INTRODUCTION

In the World Health Organization’s Western Pacific Region (WHO WPR), being born male is the single greatest risk marker for tobacco use. The male smoking prevalence (62.3%) and rate of increase are the highest in the world (Stanton, 2001). Female smoking stands at ~4% in the WPR, but rates have risen (and are higher) in some settings. Prevalence rates by sex for smoking in selected WPR countries are shown in Table 1. These figures do not include the consumption of tobacco in other forms.

Men and women face distinctive health threats related to smoking. Men risk a decline in fertility and sexual potency (American Council on Science and Health, 1996), and appear to have greater all-cause mortality related to smoking (Marang-van de Mheen et al., 2001). There is contradictory evidence about which sex is more vulnerable to lung cancer and lung disease given equal tobacco use, with speculation that age of initiation, hormones, and other factors play a role.

Table 1: Prevalence of smoking among males and females in selected countries of WHO WPR

<table>
<thead>
<tr>
<th>Country</th>
<th>Male rates (%)</th>
<th>Female rates (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>29.9</td>
<td>24.2</td>
</tr>
<tr>
<td>China</td>
<td>66.9</td>
<td>4.2</td>
</tr>
<tr>
<td>Laos</td>
<td>41.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Malaysia</td>
<td>41.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Philippines</td>
<td>53.8</td>
<td>12.6</td>
</tr>
<tr>
<td>Singapore</td>
<td>26.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Vietnam</td>
<td>50.0</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Sources: [WHO, 2000a; Dans et al., no date specified (n.d.)].

SUMMARY

In the World Health Organization’s Western Pacific Region, being born male is the single greatest risk marker for tobacco use. While the literature demonstrates that risks associated with tobacco use may vary according to sex, gender refers to the socially determined roles and responsibilities of men and women, who initiate, continue and quit using tobacco for complex and often different reasons. Cigarette advertising frequently appeals to gender roles. Yet tobacco control policy tends to be gender-blind. Using a broad gender-sensitivity framework, this contradiction is explored in four Western Pacific countries. Part I of the study discusses issues surrounding gender and tobacco, and analyses developments in Malaysia and the Philippines. Part II deals with Singapore and Vietnam. In all four countries, gender was salient for the initiation and maintenance of smoking, and in Malaysia and the Philippines was highly significant in cigarette promotion. Yet, with a few exceptions, gender was largely unrecognized in control policy. Suggestions for overcoming this weakness in order to enhance tobacco control are made in Part II.

Key words: gender; policy; Southeast Asia; tobacco control
type of use and duration interact in complex ways with social and lifestyle factors (Marang-van de Mheen et al., 2001; Payne, 2001). Female smokers risk increased cardiovascular disease while using oral contraceptives, and higher rates of infertility, premature labour, low birthweight infants, cervical cancer, early menopause and bone fractures. Female non-smokers are more likely to be exposed to environmental tobacco smoke and have elevated risks of lung cancer and heart disease, as well as the burden of caring for partners with smoking-related illnesses (Vierola, 1998; Ernster et al., 2000; Ernster, 2001).

Several WPR countries have experienced small or moderate rises in commercial cigarette use among young women (Morrow and Barraclough, 2001; Morrow et al., 2002). The Tobacco Reporter, an industry document, sounded optimistic about the Asian region in 1998:

Rising per capita consumption ... and an increasing acceptance of women smoking continue to generate new demand. [(Kaufman and Nichter, 2001), p. 78]

Like all health behaviours, tobacco use occurs within a complex social environment, which includes gender. Gender ‘specifically refers to women’s and men’s roles and responsibilities that are socially determined … [as distinct from their] biologic and reproductive characteristics …’ [(Christofides, 2001), p. 166]. These roles, however, may alter over time. Rapid socio-economic change, including the massive movement of women into the paid workforce, is underway in Asia and the Pacific. Greater female autonomy historically has been linked to smoking uptake among Western women (Vierola, 1998; Worth, 1999), prompting predictions of similar patterns in developing countries (Waldron et al., 1988). Socio-cultural influences on tobacco use are central, but the direction of associations varies across time and place. Age, socio-economic status, ethnicity, mental health and sex are the most frequently identified factors of interest, but health experts disagree about why these are implicated, or why sex is often associated independently, as well as in concert, with other factors.

