



SEATCA
SOUTHEAST ASIA TOBACCO CONTROL ALLIANCE

**The Collaborative Funding Program for
Southeast Asia Tobacco Control Research**

Tobacco Use in Southeast Asia: Key Evidences for Policy Development

**Debra Efroymson
Menchi G. Velasco**

**Financial support from
The Rockefeller Foundation and
Thai Health Promotion Foundation**

Southeast Asia Tobacco Control Alliance (SEATCA)

Under The Collaborative Funding Program for Tobacco Control Research

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Introduction to SEATCA Research on Tobacco

Several SEATCA policy relevant research on economics and epidemiology of tobacco were conducted in the countries of Cambodia, Malaysia, Thailand and Vietnam. And one research each on trade and tobacco was conducted in Indonesia, Myanmar and the Philippines. All these to evidently show the *burdens of tobacco use* in households, in government budget, in non smokers, in youth and even to health professionals who are supposed to be role models. To show burdens of tobacco use that *far outweigh gains*, and thus, tobacco control will be legislated and strictly enforced at country level.

These recent SEATCA research on tobacco covers a wide range of issues, from smoking among monks and women convincing their husbands not to smoke in their homes, to issues of financial burdens of tobacco, taxation, smuggling, and free trade. But the results all point in the same direction: the responsibility of governments to take stronger action to reduce the harm caused by tobacco.

Some of the specific issues raised in the research include:

- Smoking leads to large economic losses for the entire society and imposes big burden on both government and households' budgets.
- Tobacco spending can represent a considerable portion of household expenditures, and a significant sum of money nationwide. Tobacco use contributes significantly to poverty. Tobacco control activities could help to eliminate hunger and to reduce poverty.
- Tax revenues are likely to increase as cigarette taxes are raised. The decrease in quantities consumed would be more than compensated for by an increase in the tax rate, and health costs to treat smoking-related diseases would also decline.
- Raising tobacco taxes represents a win-win-win situation, as it will improve health, contribute to poverty alleviation, and increase government revenue. Low taxes on cigarettes contribute to their affordability, and youth and the poor are most affected by price increases.
- Government revenue from the tobacco industry is not enough to finance the cost of smoking-related diseases. Therefore, the government needs to increase the tobacco tax.
- High rates of smoking among influential groups in society, such as monks and health practitioners, are a matter of concern in tobacco control. Efforts to understand the reasons for the high smoking rates will assist in programs to achieve a reduction.
- Women's tobacco use is currently still much lower than it is for men. This reflects the social, cultural, and traditional beliefs that discourage them from smoking.

However, women are negatively affected by men's tobacco use, in terms of health effects to the smoker and other family members, and diversion of money from basic needs.

- Creating a “smoke-free home” requires a three-pronged approach, i.e. preventing the initiation of tobacco use (in homes where there are no smokers), promoting quit attempts among the young and adults (in homes with smokers), and eliminating non-smokers' exposure to second-hand smoke (in homes with smokers).
- Pervasive tobacco advertising — even where it is prohibited by law—plays a significant role in encouraging people of all ages and both sexes to smoke.
- The retention of messages from cigarette packages is fairly high.
- Finally, smoke-free places contribute to a sense that tobacco smoking is unacceptable.

Policymakers, researchers, health professionals, health advocates and others can come together to decide how to address the tobacco epidemic. Through such collaborative efforts, policy relevant research evidences in hand, and through a strong commitment to the measures that have been proven effective in reducing tobacco use, Southeast Asia can lead the world in combating the tobacco epidemic and increasing the health, wealth, and well-being of its citizens.

Tobacco and Poverty: Lessons from Cambodia and Vietnam¹

Highlights:

- 1) Analysis of the financial burdens of smoking on households in Cambodia and Vietnam
- 2) Tobacco use imposes relatively high burdens in both Cambodia and Vietnam, and contributes to inequality.
- 3) The poor tend to spend a larger portion of their expenditures on tobacco, they are more affected by tobacco use than the rich. The money wasted on tobacco makes them even poorer than they seem, and contributes to widening the gap between the rich and poor.
- 4) Smokers in Vietnam burn the amount of tobacco equivalent to 6,000 billion Vietnamese dong (VND) or US\$416.7 million each year. This sum of money can buy 1.6 million tons of rice, which is sufficient to feed 10.6 million people a year.
- 5) Smokers in Cambodia spend 6,248 billion Riels or US\$69.44 million annually, this equivalent to the price of 274,304 tons of high quality rice, 1,388,382 bicycles or 27,778 large wooden houses in the provinces. This wasted amount could also easily fill a deficit in the national budget and be a good source of financing for many of the country's reconstruction and social projects.

Recommendations from the research are:

- ◇ Efforts are needed to reduce tobacco consumption, for poverty and equity as well as improved health. To achieve significant reductions in tobacco use, particularly among the poor, an increase in tobacco taxes is needed; in addition, all promotion of tobacco products should be strictly banned.
- ◇ Tobacco control should be incorporated into poverty alleviation strategies; the association between tobacco use and poverty should be broadly publicized.
- ◇ It may be useful to raise awareness of the risk of tobacco use on family economic wellbeing. One efficient mechanism is through pictorial messages on cigarette packs, which could include economic as well as health messages.

¹ This fact sheet draws on the following research: 1) Phauk Samrech, LIDEE Khmer (League of Khmer Students from Abroad), Cambodia. *"Tobacco, Poverty and Socio-economic Status in Cambodia"*; 2) Seng Souern and Tith Vong, National Institute of Statistics (NIS), Cambodia. *"The Analysis of Smoking Behavior Survey in Cambodia, 2004"*; 3) Hoang Van Kinh, Nguyen Thac Minh, Nguyen Thi Thu Hien (Trade University), Trade University, Nguyen Tuan Lam (WHO), and Vu Thi Bich Ngoc (Institute of Finance), Vietnam. *"Financial Burden of Smoking on Households in Vietnam."*

About 36% of the Cambodian population lives below the poverty line²; in Vietnam, an estimated 18.1% of all households are poor³. Meanwhile, smoking prevalence in Cambodia in 1999 was among the highest in the region. While the rich spend larger absolute amounts on tobacco, the *proportion* of income that the poor spend on tobacco is much higher than rich households.

In Cambodia, households without smokers devoted a larger share of household expenditures to basic needs than did households with smokers. Medical care spending, however, was lower for non-smoking households than for smoking households, suggesting that smoking households experienced more health problems.

In every income group in Cambodia, smoking households lag behind non-smoking ones in term of consumption on clothing, education, housing and miscellaneous expenses. If households did not spend their income on tobacco, their education and especially housing expenditures could be significantly increased. In rural areas, food expenditure would also benefit from saving on tobacco consumption. Expenditure on tobacco in Cambodia ranged between 2.4% and 8.7% of total household expenditure.

Tobacco spending in Cambodia represents from 4.1% to 6.2% of food expenditure. The very poor in Phnom Penh spent up to nearly 10% of their food expenditure on tobacco. The money needed to buy just one pack of cigarettes could have purchased 3,244-3,800 Kcal or more of food energy from a variety of nutritious foods.

The annual spending on tobacco by Cambodian smoking households, at US\$69.44 million, would easily fill a deficit in the national budget and finance many of the country's reconstruction and social projects. The amount spent annually in Cambodia on tobacco products is equivalent to the price of 274,304 tons of high quality-rice, 1,388,382 bicycles, or to 27,778 large wooden houses in the provinces.

