was responsible for several public health issues. He himself reported to a director general who was also responsible for several public health issues. Compared to the current system, departmental directors and director generals were not only less informed on tobacco issues in their own departments (having other matters to treat as well), but were also less informed about their colleagues' tobacco control activities.

Today, there is one director general that supervises the entire Tobacco Control Program. This person has an overview of all tobacco control activities and reports directly to the assistant deputy minister. Departmental directors interact with each other in a closer, more collaborative manner, being as they are all located under the same roof and all work exclusively on issues related to tobacco.

Following the restructuring, the prestige and influence of the tobacco file was greatly improved. One big, solid organization carries more weight than numerous small working groups dispersed throughout several departments. The result is less duplication and more coherence between the projects of different groups.

Here are some specific examples demonstrating the benefits of this merger:

- Prior to restructuring, each group would forward its own inquiries to the general monitoring office, without there necessarily being any coherence between the requested data. To answer inquiries relating to monitoring statistics, the Canadian Tobacco Use Monitoring Survey is now being used as a reference tool for all concerned.
- Different activities linked to the same aspect of tobacco are better synchronized. For example, when the mass media group prepares a cessation campaign, it will cooperate with the Office of Research, Surveillance and Evaluation to identify effective methods to quit smoking, as well as the Office of Prevention, Cessation and Education to ensure that quitting tools such as pamphlets, websites, or telephone lines to assist in quitting are available and functional.
- When second-hand smoke (SHS) was determined a priority, the relevant groups within the Tobacco Control Programme coordinated both their approaches and messages, including: the Office of Prevention, Cessation and Education (SHS projects with provinces and municipalities), the Office of Research, Surveillance and Evaluation (attitudes, public knowledge of SHS), and the mass media group (mass media campaign on SHS in households and at work).
- When the Office on Regulations and Compliance prepared new warning regulations, it did so in a concerted way with those in research in order to come up with the most effective warnings.
- To improve the work of field inspectors regarding the enforcement of the law's sales to minors provisions, the Office of Regulations and Compliance started collaborating with the research group to better evaluate the measure's impact, to develop different messages in order to strengthen the tobacco reduction potential of this measure, and to determine the appropriate levels of resources to be allotted to this activity.
- Although the Department of Foreign Affairs is responsible for the Framework Convention on Tobacco Control, it named the Director General of the Tobacco Control Programme as its chief spokesperson and representative at the World Health Organization. If, as in the past, several director general were involved in the tobacco file, with each versed in only one particular aspect of tobacco control, it would have been more difficult to find someone with such a broad and

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<sup>29</sup> In the French text, refers to the masculine gender, also applicable to the feminine.

knowledgeable overview of the issue. The Canadian position would surely have suffered and Canada would not have been able to play the leadership role for which it has been recognized.

- Communication with the provinces and territories on the tobacco issue has been simplified: because of the restructuring, there is but one department that manages inter-provincial and inter-territorial communications concerning all aspects of tobacco.
- Finally, laws and regulations regarding tobacco are better protected against industry litigation in court. Because of improved coordination, a greater effort is made to minimize any discrepancy between departments, to ensure a better quality of research that supports governmental measures, and to increase coherence between the law's objectives and its enforcement.

### **Tobacco Control Department in Quebec**

The province of Quebec also merits a mention : its *Service de lutte contre le tabagisme*, created after the enactment of the 1998 Tobacco Act, contains of all of the necessary components of a tobacco control programme – regulations and legislation, information, education and support, mobilization, research, monitoring, and evaluation. Since 1998, the *Service* has administers the implementation of all tobacco control legislative measures as well as other interventions. These efforts – combined with federal measures – have produced spectacular drops in adult smoking prevalence (1998 : 34% - 2002 : 26%)<sup>30,31</sup> as well as smoking amongst youths (1998 : 30,4% - 2002 : 23,1%)<sup>32</sup> , one of the most significant drops in the world.

### **Other Experiences**

Canada and Quebec's experiences are not isolated cases. Other jurisdictions have noticed the effectiveness of an integrated and independent tobacco control programme.

Commenting on the spectacular 40% drop in tobacco consumption during the nine-year tobacco control programme (1988 to 1997), California's Health Services Ministry recommends that *“the state-level administrative office should be established as a separate unit in the state health department. It should have a strict singleness of purpose, with separate funding, and be dedicated solely to reducing tobacco use and protecting the public from exposure to secondhand smoke. This is recommended because of the political nature of the programme and the existence of a multi-billion dollar industry that will use all of its means to defeat or weaken it.”*<sup>33</sup>

As for France, Bertrand Dautzenberg and Gérard Dubois concluded: *“In France, the history of tobacco control during the last fifteen years clearly condemns the “all addiction” policy and the refusal of treating the product in an independent way. Tobacco needs a specific policy, associating prevention with care giving... Because of the differences, the medical effects, and economic, social, and domestic consequences, a per-product policy must be imposed. ...the differences between addictive products are greater than their similarities. Hence, France has a need for a coherent policy centered on each addictive product.”*<sup>34</sup>

<sup>30</sup> Health Canada, *National Enquiry on the Population's Health: Smoking in Canada, Cycle 2 (1996 -1997)*, January 1999

<sup>31</sup> Health Canada, *Surveillance Enquiry on the Use of Tobacco in Canada: Overview of Results for 2002*, July 2003.

<sup>32</sup> Quebec Statistics Institute, *Quebec Enquiry on High School Students Smoking, 2002*, 2003

<sup>33</sup> California Department of Health Services / Tobacco Control Section "A Model for Change: the California experience in Tobacco Control", October 1998.

<sup>34</sup> Bertrand Dautzenberg and Gérard Dubois, « Point de vue : Contre le tabac, pas de faiblesse », *Le Monde*, January 6, 2004.

In fact, in their analysis of the best practices for tobacco control<sup>35</sup>, the US Centers for Disease Control and Prevention state that the experience in certain American states “*has shown the importance of having all the components coordinated and working together.*” They cite the California and Massachusetts as role models, states in which all tobacco control components are grouped under one management.

### **Conclusion**

Because of the unique nature of tobacco industry products – namely addiction –as well as the incredible resources and tactics (both past and present) employed by the tobacco companies, the fight against the number one cause of preventable death and disease is long, difficult, and complex. It requires a concerted and unflagging effort from all parties – be it governments, public health employees and health groups.

Any and all division within the tobacco control forces will reduce the ability to effectively coordinate the different efforts, especially those within a government. By supporting an integrated and independent government tobacco control program, the health benefits of government tobacco control measures and efforts are greatly maximized.

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<sup>35</sup> Centers for Disease Control and Prevention, “Best Practices for Comprehensive Tobacco Control Programs”, August 1999.