Overwhelmingly, smoking is embarked upon during youth, although in Vietnam and the Philippines, older women use relatively more tobacco (Jenkins et al., 1997; Kaufman and Nichter, 2001). Advertising and media placement that glamorizes smoking, equates it with attaining maturity, or renders it normative, is difficult for some young people to resist. Other themes that appear to influence youth smoking relate to body image, social bonding and peer pressure, although these are not consistent across cultures (Aghi et al., 2001).

In high- and low-income countries alike, tobacco use is most common among poor, less educated men (World Bank, 1999). In developed countries, where female rates approach those of males, the same socio-economic relationship is found (WHO, 2000b). In countries where women use tobacco less, contradictory associations have been noted (Aghi et al., 2001; Stanton, 2001). Young, elite women in China and India are starting to smoke in greater numbers than their less affluent peers (Kaufman and Nichter, 2001), but a recent study in Ho Chi Minh City among 2020 young women found rates were higher among less educated workers than among students (Morrow et al., 2002). Tracing tobacco use patterns is greatly constrained by the lack of data disaggregated by social factors over time. A further problem is that many surveys ignore consumption of tobacco leaf in roll-your-own cigarettes, by chewing, or consumption with areca (betel nut), which are popular among older, rural women, and less-educated populations in parts of the WPR.

Another powerful association exists between smoking and mental disorders. Reviews have found females in many countries have higher rates of depression. Moreover, there is evidence that reproductive hormones may independently influence depression and smoking behaviour (Acieno et al., 1996; Jorm, 1999; WHO, 2000b; Hunter, 2001; Payne, 2001). WHO predictions of increasing worldwide prevalence of depression assume great relevance for tobacco control (Jorm, 1999; WHO, 2000b; Hunter, 2001).

There is evidence that men and women initiate, continue and quit using tobacco for complex and often different reasons (Royce et al., 1997; Kaufman and Nichter, 2001; Payne, 2001). Payne, in reviewing motivation to smoke, found ‘women more often use cigarettes as a buffer against negative feelings, whereas men appear to smoke more habitually, or to increase positive feelings …’ [(Payne, 2001), p. 1075].

Some authorities therefore question the one-size-fits-all health promotion campaigns for women, that ‘conceptualize smoking as a primarily individual, modifiable risk behaviour whose change can best be achieved by bringing graphic information on the health effects of smoking to the attention of individuals, as if they lacked any
awareness of the connection between smoking and lung cancer, heart disease and low birthweight’ [(WHO, 2000b), p. 53]. The same arguments apply equally to men, whose normative roles make them likelier than women to initiate smoking in most of Asia, with consequent negative health effects.

Industry promotion, globalization and gender in Asia

The tobacco industry in the WPR is acutely aware of the social dimension of tobacco use in different populations. It has superbly exploited gender and class for commercial advantage, cleverly altering images and messages over time and across cultures, and has embraced the potential of global communications technologies. In Indonesia, cigarette advertisements frequently portray images of tough, rugged men who enjoy their music loud, their coffee strong and their *kretek* cigarettes (Barraclough, 1999). Depending on local tobacco controls, the industry uses smokers attired in designer clothing (representing financial security), sports and ‘adventure’ sponsorship (suggesting fitness and risk-taking), and images of social or sexual success to appeal to males (Vierola, 1998; Philippines Senate, 1999).

Notions of liberation, glamour and social inclusion are implicit in tobacco promotion targeted at the Asian female market, where laws permit advertising (Philippines Senate, 1999; Kaufman and Nichter, 2001). Westernization as a wealth symbol may explain the presence of light-skinned female smokers in Philippines advertisements. Given conventional Asian ideals of slenderness for women, the appeal of a putative slimming agent (cigarettes) may grow as obesity becomes more prevalent.