Tobacco spending imposes a relatively heavy burden on poor households in Vietnam as well. While the richer quintile spent an absolutely larger sum, as a percentage of total expenditures, tobacco spending was higher among poor households (5.29%) than among rich ones (3.60%). Total cigarette expenditure in Vietnam in 1998 was calculated, in different methods, as 5,834, 6,564, or 8,213 billion VND (US\$416.7, US\$494, or US\$537 million), equivalent to 1.6-1.8 million tons of rice, which is sufficient to feed more than 10.6 million people per year. The contribution to the state budget by the tobacco industry accounts for only one-third of the total tobacco spending by Vietnamese smokers.

In both Vietnam and Cambodia, tobacco use contributes to inequality. Since the poor

² Royal Government of Cambodia, Second Five Year Socio-Economic Development Plan 2001-2005, 2001. Page 94, Subsection 2.2: Poverty.

³ General Statistics Office of Vietnam, (http://www.gso.gov.vn/default_en.aspx?tabid=508&ItemID=2961).

are more likely to use tobacco than the rich, and spend a larger portion of their expenditures on tobacco, they are more affected by tobacco use than the rich. The money wasted on tobacco contributes to widening the gap between rich and poor.

In Vietnam, tobacco spending causes many households to fall below the poverty line. Tobacco spending does not contribute to improving household living standards, but rather reduces household disposable income. After separating tobacco spending from total household expenditures, 1.5% of the population whose living standards used to be above the food poverty line fall into the category of food poor households. If the amount spent on tobacco was instead used to purchase food, then 11.2% of food poor people would be able to emerge from poverty.

Tobacco spending thus contributes to poverty in two ways: tobacco expenditure is welfare-reducing, and at the same time reduces welfare-enhancing expenditures for education, health or nutrition. Tobacco spending also contributes to widening the gap between the rich and the poor, because the poor have higher rates of smoking and spend a higher proportion of their income on tobacco.

Demand Analysis and Tobacco Taxes in Vietnam and Malaysia⁴

Highlights:

- 1) Imposing a uniform high tax of 65% on tobacco in Vietnam will result in a rise of 16 – 32% in prices of low-priced cigarettes, a decrease of about 27% in tobacco consumption, and an increase of more than 11% in the tobacco tax revenue of the government. So imposing a uniform high tax on tobacco not only benefits the poor, but also does not hurt the government budget.
- 2) In Malaysia, a 10% increase in price would result in a 3.8% reduction in cigarette consumption over the long-run if annual tobacco tax increases were made. An increase in cigarette excise tax from the current level of RM 1.60 (US\$0.42) per pack to RM 2.00 (US\$0.53) per pack would increase the average cigarette price by 5.9% and reduce the consumption by 2.25%. This reduced consumption would translate to between 174 and 179 fewer tobacco related deaths per year among the adult population. At the same time, the government would collect additional RM 437 million (US\$116 million) in cigarette excise taxes, or almost 23% more compared to what it will otherwise collect.

Recommendations from the research are:

- ◇ In Vietnam, there's a need to strengthen the national tobacco control strategy including government measures and public education programs for the poor households.
- ◇ Tobacco control programs should be expanded to cover more extensively the southern regions of Vietnam – its rural and isolated areas, where the highest smoking rate is more prevalent, and at the same time addressing the other regions of the country with relatively lower smoking rates.
- ◇ Annual cigarette tax increase in Malaysia that will result in a win-win situation: an improved public health and an increase in government revenues.
- ◇ Additional government revenues from proposed annual tax increase in Malaysia can be used to help smokers in their cessation efforts and to support tobacco farmers to switch to alternative crops

Imposing taxes on tobacco is one of the most efficient and effective measures that can be implemented to reduce tobacco use.⁵ Simply raising the tax on tobacco

⁴ This fact sheet draws on the following research: 1) Hoang Van Kinh, Hana Ross, David Levy, Nguyen Thac Minh and Vu Thi Bich Ngoc, Vietnam. "The Health and Economic Impacts of a Uniform High Tobacco Tax in Vietnam"; and 2) Al-Sadat, Nabilla A.M., University of Malaya, Malaysia, Hana Ross, Zariah Zain, Haniza, MA, Mohammed Syed Al-Junid, Mohamed Izham Mohamed Ibrahim. "Demand Analysis of Tobacco Consumption in Malaysia."

⁵ Chaloupka, FJ, Hu, T, Warner, KE, Jacobs, R, and Yurekli, A. "The Taxation of Tobacco Products," in P. Jha and F. Chaloupka (eds.), Tobacco control in developing countries 2000, pp. 237-272.

products achieves a significant decline in use, while also increasing government revenues. In Vietnam, smokers of low-priced cigarettes accounted for a large share of total cigarette consumption. Most consumers of low-priced cigarettes were poor. They spent a larger proportion of their household disposable income on cigarettes than richer smokers; consequently, they bore the largest relative economic burden from tobacco use.

Research in Vietnam showed that imposing a uniform tax of 65% on tobacco would result in an increase of 16-32% in the price of low-priced cigarettes, a decrease of about 27% in tobacco consumption, and an increase of more than 11% in the government's tobacco tax revenue. That is, imposing a uniformly high tax on tobacco would not only benefit the poor, it would also increase government income.⁶

The Malaysian study showed that a 10% increase in price would result in a 3.8% reduction in cigarette consumption over the long-run if annual tobacco tax increases were made. A simulation model revealed that an increase in cigarette excise tax from the current level of RM 1.60 (US\$0.42) per pack to RM 2.00 (US\$0.53) per pack in 2006 would increase the average cigarette price by 5.9% and reduce the consumption in that year by 2.25%. This reduced consumption would translate to between 174 and 179 fewer tobacco related deaths per year among the adult population. At the same time, the government would collect additional RM 437 million (US\$116 million) in cigarette excise taxes, or almost 23% more compared to what it will otherwise collect in 2005. In both cases, therefore, demand analysis showed that taxation is an effective method of reducing consumption while increasing government revenue.

The Malaysian researchers further estimated that the income elasticity of cigarette demand in Malaysia was +1.0, meaning that a 10% increase in income would lead to a 10% increase in cigarette demand. Therefore, it can be expected that the tobacco epidemic in Malaysia will spread with income growth if no stringent tobacco control measures are taken.

The results of the Vietnamese research indicate that tax revenues are likely to increase as taxes are raised for domestic unfiltered and domestic filtered cigarettes to the level of the existing rate for foreign filtered cigarettes. The decrease in quantities consumed would be more than compensated for by an increase in the tax rate. That is, health and economic concerns can be met with one action: consumption declines but revenues increase.

Cigarette tax increases in Malaysia would result in a win-win situation: improved public health and an increase in government resources. Ideally, these newly obtained resources would be used to help smokers to quit since they came from those who have the most difficulty giving up their smoking habit. They could also be used to support tobacco farmers to switch to alternative crops.

⁶ Since conducting this research, the tax structure in Vietnam changed to a uniform tax of 55%.

While this fact sheet focuses on just two countries – Vietnam and Malaysia - the information presented is applicable elsewhere as well. Keeping tobacco taxes low - whether overall or only on the types of tobacco most used by the poorest - in order to avoid harming the poor economically could be seen as an odd form of subsidy, one which encourages a behavior that governments are otherwise trying to discourage. Since the poor are the least able to afford spending money on tobacco, there is a great incentive to discourage their tobacco use. Raising tobacco taxes represents a win-win-win situation, as it will improve health, contribute to poverty alleviation, and increase government revenue.

Two key arguments may be put forward against increasing tobacco taxes: that they will contribute to smuggling, and that they will harm those most addicted among the poor. The first argument is easily countered by the information indicating that taxation levels are not responsible for smuggling, and that other actions (increasing penalties, using tax paid markings, and increasing police enforcement) are far more effective at reducing smuggling than reducing taxes. As for the second argument, since the poor overall will reduce their tobacco use and thus their expenditures on tobacco if prices go up, it makes no sense to keep prices low on a deadly product, thereby encouraging its use. Finally, concerns over possible negative consequences to highly addicted users can be assuaged in more helpful ways, such as by spending some of the increased taxation revenues on cessation assistance to the poor or other programs to improve their wellbeing, rather than to subsidize their addiction.

ASEAN Free Trade Area and Tobacco: A Regional Summary⁷

Important conclusions and policy implications:

- ◇ The CEPT scheme relatively favors imported cigarettes. Future smoking control measures will face tougher resistance from foreign tobacco producers.
- ◇ An increase in excise tax is the best way to protect ASEAN smokers. Higher excise taxes will reduce the decrease in prices, the increase in demand, and the increase in health costs. Governments should increase cigarette excise taxes at a higher rate than the fall in tariffs. Otherwise, the main beneficiary of AFTA will be foreign cigarette producers.
- ◇ Decreases in the relative price of cigarettes over time encourage smoking; governments should thus regularly increase excise tax rates. Excise tax indexation with inflation can be an effective instrument to ensure rising actual cost of cigarettes and continuing reduction in demand.
- ◇ Excluding tobacco from the AFTA' CEPT scheme is the best solution for all ASEAN countries. The inclusion of tobacco in the AFTA's CEPT scheme is an important lesson for all countries.
- ◇ In Indonesia, loyalty to domestic brands protects local smokers, but the Indonesian cigarette market is a target for foreign cigarette producers. If price reduction is large enough, Indonesians will switch to imported cigarettes.
- ◇ Price control will not generate a change in cigarette demand but may have adverse effects since the government's foregone tax revenue will go to cigarette producers and importers, especially in Thailand. Producers and importers may use additional profit for political lobbying, non-price promotion, and other activities that offset smoking control measures.

Arguments in favor of free trade are not applicable to tobacco. Lower cigarette prices that follow the establishment of free trade areas would allow more cigarette consumption; consequently, the health cost of smoking and the number of tobacco related deaths would rise, while tobacco tax revenue would likely be reduced.

Under the ASEAN Free Trade Area (AFTA), member countries agreed to eliminate trade barriers on most goods and services among themselves, including tobacco and tobacco products, while continuing to apply barriers against the rest of the world. Taking into account the income and price impacts, the overall impact of trade

⁷ This fact sheet draws on the following research: 1) Sarntisart, Isra, Centre for Development Policy Studies (CDePS), Faculty of Economics, Chulalongkorn University, Thailand. "AFTA and Tobacco: A Regional Summary"; 2) Saad, Ilyas, Indonesia. "Likely Impacts of AFTA on Cigarette Consumption: Indonesian Case"; 3) Austria, Myrna S., De La Salle University, Philippines. "The Economic and Health Impact of Trade Liberalization in AFTA: the Case of the Philippines," 2006; 4) San San Aye, Ministry of Health, Myanmar, "Impacts of Tobacco to Health and the Economy in Relation to AFTA: Myanmar," 2006; and 5) Sarntisart, Isra, "AFTA and Tobacco in Thailand," 2005.

liberalization on cigarette demand is largest in low-income countries.

Tobacco and cigarette production plays a very small role in the Thai economy. In 2003, the Thai population was slightly over 62 million and smoking prevalence was about 25%. Thailand has been a net importer of tobacco. The share of cigarette imports from AFTA member countries, very low in the pre-2000 period, has continuously increased and by 2003 represented nearly 81% of tobacco imports.

The impact of AFTA on Indonesian smokers is limited because of the dominance of clove cigarettes ("kretek"). Clove cigarettes represent nearly 90% of the Indonesian cigarette market. However, a simulation using a 10% decrease in cigarette prices shows that demand will increase by 6.1%. With total smokers already more than 132 million, smoking attributable deaths will be striking. Long-term health costs will be as much as US\$21 billion, much larger than other ASEAN countries.

With the openness of Myanmar foreign trade, cheaper foreign cigarettes have penetrated the Myanmar market and smoking prevalence rates are now slightly over 30%. The implementation of AFTA has further reduced the domestic prices of imported cigarettes, meaning a huge decline in real tobacco prices in recent decades. In 2005, an estimate showed that there would be a nearly 2% increase in cigarette demand following the implementation of AFTA, rising to 3.9% in 2008. Estimates of the increases in deaths are 976 in 2025, 945 in 2026, 949 in 2027, and 922 in 2028.

The Philippines analysis shows two alternative possibilities. First, the tariff rate reduction from 11.67% to 5% in 2003 will decrease cigarette prices by 5.45%. Consequently, demand will increase by 2.14% or 4.62 million packs. Second, the government may decide to increase the excise tax, which will partly offset the impact of AFTA. If the tariff rate is reduced to 5%, but the excise tax is increased, there would be only a 4.10% decrease in price, and a 1.61% increase in demand (or less than 4 million packs).

In Thailand, analysis shows that a decrease in tariff rates on tobacco would reduce the tax burden on importers and the local producer (TTM), and adversely affect government revenue. In the case of imports, total government revenue would be reduced by approximately 11% of the pre-AFTA value or nearly 1,200 million Baht, while cigarette importers would earn 12% more profit. For TTM cigarettes, total tobacco tax revenue would decrease by over 7 million Baht. If the government decided to lower the retail prices of both types of cigarettes, demand would increase and imported cigarettes would gain more market share. Consequently, the government tobacco revenue would decrease by about 1,034 million baht (US\$25.85 million). A very optimistic estimate shows that the enforcement of AFTA in 2003 would cost the Thai economy around 82 million baht (more than US\$2 million) in increased deaths.

Health Costs of Tobacco⁸

Highlights:

- 1) In Vietnam, the total cost or economic loss attributable to COPD, Ischemic Heart Disease, and Lung Cancer in 2005 was 1,162 billion VND (US\$77.50 million)
- 2) Vietnam spent about 1,161,829 million VND (US\$77 million) on hospital treatment of three smoking-related diseases (COPD, Ischemic Heart Disease, and Lung Cancer). This represented about 4.3% of total health care expenditure and about 0.22% of GDP in 2005.
- 3) In Thailand, the total cost or economic loss attributable to COPD and Lung Cancer in 2003 was approximately 20.51 billion baht (US\$514 million), which represents 0.35 % of GDP for that year. This also accounted for 8.36% of total 2003 health care expenditure.
- 4) The total health care cost for top 3 diseases (COPD, Coronary Heart Disease and Lung Cancer) caused by smoking consisted of total direct cost and total indirect cost is equal to Baht 145,028.80/person/year (US\$3,625.72) in Thailand.