Enacting effective tobacco control policies in a globalized world presents a number of opportunities. Shared international understandings of human rights and the health promoting role of governments have culminated in the WHO spearheading efforts to finalize its most ambitious and contentious initiative, the Framework Convention on Tobacco Control (FCTC). Through the exchange of information with great immediacy (via the Internet), non-governmental organizations (NGOs) committed to tobacco control have grown in scope and confidence. Many of these NGOs are gender-blind, while some focus on women [e.g. International Network of Women Against Tobacco (INWAT) and Indonesian Women without Tobacco].

On the other hand, threats to tobacco control also emanate from globalization. As Collishaw and Callard have noted, ‘Much of the increased spread of use [of tobacco] can be traced to the vectors of liberalised trade, more active multinational corporations and increased westernization’ [(Collishaw and Callard, 2001), p. 11]. Even where countries have enacted stringent controls on advertising, globalization ensures at least some degree of unfettered promotion, either through satellite television and the Internet, both virtually uncontrolled, or through imported magazines.

Tobacco control policy and gender

The above discussion makes clear the value of considering smoking ‘as an individual response to a social environment’ rather than ‘a voluntary lifestyle choice’ [(WHO, 1994), p. 27]. Yach et al. have argued that, to be effective, health policies and programmes must appropriately address social norms, roles, cultures and communication styles of target populations (Yach et al., 1998). Gender is perhaps the most consistently significant social influence on smoking, yet compared with social class, it is treated as an overarching covariant, a kind of ‘given’ that needs no elaboration. For example, the World Bank (World Bank, 1999) discusses tobacco trends according to age, region and socio-economic status, but sex differentials are presented without comment and gender is not mentioned.

As Christofides (Christofides, 2001) has noted, most tobacco control policies are gender-blind. The only gender-specific component that tends to be included is the emphasis on persuading pregnant women to quit smoking, primarily driven by foetal health concerns (as confirmed by high relapse rates). Warning labels addressed to pregnant smokers are rarely replicated by those to fathers, whose smoking also endangers their families. Moreover, where generic anti-smoking campaigns and policies are enacted, those (often women) using smokeless forms may not consider themselves at risk.

In popular discourse, ‘gender’ is used as a proxy for ‘women’ (Courtenay, 2000), which has the effect of deflecting attention from the deleterious effects on both sexes of normative social roles, which are known only too well by the tobacco industry. To ignore gender in tobacco policy is a strange oversight, given its connection with tobacco use and its prominence in tobacco promotion.
This article reports on a study undertaken in four WPR countries in 2000–2001. The study aimed to contribute to more effective tobacco control through assessing the extent to which gender is explicitly present in existing or proposed policies. The four countries chosen, Malaysia, the Philippines, Singapore and Vietnam, represent wide variations in population size, culture, religion, ethnicity, urbanization, political system, standard of living, educational levels, gender awareness, health system, tobacco use and tobacco control policy, which enabled us to consider issues within different contexts. Some of these indicators are summarized in Table 2.

**METHODS**

Each country was visited to collect secondary data on tobacco use, production and promotion, and tobacco control policy documentation, and to interview officials charged with policy development. Through semi-structured questionnaires based on a review of the existing literature and our previous research in this area [e.g. (Barraclough, 1999; Morrow and Baraclough, 2001; Morrow et al., 2002)], we asked about the history and process of policy formulation and future planned policy development or change. Within this framework we considered the extent to which gender was a focus for policy or programme formulation, and whether informants saw it as relevant. We also investigated whether both men and women were involved in the development of tobacco control policy. The study plan was approved by The University of Melbourne’s Health Sciences Human Ethics Subcommittee.

We identified our respondents through existing contacts and databases supplied by health officials engaged in tobacco control in Southeast Asia. Respondents were primarily individuals responsible for policy development within health ministries. We also contacted university researchers, NGO activists and, in the Philippines, a legislator. We explained the purpose of the study and assured prospective participants of privacy and confidentiality. In all countries we were able to meet relevant officials and gather necessary documents. All materials and documents collected, with the exception of the Malaysian National Health and Morbidity Surveys and some statistical data from Singapore, are on the public record, although personal opinions from some informants were offered on condition of anonymity.