Recommendations from the research are:

- ◇ Establish a permanent mechanism to track tobacco-related health care costs.
- ◇ Policy-makers could consider a national health campaign to coincide with a sharp rise in the rates of tax on cigarettes and other tobacco products.
- ◇ Educate, encourage, and stimulate government, law enforcers, and the population to be aware of tobacco consumption problems and the need to enforce existing laws and policies. Strong enforcement should be followed by strong punishment of violators.

Tobacco use is one of the most important contributors to premature deaths and avoidable morbidity in low and high income countries. The economic consequences of tobacco use include higher health care costs, indirect cost like transportation to and from health care facilities, and productivity losses due to morbidity and premature mortality.⁹ Public costs of smoking represent a burden for the state budget, while private costs of smoking impose a burden on households and reduce their spending power.

In Thailand, the expenditure for one COPD patient from smoking/year in 2003 was

⁸ This fact sheet draws on the following research: 1) Vu Xuan Phu, Dang Vu Trung, Hanoi School of Public Health (HSPH), Vietnam), Hana Ross, International Tobacco Evidence Network (ITEN), USA, "Cost of Hospitalization for Three Smoking Related Diseases, Vietnam"; and 2) Sathirakorn Pongpanich, Ph.D., College of Public Health, Chulalongkorn University, Thailand. "A Comparative Analysis between Present and Future Tobacco Related Health Care Costs in Thailand."

⁹ World Bank, 1999. Op cit.

approximately baht 10,740.81 (US\$268). Approximately 55% of COPD patients acquire COPD from smoking. The total cost or economic loss of COPD in 2003 was approximately 13.96 billion baht (US\$350 million), which represents 0.24 % of GDP for that year. In addition, it also accounted for 5.7% of total 2003 health care expenditure in Thailand.¹⁰

In 1990 figures, the total cost or expenditure of patients being treated for CHD was approximately 20,165 million baht (US\$504 million), which represents 0.33% of GDP for that year and 8.27% of total 2003 health care expenditure.¹¹ The total cost or economic loss attributable to lung cancer in 2003 was approximately 6.547 billion baht (over US\$164 million), which represents 0.11% of GDP and 2.66% of total 2003 health care expenditure.

The tobacco industry contributes to government revenue in two ways. First, the Thailand Tobacco Monopoly, the only cigarette producer, generally contributes around 3.5%-4.5% of government revenue. In 2003, this was slightly more than baht 38 billion. The second part is tax revenue from imported tobacco and tobacco products. In 2003, the total government revenue from cigarettes was around baht 43 billion - more than 5% of total government revenue. But from an economic perspective, tobacco taxes represent only a redistribution of existing resources. Therefore, taxes collected on tobacco could be collected on alternative products without reducing people's spending power.

The Vietnam study confirms that smoking leads to large economic losses for the entire society and imposes a big burden on both government and household budgets. The majority of patients in this group were in their late 50s, primarily male (72%) and current or former smokers (66%). The costs associated with hospitalization of these patients were large. On average, a patient stayed in a hospital 26 days; average costs for one in-patient episode were 31,399,800 VND, 12,358,200 VND, and 3,744,400 VND (US\$2,093, US\$824, and US\$250) for ischemic disease, lung cancer and COPD, respectively.

Smoking increases the likelihood of getting a smoking-related disease and of incurring higher social costs when hospitalized. A smoker was 81% more likely than a non-smoker to incur higher social costs of hospitalization. Those social costs of smoking were shared by government, insurance companies and households.

The macro level analysis revealed that about 72.5% of social costs related to the treatment of the three diagnoses in Vietnam could be attributed to smoking. Vietnam spends about 1,161,829 million VND (US\$77 million) annually on hospital treatment of three smoking-related diseases. This represented about 4.3% of total health care expenditure and about 0.22% of GDP in 2005.

¹⁰ National Health Account of Thailand 2003

¹¹ National Health Account of Thailand 2003.

Smoking-related COPD creates the greatest financial burden, costing society about 1,033,541 million VND (US\$69 million) per year, followed by smoking-related lung cancer (78,143 million VND or US\$5.2 million) and smoking related ischemic disease (50,145 million VND or US\$3.3 million). These costs fall most heavily on the government, which bears 51% of smoking related costs. Families and insurance sector bear about 34% and 15% of these costs, respectively. Despite the alarming results with respect to the economic burden of smoking, the researchers conclude that these costs are actually severely underestimated.

The Vietnamese study demonstrates that tobacco smoking has an enormous economic impact on Vietnamese society, imposing costs of at least 1,162 billion VND (US\$77.5 million) annually. The data indicate that Vietnam might be in the early stages of the tobacco epidemic, meaning that these costs will rise rapidly with economic growth and increased smoking rates among women. However, this threat can be avoided by adopting strong tobacco control measures that will not only reduce suffering caused by smoke-related diseases, but also lead to better economic performance.

Similarly, the Thai study demonstrated that government revenue from the tobacco industry is not enough to finance the cost of smoking-related disease (SRD). Therefore, the government needs to increase the tobacco tax and if it is still not enough, it may need to increase revenue by taxing other products to supplement tobacco revenue to pay for these differences.

Socio-demographic and Psychological Trends of Youth Smoking¹²

Highlights:

- 1) Factors, such as, age, sex, family problems, performance in school and smoking status among friends, teachers, parents and family members influenced students' smoking behavior and initiation.
- 2) Most of current young smokers were able to conveniently purchase cigarettes at stores, although by law, it is prohibited.
- 3) More female students in urban areas smoke than in rural areas.
- 4) Parental control and high cost of cigarettes prevent youths from smoking.
- 5) In Vietnam, most male students know about the dangers of smoking but is invalidated because of teachers seen smoking in the university.
- 6) In Thailand, 1/3 of the current young smokers added narcotic substances, such as, cannabis to their cigarettes.
- 7) In Malaysia, exposure to direct and indirect advertising is high and advertising messages appeal to the emotions of the young.

Recommendations from the research are:

- ◇ Design multi-year media campaigns using a strong social marketing approach.
- ◇ Develop cessation programs that target teens before addiction begins.
- ◇ Implement and enforce comprehensive advertising bans.
- ◇ Expand and enforce smoke free areas.
- ◇ Strongly enforce no tobacco sales to minors.
- ◇ Increase cigarette prices.
- ◇ Implement school and community-based programs that adopt a social influential model, which also targets familial environments.
- ◇ The prohibition of smoking in schools should be more seriously implemented at local and national level to make it effective.
- ◇ Conduct program evaluation of preventive and control measures.

Smoking rates are rising among young people in Thailand, Vietnam, and Malaysia. A Thai study of secondary and vocational school children aged 12 and 19 years found a smoking prevalence of 6.8% in 2003. Smoking rates among 15 to 19 year olds

¹² This fact sheet draws on the following research: 1) Vichit-Vadakan, Nuntavarn, Aekplakorn, W, Tanyanont, W, and Poomkachar, H., Chulalongkorn University, Thailand. "Prevalence of Smoking and Related Factors in School Students", Thailand 2003; 2) Vu Pham Nguyen Thanh et al., Institute of Sociology, Vietnam. "Perceptions of Tobacco and Smoking among Male Youth in Vietnam". 2003; 3) Foong, Kin, and Khor, Yoke Lim, Universiti Sains Malaysia. *Tobacco Advertising and Smoking amongst Adolescents: A Qualitative Study in Malaysia*. 2003.

doubled between 1999 (6.35%) and 2003 (15.6%). Substantial increases were found among both sexes.

A study of 1,200 Vietnamese male students aged 16 to 23 years old in Hanoi City and Phu Ly town found that 43.2% of young people had experimented with smoking. One in three males smoked at least one cigarette daily. Most young people initiated smoking while still in their teens (age 13-18). Most Thai and Vietnamese students smoked less than 10 cigarettes daily and preferred local brands. On average, the smokers spent about US\$0.50 per day.

The reasons given for smoking among young people in Thailand, Vietnam and Malaysia were very similar. Peer influence and curiosity were the most frequently reported reasons for smoking uptake. Smoking initiation often occurred while socializing with friends. Imitating adults such as parents, older siblings, and teachers were often cited.

Smoking was commonly perceived by the students as a means of relaxation, to enhance one's image, and to control body weight. Male youth in Vietnam said they smoked when bored, during social gatherings, and when stressed. Female students were more likely to smoke when they experienced family problems and were influenced by male friends. Thai adolescent smokers felt that smoking enhanced maturity, masculinity, and made teens look more attractive and cool.

Thai adolescents with family problems, poor academic performance, poor relationship with parents, who were school violators, and/or who had smoking adults in their environment were more likely to smoke than youth who did not face any of these issues. Knowledge about health effects bore little relationship to smoking by young people.

Most adolescent smokers in each of the three countries purchased their own cigarettes and were never refused by sellers. Cigarettes were sold as loose sticks in most places.

Generally, knowledge about the harmful effects of smoking was high. More than 80% of the Thai, Vietnamese, and Malaysian youth knew that smoking was harmful to the health of smokers and non-smokers, and that smoking was addictive.

Exposure to both direct and indirect tobacco advertising was high. In Thailand, 70% of adolescents reported having seen cigarette advertising in stores, while 25% had noticed such advertising in newspapers and/or other printed media. Almost all Vietnamese students had seen characters smoking in movies. Direct cigarette promotion was also widespread in all three countries.

Factors in the broader social and physical environment such as accessibility to tobacco products as well as advertising and promotion of such products were also likely to have contributed to the pervasiveness of youth smoking.

The tobacco industry has repeatedly denied that they target youth through intensive

marketing and advertising. However, evidence revealed that the industry has very successfully created a positive image of tobacco use among adolescents. Messages conveyed by advertising images appealed to this young population. Adolescents in Malaysia and Thailand believed that smokers are more mature, stylistic, attractive to the opposite sex, and macho. This suggests that cigarette advertising has most likely increased the perceived social value of smoking among young people and was likely to have influenced the rate of adolescent smoking.

Easy access and widespread availability of cigarettes significantly contributed to the high rate of smoking among adolescents. Of particular concern is the finding that tobacco use can potentially lead to other risk behaviors such as use of illicit substances, suggesting that tobacco might be a gateway drug. One-third of current adolescent smokers in the Thai study have experimented with narcotic substances.

Adults are role models that children emulate; thus, cessation programs targeting adult smokers would indirectly influence the likelihood of smoking among children and adolescents through reduction in negative role models.

Measures that denormalize smoking are important to enhance negative perceptions about smoking, that is, that smoking is not widespread and that it is not socially acceptable to smoke.

By changing youth's attitudes and beliefs toward tobacco, stronger tobacco control policies are likely to reduce cigarette consumption by youths, which in turn is likely to translate into a decrease in the future burden of tobacco nationally and globally.

Knowledge, Attitudes, and Practice: Tobacco Use among Health Professionals, Medical Students and Monks¹³

Highlights:

- 1) Quit rate in health professionals and medical students in Vietnam is low.
- 2) 45% of male medical students and 35.6% of male health professionals (mostly doctors and dentists) smoke. Female medical students and female health professionals account for 2% smokers.
- 3) 99% of health professionals and 85% of medical students who participated in the study, were fully aware of the hazards and dangers of smoking.
- 4) Exposure to secondhand smoking of family members and friends is smoking predictor for medical students
- 5) The national smoking prevalence in monks is 37.2%, although lower than previous studies, is still very high.
- 6) 50% of smoking monks are from East and South of Thailand.
- 7) 1/3 of the monks surveyed had knowledge of smoking ban in temples.
- 8) Worshippers always include cigarettes as part of their offerings to the monks.
- 9) Quit rate is high for former smokers after entering the monkhood.

Recommendations to reduce smoking in health professionals:

- ◇ Need for strict tobacco control regulations or policies in all the hospitals.
- ◇ Improve and promote health professionals as role models non smokers to their patients and the public.

Recommendations to reduce smoking in medical students:

- ◇ More attention should be given to early smoking prevention, when medical students start studying at the university.
- ◇ National tobacco control policies should include official and strong regulations on non smoking areas and penalties for violations. These should be strictly enforced in the medical universities.
- ◇ Promotion of “*medical students as role models for non-smoking*” and the health hazards of smoking. Medical students should be involved when they entered

¹³ This fact sheet draws on the following research: 1) Dao Ngoc Phong, Nguyen Van Huy, Dao Thi Minh An, Hanoi School of Public Health, Vietnam. “*Tobacco Use among Vietnamese Medical Students and Health Professionals*”. 2003; 2) Charoenca, Naowarut, Kungskulniti,, N, Kengganpanich, T, Kusolwisitkul, W, Pichainarong, N, Kerdmongkol, P, Silapasuwan, P., Mahidol University, Thailand. “*Smoking prevalence among Monks in Thailand,*” 2003.

their first year in the universities.

Recommendations to reduce smoking among monks:

- ◇ Involve monks in developing tobacco control programs.
- ◇ Continue education to raise awareness of smoking laws in religious places including prohibiting worshippers offering cigarettes to monks.
- ◇ Encourage monks to take an increasing role in tobacco control advocacy.
- ◇ Provide cessation services for monks and the public, starting in selected wats (temples).
- ◇ Incorporate tobacco control into Buddhist educational programs.

Since health professionals and monks are respected members of society whom people are likely to emulate, their smoking behavior is a matter of concern, yet research has found high rates of smoking and limited success in quitting among Vietnamese health professionals and Thai monks.

The rate of smoking among male medical students is 45% and in male health care providers it is 36%. While smoking among males is common in Vietnam, smoking among female medical students and health care providers (2%) is a new phenomenon.

Medical students in Vietnam estimated that they spent an average of US\$ 3.60 per month on cigarettes, about 10% of their total cost of living. Three-fourths of the medical students surveyed had tried to quit smoking at least once. Approximately two-thirds of them had intentions to quit smoking within the upcoming 12 months. Health professionals did not show much success with quitting. About 70% of them had tried (unsuccessfully) to quit for one week. Only 25% of the health care providers expressed an intention to quit smoking within the next 6 months. Only a very small percentage (6%) had successfully quit.

More than 85% of the medical students participating in the study expressed awareness that smoking was harmful to the health of smokers. Belief that secondhand smoke was harmful to other people's health was even higher (91%). Health care providers (99%) also had a very high awareness of the hazards of both active and passive smoking. Four-fifths of the health care providers believed that patients' ability to quit would increase if they were advised by their health care providers to do so. The reverse would happen if health care providers were smokers.