After these visits, we assessed policy documents and responses made within interviews, particularly in view of prevailing national patterns of tobacco use. Our assessment drew partly on the framework developed by Kabeer, used to categorize policies according to the degree to which gender is explicit (Kabeer, 1994). Christofides (Christofides, 2001) has described the application of this framework for tobacco control policies. At one end of a continuum are gender-blind policies; these refer generically to ‘smokers’, but typically are based upon epidemiological evidence related to men. Gender-neutral policies incorporate sex-disaggregated data on tobacco initiation and cessation; ideally, these are age-linked and reflect trends over time. Such policies divide resources and responsibilities according to the evidence, targeting the different concerns of men and women. Gender-specific policies favour one sex on the grounds of past neglect, produce detailed interventions for them, but continue to cover issues relevant to the other sex. Gender-redistributive policies aim to redress past neglect.

| Table 2: Selected indicators for Malaysia, Singapore, the Philippines and Vietnam |
|---------------------------------|--------|--------|--------|--------|
| Population in millions (1999)  | 21.8   | 3.9    | 74.2   | 77.1   |
| Urban population, % (1999)     | 56.7%  | 100%   | 57.7%  | 19.7%  |
| Life expectancy at birth, years (1999) | 72.2 | 77.4 | 69 | 67.8 |
| Adult (≥15 years of age) literacy rate, % (1999) | 87% | 92.1% | 95% | 93% |
| GDP per capita, PPP a US$ (1999) | $8209 | $20 767 | $3805 | $1860 |
| Main religion(s) | Islam, Buddhism, Chinese folk religion | Buddhism, Chinese folk religion | Catholicism | Buddhism, Catholicism |

disadvantage by allocating resources and power predominantly towards the neglected sex in order to effect radical change in their status. While the framework’s genesis clearly lies in women’s historical disadvantage, we have applied it to consider disadvantage or risk for either sex.

RESULTS

Malaysia

Malaysia is a tobacco-producing nation with an official agency to regulate and promote the tobacco industry. As well as being an important source of taxation revenue, the industry is also identified with the wider public policy of assisting ethnic Malay economic development, particularly in less industrialized states. Several government investment agencies are major shareholders in the local cigarette manufacturing industry, which is dominated by transnational corporations.

As in other Asian countries, tobacco has an important cultural role. Among men of all major ethnic groups, the exchange of cigarettes is often used in social intercourse, and the provision of cigarettes is common at gatherings such as Malay weddings and Chinese funerals. In recent years smoking has increasingly become a religious issue for Muslims with controversy about whether it should be classified as ‘makruh’ (advised against) or ‘haram’ (forbidden). Anecdotal evidence suggests that while it remains acceptable for men, smoking by women is not socially sanctioned in Malaysia, although such disapproval is not universal. As one informant explained, ‘If a woman is successful, then smoking is okay. If she is an ordinary woman, it is not’. According to several informants, the urban ‘professional’ woman no longer sees any stigma attached to smoking.

Information about the prevalence of smoking in Malaysia is based upon the National Health and Morbidity Surveys (NHMS) of 1986/1987 and 1996/1997. Only the second survey was truly national, since the first was restricted to Peninsular Malaysia and excluded the states of Sabah and Sarawak. The 1996/1997 survey of 32,991 Malaysians aged ≥18 years found a marked difference in the mean initiation age between males (19.5 years) and females (24.5 years). Among those who reported ever having smoked, the quit rate was substantially higher among females (29.7%) than among males (17.3%). Women (29.6%) were more likely to smoke ‘rokok daun’ (hand-rolled cigarettes wrapped in a corn leaf). The national prevalence for smoking such cigarettes, common in rural areas, was 14%. The proportion of heavy smokers (>20 sticks daily) was higher among males (33.7%) than among females (17.7%) [(Institut Kesehatan Umum, 1997), pp. 120–124].