Medical students who did not believe in the harms of smoking were 9 times more likely to smoke. Those with a positive attitude towards smoking were 4 times more likely to smoke. Knowledge about the health hazards of smoking, on the contrary, did not deter smoking. Students who were exposed to family members who smoked daily were 5 times more likely to smoke. Those exposed to non-family members who smoked daily were about twice as likely to smoke. Television was the most common source of anti-tobacco information.

Most health providers were interested in being trained in tobacco control

methodologies. They recommended a comprehensive approach that would include health education, legislative policy and a law banning smoking in all health facilities, and training in anti-tobacco measures.

Knowledge of the health risks of tobacco use is not sufficient to change attitudes and beliefs that are crucial elements for behavioral change, even among health care professionals. In Vietnam, there is an urgent need to establish a national policy of smoke-free health facilities, which would deter health professionals from smoking and encourage quitting. Assistance in cessation could also prove useful.

In Thailand, research found that 25% of monks were current smokers, and another 19% were ex-smokers; 90% of current smokers initiated smoking prior to entering monkhood; and 75% of monks who smoked had initiated smoking at the age of 17. Reasons for smoking included to reduce stress, experimentation, to relieve boredom, social reasons, and to look cool. Smoking was found to be associated with older age, non-novice status, longer period of monkhood, temple residence, and lower education.

One-third of the monks knew about the law banning smoking in religious places in Thailand. Experimenters and never-smokers were more knowledgeable about these regulations than were current and ex-smokers. Approximately 90% of the monks were aware that secondhand smoke causes diseases and that quitting smoking would reduce health risks, while 60% knew that smoking posed a major morbidity and mortality risk for monks. Current smokers had significantly lower knowledge of health risks related to smoking. 82% felt that people should be told not to offer cigarettes to monks. 57% felt that monks should refuse cigarettes offered to them and that non-smoking monks had a better public image and acceptance than monks who smoked. 80% would support a campaign to educate the public against offering cigarettes to monks. Three-quarters of current smokers said that they wanted to quit. Half had attempted to quit within the previous 12-month period.

Lack of will to quit, poor knowledge of cessation methods, and absence of advice were the main reasons given for failure to quit. Smoking within the temples was common. Buddhist monks play an important role in setting normative activity patterns among Thai males and community values for healthy living. Thus, adopting a no smoking policy in wats and among monks generally is vital to efforts to reduce male smoking in the general population. A policy of non-smoking wats would facilitate novices to quit smoking and further education within the wats should help to reinforce the health, social, and religious benefits of being smoke-free.

Analysis of Smoking Behavior in Cambodia¹⁴

Highlights:

- 1) The overall prevalence age 20 + for males and females in Cambodia is 53.9 percent and 6.0 percent, respectively.
- 2) The overall prevalence age 20 + for males and females in urban is 39.8 percent and 5.2 percent, respectively.
- 3) The overall prevalence age 20 + for males and females in rural is 56.2 percent and 6.1 percent, respectively.
- 4) The average age of initiation is 20 years of age. There are differences in mean age of initiation according to geographic region, educational level, etc.
- 5) About 10% of Cambodians begin to smoke at the age 10-14, and this is alarming.
- 6) Smoking prevalence is much higher among both men and women who had not attended school.

Recommendations from the research:

- ◇ Research on tobacco use should be undertaken regularly in Cambodia in order to measure trends in smoking prevalence, consumption, spending, and attitudes.
- ◇ Tobacco control research capacity should be strengthened.
- ◇ Anti-tobacco campaigns should be extended to reduce the appeal of tobacco use, to make people aware that tobacco use is an important contributor to the development of disease and death, and to highlight its contributions to the loss of family income (through spending on tobacco and treatment of tobacco-related diseases).
- ◇ Government should give serious consideration to all strategies aimed at reducing tobacco use, especially policies and regulations that became obligatory under the Framework Convention on Tobacco Control (FCTC), such as:
 - Increasing taxes and prices on all tobacco products;
 - Banning all forms of tobacco advertising, promotion and sponsorship;
 - Requiring tobacco packaging to include strong health warnings, and banning misleading terms such as “light” and “mild”; and
 - Creation of smoke-free areas in work and public places.

In general, the lower prevalence of smoking among women in Cambodia reflects the social, cultural, and traditional barriers that discourage them from smoking. Smoking prevalence was much higher among both men (67.4%) and women (11%)

¹⁴ This fact sheet draws on the following research: Seng Souern and Tith Vong, National Institute of Statistics (NIS), Cambodia, “*The Analysis of Smoking Behavior Survey in Cambodia 2004.*”

who had not attended school. Smoking prevalence decreased gradually from lower to higher educational levels for both sexes and in both rural and urban areas. 12% of all smokers began smoking before the age of 15. More females than males began smoking before the age of 15 (18.5% versus 11%); less educated males started to smoke earlier than did more educated males.

Almost half of the urban and rural current smokers wanted to stop smoking. The percentage of those who indicated a desire to quit smoking now was quite low compared with quitting at some point in the future or not at all, and desire to quit smoking was much higher among the younger smokers and among those living in urban areas. This may be related to better access to information on the dangers of smoking among these groups.

Almost half of the male smokers reported that they regretted that they had started smoking. For both sexes, approximately two out of three current smokers had tried at some point to quit smoking. Females in rural areas had tried the least to quit smoking. Almost 97% of current smokers who reported a current desire to stop smoking and 87% of current smokers who desired to stop smoking at some point had attempted to do so, but had not succeeded. Providing cessation services may be a very effective way to help these smokers.

Occasional smoking was much more prevalent among the lower income groups, probably because the poor are more price-sensitive and therefore smoke less frequently than do the rich. Two-thirds of current smokers reported preferring “light” or “mild” products. This preference was based on the smokers’ dangerous misconception that light/mild products were less harmful to their health and that they had a better flavor.

Approximately 83% of all respondents were aware that smoking tobacco caused either “a great deal” or “a fair amount” of harm to their health. Awareness levels were lowest among those in rural areas.

Radio advertisements were noticed by 84% of respondents within the previous month, followed by television advertisements (82%) and billboards and/or posters (44%). Within the past six months, about 10% of the respondents reported being exposed to one or more of the following: being given free cigarette samples, being involved in competitions linked to cigarettes, or being given a free gift that contained cigarette advertising. In terms of exposure to tobacco advertising by age group, the 20+ age group reported more exposure than did the 5-19 age group (12% versus 7%). Interestingly, 75% of the survey respondents felt that cigarette advertising should not be allowed in Cambodia.

78.8% of the respondents indicated being exposed to an anti-tobacco campaign in the past 6 months.

Unlike cigarette smoking, tobacco chewing was more common among women than among men, reported at 9.3% and 0.7%, respectively. Almost 22% of females with no

education in rural areas chewed tobacco compared to only 1.5% among highly educated females in urban areas.

Women who smoked or chewed considered it modern, attractive, and a way to reduce stress. The negative or undesirable perceptions related to having bad manners' and damaging the health. Few respondents viewed women's tobacco use positively. Among respondents in the 5-17 age group, 44% perceived that women who smoked and chewed tobacco have bad manners and 34.9% that she would damage her health. Among both the 18-44 and the 45+ age groups, almost half thought it was bad manners to use tobacco, and one-third thought it damaged health.

Women and Tobacco: Smoke-free Homes¹⁵ in Cambodia, Malaysia and Vietnam

Highlights:

- 1) Persuasion messages should specify the diseases and severity that passive smoking causes, especially among children and women.
- 2) The most convincing reasons to get smokers not to smoke inside the house is that smoking may harm their children's health.
- 3) Messages should highlight the role of fathers in setting a good example for children and the importance of their well-being.
- 4) Examples of smokers who had become healthier after quitting, or of smokers who kept smoking and then got smoking-related diseases, can be helpful for personal comparisons.
- 5) The culturally-acceptable messages that are most likely to succeed: clearly state the adverse effects of smoking, explain the steps to stop smoking, and remind people that smoking is *haram* (forbidden) according to the Muslim religion.
- 6) Successful messages must be short and precise and strategies gentle and loving. One should offer full moral and family support.
- 7) The main barrier to developing culturally-acceptable messages for young women to create a "smoke-free home" lies in "human will" not in science.
- 8) Barriers to persuasion include: the father's addiction, his poor attitude towards smoking, and inappropriate persuasion techniques.
- 9) Supportive factors include an engaged mother, a good father-daughter relationship, and involvement from the father's peers.

Recommendations from the research:

- ◇ Effective smoking cessation programs for adults that need to be widely disseminated and promoted.
- ◇ Development of other effective interventions in the reduction of smoking rates among adults.
- ◇ The government should take action to limit the quantity of tobacco available

¹⁵ This fact sheet draws on the following research: 1) Ngo Le Thu, Vietnam Steering Committee on Smoke and Health (VINACOSH) and Nguyen Thac Minh, Vietnam University of Commerce, Vietnam, "Creating Smoke-Free Homes"; 2) Soreach Sereithida, Women's Development Association (WDA), Cambodia. "Intervention Study to Develop Culturally-Acceptable Messages or Strategies for Women to Take Action at the Household or Community Level"; 3) Hairi, Farizah, Anwar Suhaimi, Noran Naqiah Hairi, Nur Azhana Hairi, M. Rohaizad Zamri and Teoh Li Ying, University of Malaya, Malaysia. "Developing Culturally-acceptable Messages Towards a Smoke-free Home through Young Women".

for sale and should disseminate information about the bad impact of smoking at the grassroots level.

- ◇ NGOs should promote awareness about tobacco/smoking and its impact to the remote, rural communities.
- ◇ NGOs should work closely with local authorities and other agencies to support smoking cessation.

Research conducted recently in Cambodia, Vietnam, and Malaysia suggests that gender norms and traditional values make it difficult for women to influence tobacco use among men. In Cambodia and Vietnam, male smoking is considered both normal and culturally acceptable, while female smoking is generally less socially acceptable. In Malaysia, there is an increasing trend of young female smokers.

Cambodian women and men all were aware of the harmful health effects of smoking. The women also expressed concern about their husbands' other unhealthy habits such as drinking alcohol. The reasons cited by these women for their husbands' smoking included addiction, habit, imitating a friend, and reducing stress. Cambodian women married to smokers were concerned about the money their husbands spent on smoking: *"The sum that my husband spends on cigarettes each week could buy 7-8 kg of rice."*

Both Vietnamese men and women were aware that smoking harms the health, but few were aware of specific harmful effects. Lower-income men realized that their spending on tobacco represented a significant decrease in their ability to afford other household expenditures, while one said that one pack of a common cigarette cost the same as two kilograms of rice.

All of the Malaysian rural young women participants perceived that smoking was harmful to the health of the person who smokes. Young urban women seemed to be less aware of the harmful effects of smoking. According to the young women, the amount of money their fathers spent on tobacco varied from as low as 5% to as high as 65% of the total household expenditure. Almost all of the female Malaysian participants were worried that the money spent on tobacco would reduce essential spending for food, health care, and education. One young woman expressed that *"spending part of the family's income on tobacco is a selfish act."*

All of the Cambodian women believed that exposure to secondhand smoke was harmful to their health and were afraid that they would get the same diseases as their husbands who smoked. Vietnamese women not only did not understand about the harm of passive smoking, some were not even sure what was meant by passive smoking. Neither Vietnamese men nor women could specify any diseases caused by passive smoking. The term 'passive smoker' was also not familiar among the rural young women in Malaysia. Nevertheless, the harmful effects of tobacco on passive smokers were understood. Some of the urban young women also had never heard about passive smoking or did not know the exact meaning of the term.

Most (80%) of the participating Cambodian women had tried to advise or persuade their husbands not to smoke in the home. Few indicated that they had been successful in convincing their husbands to actually quit. This is due in part to the women's low status in the home, with men being used to making decisions rather than taking their wives' advice.

Most of the women participating in the Vietnamese study said that they had asked their husbands to quit smoking, but that their husbands had not heeded their advice. Despite the fact that the Vietnamese men were aware that their smoking harmed the health of others, most of them still smoked inside the house. The lack of in-depth information about the problems of smoking suggests the need both for better mass media campaigns, and for stronger warnings on cigarette packs. Men's reluctance to hear advice from their wives suggests that women may not be the best target group for changing their husband's behavior.

Only half of the young Malaysian women participants had tried to advise their father to smoke outside the house, usually unsuccessfully. The Malaysian fathers reported that they usually smoked anywhere and whenever they wished.

This suggests that messages—including those on cigarette packs—should specify diseases and their seriousness, for both active and passive smokers. Since men were more aware and concerned about the effect of passive smoking on their children than on their wives, messages about passive smoking should include the harm to all women, not just pregnant women. Some smokers mistakenly believed that smoking water pipes is far less harmful than smoking cigarettes, both for themselves and for those exposed to the smoke. Messages should thus make clear that smoking water pipes harms active and passive smokers as much as smoking cigarettes.

The main reason that men gave for not smoking inside the home was concern that smoke could harm their children's health, as well as pressure not to do so by their children. Messages should remind smokers about their vital role and responsibility in protecting their children's health, and should use children as allies in persuading men not to smoke indoors and to quit smoking.

Creating a "smoke-free home" requires a three-pronged approach: 1) preventing the initiation of tobacco use (in homes where there are no smokers), 2) promoting quit attempts among the young and adults (in homes with smokers), and 3) eliminating non-smokers' exposure to second hand smoke (in homes with smokers). Creating smoke-free homes requires commitment from the family, health care providers, policy-makers, and anti-tobacco advocates.