Whilst it is not possible to obtain national data on trends over time, some comparisons between the 1986/1987 and 1996/1997 surveys are possible. The prevalence of current smokers (those who reported smoking at the time of the surveys) is set out in Table 3. These findings led the authors of the NHMS 1996/1997 to conclude that:

While the prevalence of smoking in women is reported to be on the rise worldwide, no such trend is observed in Malaysia where the prevalence of 3.5% does not differ much from the 4.0% ... reported 10 years ago. This is probably attributed to the fact that smoking in females is still not an accepted social norm. [(Malaysia, Ministry of Health, n.d.), p. 24]

Despite these results and the above comments by the survey’s authors, all persons interviewed in the course of our study believed, based upon their own observations, that the prevalence of female smoking was increasing in Malaysia. Preliminary results from further national surveys not yet publicly released suggests that the 1996/1997 rate of 3.5% for females has now risen to 4.0% (personal communication, March 2002).

Tobacco control in Malaysia

Under the Control of Tobacco Products Regulations 1993, smoking in public places is restricted. Persons under 18 years of age are prohibited from possessing tobacco and visiting vending machines, and free samples are not permitted. The advertising of tobacco products in the mass media is also restricted.

Table 3: Comparison of the prevalence of current smokers, by sex, in Malaysia, between the 1986/7 and 1996/7 National Health and Morbidity Surveys

<table>
<thead>
<tr>
<th></th>
<th>1986/7 NHMS Survey</th>
<th>1996/7 NHMS Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males</strong></td>
<td>41%</td>
<td>49.2%</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>4%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Source: [(Malaysia, Ministry of Health, n.d.), p. 23].

population ≥15 years of age and restricted to peninsular Malaysia.

population ≥18 years of age throughout Malaysia.
media is illegal. All cigarette packets must carry a general health warning which, unlike those in neighbouring Indonesia and Thailand where there are references to pregnancy and impotence, is not only gender-blind but has remained unchanged since 1978. A major defect in Malaysian controls is that tobacco companies are still able to use their brand names in advertising through the simple expedient of marketing ‘non-tobacco’ services and products (‘brand stretching’). In 2000, British American Tobacco (BAT) and Japan Tobacco International (JTI) were the first and third largest advertisers in all Malaysian mass media, respectively, spending some 160 million Malaysian Ringgit (Audit Bureau of Circulations News, March 2001).

Control over tobacco brand-name advertising in the electronic media falls within the code promulgated by the Ministry of Information. Advertising should not project ‘an excessively aspirational lifestyle’. The code also explicitly affirms a commitment to gender equity, specifically prohibiting the exploitation of ‘sex appeal’, while enjoining advertisers to ‘project the equal participation and contribution of women and men in family life, in the economy, society and the development of the country’ (Malaysia, Ministry of Information, n.d.). Gender is endemic in advertising (brand stretching) in Malaysia. The Cartier Vendome brand has a clear potential to appeal to women due to its associations with the Cartier fashion house and the description of its menthol brand as ‘pearl-tipped’. The Consumers Association of Penang has accused tobacco corporations of ‘seducing women and young girls to attend entertainment events sponsored by specific cigarette brands’ and has singled out JTI for its Salem music concerts featuring ‘slim, attractive young females’ [(Utusan Konsumer, 2001), p. 15]. However, most promotion is targeted at males and is strongly normative of conventional male roles. One of the most prominent vehicles for tobacco promotion is through sponsorship by Dunhill of the national soccer competition. The Marlboro brand has been associated with grand prix racing for both motorbikes and motorcars, and with men’s cowboy clothing. The Pall Mall brand is used both for cigarettes and ‘authentic action gear’ for men. Another brand, Perilly’s, has been used to sponsor action films on national television as well as aerobatics displays. Camel’s brand stretching even extends to a range of men’s underwear. Despite such a focus on the male consumer, a 1999 report on the Malaysian tobacco industry commissioned by BAT Malaysia observed that:

…there are emerging trends of potential growth in new markets amongst more affluent customers. This may potentially include women, a sector of the economy which has until now, not been a large consumer of these products. [(PriceWaterhouseCoopers, 2000), p. 2]

Gender awareness in relation to tobacco use is apparent within the Malaysian Ministry of Health in terms of both males and females. Concern has been expressed about the need to deal with the association of smoking with masculinity and maturity among men in future intervention programmes [(Malaysia, Ministry of Health, n.d.), p. 24]. And the possibility that social change may herald a rise in female smoking prevalence has been conceded by the Ministry of Health:

…modernisation, changes in women’s role in society, social interests and smokers’ perception and experience regarding the maintenance of lower body weight, which has resulted in the higher prevalence of smoking elsewhere, may well change the future pattern of smoking in Malaysian women. [(Malaysia, Ministry of Health, n.d.), p. 24].

Several initiatives aimed at women and smoking have appeared. Pamphlets from the Ministry of Health on the effects of active and passive smoking have identified the wives of smokers as victims. They have also recognized that women, too, can be smokers, by warning of the bad example given by smoking parents to their children (Unit Pelajaran Kesihatan, 1990; Jabatan Kesihatan Negeri Pulau Pinang, n.d.). In 2000, the Ministry of Health’s representative at the 1999 WHO Kobe Conference convened a forum on women and smoking in Penang, and there are plans for a national forum on female smoking. In 2001 the National Heart Foundation coordinated a workshop on women and passive smoking as part of the WHO’s No Tobacco Day. The National Poisons Centre at the Universiti Sains Malaysia, an organization active in tobacco control, features a web page on women and smoking, although the content is based upon general material drawn from international sources (www.prn.usm.my/tobacco.html).

The Malaysian government has permitted tobacco companies to take part in campaigns to discourage youth from smoking. Gender sensitivity has been apparent within a programme designed by the Confederation of Malaysian Tobacco
Manufacturers to discourage under-age smoking. The ‘On Top of the World Without Smoking’ campaign, presented in association with the Ministry of Youth and Sports, featured three girls and two boys as role models in its series of advertisements run in the national press in 2000. Control measures within government schools are clearly influenced by gender, since beating with a rotan is prescribed only for recalcitrant boy smokers.

The Philippines

Tobacco has a strong cultural and economic role in the Philippines. The National Tobacco Administration is a government agency with a statutory mandate to regulate and promote the industry, which in 1994 provided a livelihood to ~2 million Filipinos [(Rebullida and Angluben, 2000); (University of the Philippines, 2000), p. 18]. Smoking rates are among Asia’s highest for both men (54%) and women (12.6%) (Dans et al., n.d.) (see Table 4). Data do not cover chewing, e.g. with areca, popular among women in some rural areas.

Respondents from all subgroups in an ethnographic study among 500 urban dwellers of various ages and social classes agreed concepts of masculinity reinforced male smoking [(University of the Philippines, 2000), p. B-11]. More males had tried quitting than females. One woman wondered why she should ‘divorce’ her ‘favorite Hope’ (a brand of cigarette), her ‘constant companion’, while another refused to quit for fear of weight gain. The association between emotional state and female tobacco use emerged in another ethnographic investigation in the Philippines, which found some women smoked ‘as a substitute for expressing feelings’, particularly anger and unhappiness [(Kaufman and Nichter, 2001), p. 83].

Gender is widely exploited within advertising to appeal to both sexes in the Philippines. Images are varied, and include fitness, risk-taking, glamour, affluence, and social and sexual success. Richard Gomez, a popular handsome actor and athlete, employed as a spokesman for Fortune Tobacco (the country’s largest manufacturer), was also appointed under the previous Estrada administration as a cabinet-level adviser for youth and sports. Industry documents described the Marlboro (national cycling) Tour in the Philippines thus:


A different type of aspiration appeal is reflected in the scenes of white water rafting that promoted the Marlboro Adventure Team: ‘Live on the edge. Make the Team’ (Philippines Senate, 1999).