Women and Tobacco: Reasons for Use, and Prevention Strategies¹⁶ in Cambodia, Malaysia and Thailand

Highlights:

Cambodia

- 1) Community people strongly disliked smoking among young women; however, smoking among old women was less stigmatized.
- 2) Tobacco chewing practiced by old women was considered as a traditional practice and it was considered not risky.
- 3) In women's perceptions, hand-rolled cigarettes are safe, while commercial cigarettes are harmful because the industry may add addictive chemicals.
- 4) Community women did not know about the impact of secondhand smoke or about the impact of smoking on the environment and on the household budget.
- 5) Most smokers did not know how to quit smoking. Some have tried to quit on their own while they were sick, but they relapsed

Malaysia

- 6) Having a mother who smokes is a strong risk factor for smoking initiation and significantly predicts ever and current smoking.
- 7) Current smoking was 7 times more likely among young women whose close friends smoke and 25 times more likely among young women whose mothers smoke.
- 8) Social, physical and immediate environments contribute to smoking experimentation.
- 9) Concern for personal health, wanting to set an example for children, and parental disapproval motivate most smokers to consider quitting smoking.
- 10) Malaysian society's disapproval of smoking and the current warning labels on cigarette packs do not motivate more than 70% of the smokers to quit

¹⁶ This fact sheet draws on the following research: 1) Chhea Chhordaphea and Koeut Pichenda, National Centre for Health Promotion (NCHP), Ministry of Health, Cambodia. "Health Knowledge and Gender Attitudes Related to Women and Tobacco Use in Kratie Province, Cambodia"; 2) Sanguanprasit, Boosaba, Oranuch Pacheun, and Lakana Termsirikulchai, Mahidol University, Thailand. "Knowledge and Attitudes Related to Women and Tobacco among Young Thai Women"; 3) Khor Yoke Lim, Foong K., Farizah H., Zariah Z., Rahmat A., Maizurah O., Razak L., Tan Y.L., Universiti Sains Malaysia, "Factors Associated with Tobacco Use among Female College and University Students in Kuala Lumpur, Malaysia"; 4) Vichit-Vadakan, Nuntavarn, Chulalongkorn University, Thailand. "Peer Communicators: Bridging Communication Gaps in Tobacco Control among Female Youth."

Thailand

- 11) The proportions of fourth year female students who ever and currently smoked in the private university was highest in proportion, than in the public university which had the lowest.
- 12) Public university had the highest score in knowledge about tobacco.
- 13) Factors significantly relating to current smoking behavior were daily allowance, spending leisure times with friends, having fathers who smoked, having closed friends who smoked, levels of knowledge about tobacco, cumulative GPA, and attitudes towards smoking and female smoking.
- 14) Factors associated with smoking include images of smoking as stylish and macho, and a propensity to experiment.
- 15) Most respondents felt that current anti-smoking campaigns had no impact on the smoking behavior of young adults because the messages were unconvincing, unappealing, and not appropriately targeting the audience.
- 16) Most respondents knew the harmful health effects of smoking, but stressed that effective messages should focus on the specific fears of young adults, such as poor sexual performance for males and physical appearance for females, and concern about the welfare of their loved ones.
- 17) Television is the most effective media for expanding the coverage of anti-smoking campaigns.

Recommendations from the research:

- ◇ The tax on all tobacco products should be increased to make them unaffordable to youth.
- ◇ All forms of tobacco promotion should be banned. Banning of the depiction of smoking and tobacco products in the media should also be considered.
- ◇ Display of cigarette packs and ads in stores represents an important form of advertising, and should, as in Thailand, be banned.
- ◇ All universities should pass and enforce strict smoke-free policies. Allowing students to smoke on campus sends a clear message that smoking is acceptable.
- ◇ Warnings on cigarette packs should be clear, strong, specific, and use pictures.
- ◇ Anti-tobacco media campaigns should be expanded through all possible means, such as mass media (TV, radio, newspapers) and inter-personal communication.
- ◇ Proper help should be provided to help people quit using tobacco.
- ◇ 'Smoke-Free Home' campaigns should be intensified.
- ◇ Members of the target audience, including female youth, should be involved

in the development of anti-smoking campaigns, including improving refusal skills.

- ◇ Research activities should be extended in order to develop strategies and actions for tobacco control among women and girls.

In Cambodia, 47% of men and 6% of women over age 15 use tobacco. Rates are higher in older age groups: 72% of males and 10% of females aged over 40 years. Tobacco use among women is as high as 21%-53% in the northeast provinces. The smoking prevalence within the Malaysian female adult population is significantly lower (3.5%) than that of the male population (25%).

Smoking prevalence among the female population in Thailand is less than males, although smoking prevalence among female youth (15-24 years) has increased in recent years. Among Thai female university students, a fifth (19.8%) had ever smoked, with the current smoking prevalence 3.1%. Among the Malaysian young women, one-fifth (21%) had tried smoking, and 4.3% were current smokers. The prevalence of ever smoking among the younger Thai female students (grades 7-12) was 13.4%, of which 5.1% were current smokers.

When Cambodian women analyzed costs related to tobacco use, they were surprised to learn how much money their family loses. Young Thai students mentioned harm to the nation's economy from tobacco use. In Cambodia, among both users and non-users, no strong negative attitudes were expressed towards tobacco use among "old" women. But tobacco use, particularly smoking, was seen as absolutely unacceptable among young women aged 15-25 years. Almost all Cambodian women expressed regret that they had started smoking.

Despite being well aware of the health hazards caused by tobacco use, Thai university students did not strongly oppose female smoking. Most (71%) thought that smoking was an individual's right, and a third (34%) were not sure or disagreed with the statement that female smoking was not acceptable to Thai society. Most Malaysian students disagreed with the statements that male smokers looked more attractive and masculine, and most agreed that men who smoke smell bad. Both non-smokers and smokers prefer men who do not smoke, but more non-smokers than smokers expressed strong attitudes against smoking.

Most of the young Thai students (grades 7-12) agreed that smoking was harmful to one's health. They also believed that the health effects from smoking could affect their academic performance. However, even though they knew that smoking was dangerous, that knowledge had little effect in the face of peer pressure.

Most Cambodian women said they had never tried to quit, and they thought that quitting might not be possible for them since, as long-time users, they were very addicted to tobacco. Half of Thai university students thought that quitting smoking was difficult, though only 30% of those who had tried to quit succeeded. Two-thirds of the Malaysian students who smoked had tried to quit smoking. Almost all (95%)

of the Thai smokers in grades 7-12 thought they could stop smoking if they wanted.

The extent of tobacco advertising varied across the countries. Thailand, with strict laws, had very little tobacco advertising, while advertising was abundant in both Malaysia and Cambodia. Pervasive tobacco advertising—even where it is prohibited by law—plays a significant role in encouraging people of all ages and both sexes to smoke. Low taxes on cigarettes contribute to their affordability, and youth and the poor are most affected by price increases. The retention of messages from pack warnings is fairly high, especially in Thailand, where the messages are pictorial and detailed. Finally, smoke-free places contribute to a sense that smoking is unacceptable. Strengthening tobacco control policies would thus have a significant effect on reducing tobacco use among women and girls.

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About SEATCA

The Southeast Asia Tobacco Control Alliance (SEATCA) works closely with key partners in ASEAN member countries to generate local evidence through research programs, to enhance local capacity through advocacy fellowship program, and to be catalyst in policy development through regional forums and in-country networking. By adopting a regional policy advocacy mission, it has supported member countries to ratify and implement the WHO Framework Convention on Tobacco Control (FCTC)

Contact persons:

Ms. Bungon Ritthiphakdee: **SEATCA Director**

Email: bungon@seatca.org

Ms. Menchi G. Velasco: **SEATCA Research Program Manager**

Email: menchi55@yahoo.com

Southeast Asia Tobacco Control Alliance (SEATCA)

Address: Thakolsuk Apartment Room 2B, 115 Thoddamri Rd., Nakornchaisri
Dusit, Bangkok 10300, THAILAND

Tel./Fax: +662 241 0082

Website: <http://www.seatca.org>

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Dusit, Bangkok 10300, THAILAND

Tel./Fax: +662 241 0082

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