Tobacco control in the Philippines

Tobacco advertising is big business in the laissez faire Philippines. A Senate White Paper acknowledges the country is ‘tragically lagging when compared with our own neighbors in Southeast Asia’ [(Philippines Senate, 1999), p. 27]. There are virtually no controls on the promotion or sale of tobacco in the Philippines. Minors may freely buy or sell it, and mass media advertising is allowed. Warning labels on cigarette packages are voluntary, and only a few local ordinances control smoking in public places and on public transportation. Current policy lacks ‘teeth’ from the sides of both demand and supply. Critics say that tobacco taxes serve primarily as revenue, rather than as a deterrent: tax rates are substantially lower than recommended by the WHO, and lowest

Table 4: Prevalence of smoking in the Philippines

<table>
<thead>
<tr>
<th>Year of survey</th>
<th>Male 1980(^a)</th>
<th>1989(^b)</th>
<th>1991(^c)</th>
<th>1998(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>54%</td>
</tr>
<tr>
<td>Female</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>12.6%</td>
</tr>
<tr>
<td>Overall</td>
<td>–</td>
<td>46.5%</td>
<td>32.7%</td>
<td>–</td>
</tr>
<tr>
<td>Urban adolescents</td>
<td>2.6% (aged 12 years)</td>
<td>–</td>
<td>28%</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>15.6% (aged 15 years)</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Median age of initiation</td>
<td>–</td>
<td>–</td>
<td>13–15 years in urban areas</td>
<td>–</td>
</tr>
</tbody>
</table>

\(^a\)1980 survey in a Manila school (Dans et al., n.d.).

\(^b\)1989 National Smoking Prevalence Survey (Dans et al., n.d.).

\(^c\)1991 survey in urban public and private schools (Dans et al., n.d.).

\(^d\)Fifth National Nutritional Survey of 1998: two-stage stratified sampling of 4541 individuals aged ≥20 years; cigarette and cigar use (Dans et al., 2000).
on the cheapest cigarettes. Moreover, 15% of excise is returned to Local Government Units in tobacco-growing provinces to ‘encourage them to plant more [tobacco]’ [(Navarra, 2000), p. 4].

In 1988, a National Coalition on Tobacco Control was established, and smoking was banned on domestic flights. In 1992, the Philippines Medical Association started cessation workshops. The biggest public campaign has been ‘Yosi Kadiri’ (slang for ‘cigarettes are disgusting’), aimed at youth, launched in 1994 by the Department of Health (DOH) (Torres et al., 2000). It faltered through insufficient budgetary and legislative support (The DOH ‘Yosi Kadiri’ Campaign, 2000).

One of the country’s most prominent champions of tobacco control is a former Health Secretary, Senator Juan Flavier, who has drafted legislation and vigorously attempted to garner support for its passage through Congress. Senate Bill 1554 and House Bill 1198, introduced in 1999, would regulate labelling, sale and advertising of tobacco products, and ban smoking on public transport and in enclosed spaces. House Bill 4244 would prohibit sale of tobacco to minors, and regulate production and manufacture of tobacco products [(Torres et al., 2000), p. 3]. With predictions of overnight catastrophe for farmers and destitution for those reliant on the public purse, congressmen from tobacco-growing regions successfully opposed these bills (Philippines Senate, 1999; Philippines National Tobacco Administration, 2000; Tan et al., 2000).

In the face of this legislative hiatus, the DOH began efforts on several fronts. It initiated a national response to the WHO Framework Convention in mid-1999, involving roundtable discussions under the auspices of the University of the Philippines (University of the Philippines, 2000). Reports were presented on economic, health, behavioural and policy dimensions. The industry was permitted to table documents, as were social and medical researchers, and open discussion took place on possible courses of action and the potential impact of each. The role of gender in tobacco use and maintenance was singled out as an important influence for both sexes.

A second round of discussions (‘Consensus Building among Government Agencies and Stakeholders on Tobacco and Health’) continued in 2001. The DOH has established a ‘Tobacco Circle’, comprising the University, NGOs and medical associations, to advocate for national legislation. Although activist groups and individuals persevere (with increasing support from the DOH), their efforts have not yet borne fruit in effective tobacco control.

NOTE ADDED IN PROOF

Since this article was written, the Malaysian government has announced that indirect advertising by tobacco companies will be phased out under proposed legislation dealing with tobacco control.

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