**Appendix 1: Summary of Reviewed Papers**

Table 4: Studies examining tobacco and poverty-related issues in Vietnam and globally

| **Authors, year and location** | **Year of assessment** | **Population and design** | **Covariates and Analysis** | **Definitions used** | **Key findings related to this paper** | **Comments and limitations** |
| --- | --- | --- | --- | --- | --- | --- |
| * *Studies investigating smoking prevalence and health burden* | | | | | | |
| Murray CJL and Lopez AD. 1996[6]  Global | 1994-1995 | WHO report annex; summarized assessment of current disease burden attributable to ten identified risk factors. | Number of deaths, years of life lost (YLL), years lived with disability (YLD), and disability-adjusted life years (DALY); data presented globally, by region, and by groups of countries. | Includes definitions for years of life lost (YLL), years lived with disability (YLD) and disability-adjusted life years (DALY). | In 1990, tobacco caused 3.7% of total deaths in developing countries and 1.4% of total DALYs. | * Some discussion on methodologies and its limitation given in report. |
| Minh HV et al. 2006[11]  Bavi district, Vietnam | 2002 | Survey; cross-sectional, representative sample; 2,000 individuals aged 25-64 years. | Relationship between smoking prevalence, quit behaviors, and SE variables (education, occupation status, annual income); Cox regression used to estimate role of each SE factor. | * Regular use is switch from non-daily to daily use; cessation is switch from daily to non-daily use. | * Low education, low income, and being a farmer related to higher smoking prevalence; low income groups have higher initiation risk and lower chance of quitting. | * Self reporting is the subject of recall bias and underreporting |
| Dao LH et al. 2003[12]  Bavi district, Vietnam | Jan 1999- March 2000 | Survey; representative sample; 11,300 households; verbal autopsy reports to collect mortality data via quarterly household visits; 189 deaths recorded and included. | Cause of death and demographic characteristics of deceased. | Causes of deaths coded using ICD 10. | * Leading causes of death were cardiovascular and infectious diseases (20.6% and 17.9% of the total, respectively) | * Validation of verbal autopsy is questionable. * The small rural study area is not nationally representative. |
| Hoang VM et al. 2009[13]  Vietnam | 2005 | Data review of international and national journals and government documents. | * Burden of chronic diseases; relative risk factors; economic determinants of diseases with associated risk factors. | * NA | * Chronic disease is leading cause of death; poor more vulnerable to chronic disease and high risk behaviors; chronic diseases cause economic losses for families and individuals; in 2005 loss was 20 million USD. | * NA |
| Levy DT et al. 2006[14]  Vietnam | Nov 2001-Oct 2002 | Simulation modeling using prevalence of smoking from NHS (55%) and RR of mortality adopted from China (1.35) | Population model, smoking model, smoking attributable death mode, and policy modules used to project smoking prevalence trend over time and estimate number of smoking attributable deaths under different policy intervention assumptions. | * Smoking status based on smoking 100+ cigarettes in lifetime; distinction made between current and past smokers; smoker categories broken down by number of years smoking, age, and gender. | * 100% tax increase and other strong TC policies implemented would drop smoking prevalence by 38.5% for males and 31.8% for females by 2033 relative to 2002 levels; over 231,500 lives saved by 2033 using relative risk of 1.35, or 325,000 lives with relative risk of 1.55. | * The model relies on simplified assumptions because there was insufficient information available to undertake more detailed analysis. |
| Hoang VM et al. 2008[15]  Bavi district, Vietnam | 2005 | Survey; cross-sectional representative sample; 2,500adults aged 25-74; self-administered questionnaire. | Prevalence of major chronic diseases and relationships to socioeconomic status and selected lifestyle risk factors. | NA | Smoking prevalence59% among men and 0.7% among women; tobacco use associated with higher probabilityof having at least one chronic disease; economic status negatively related to the risk of NCD in women. | Self-reporting is subject to under-reporting and recall bias |
| Euromonitor International 2009[20]  Vietnam | 2002-2007 | Market analysis of secondary data and policy reviews. | * Situational analysis of tobacco market and related policies and legislation in Vietnam; particular emphasis on smoking prevalence, taxation, tobacco trading/import/export, and illicit trade estimates. | * NA | * Smoking prevalence high among males and increasing among women; inconsistent government policies related to or impacting on tobacco control; ineffective control of illicit trade and weak law enforcement. | NA |
| Jenkins CNH et al. Tobacco use in Vietnam: prevalence, predictors, and the role of the transnational tobacco corporations. *JAMA* 1997;**277**(21):1726-1731.  2 cities and 2 rural communes in Vietnam | 1995 | Survey; random sample; 2,004 men and women aged 18 years or older; urban survey: multistage cluster design; rural survey: systematic sample using face-to-face interviews. | Prevalence and correlates of tobacco smoking; amount and duration of smoking; age at initiation; quitting behavior; knowledge of health hazards of and attitudes toward smoking; cigarette brands smoked, preferred, and most recognized. | NA | Smoking prevalence 72.8% among men and 4.3% among women; males smoked mean of 15.5 years and median age at initiation was 19.5 years; non-Vietnamese cigarette brands most recalled. | First study on smoking prevalence conducted in Vietnam. |
| Le NT et al. Situation of tobacco smoking in Vietnam in 1997. In: *Study reports on tobacco smoking prevalence and related disease in Vietnam.* Hanoi: VINACOSH 1999:2-23.  Four Vietnamese provinces | 1997-1998 | Qualitative survey; representative sample; 7,220 people. | Description of smoking characteristics; KAP of smokers, ex-smokers, and non-smokers toward smoking | NA | Smoking prevalence 50% in males and 3.4% in females; prevalence highest among military personnel and lowest among students; 93.6% aware of smoking harms; 69% offered cigarettes to guests. | Sample age range not clear; definition of smoking not made available. |
| Huynh BT. Tobacco use and related factors in Ngu Hanh Son district, Da Nang City, 2004. *Med Prac Jour* 2006;**533**(Monograph of Research on Tobacco Control for period 1999-2005):57-64.  Ngu Hanh Son district, Da Nang City, Vietnam | Not indicated | Cross sectional survey; representative sample; 840 people; self-administered questionnaires. | Description of demographic characteristics; smoking status; KAP toward smoking; quitting experiences. | NA | Prevalence of smoking 59% in males and 3.8% in females; most started smoking at age 18-24 (61%); majority (73%) had smoked more than ten years; 91% agreed that smoking harmful; 77% wanted to quit; 57% had failed quit attempts, largely due to peer pressure. | Need to strengthen communication about and enforcement of smoke-free policies. |
| Tran TKTH, Pham THA, Nguyen DQ, Vu PNT. *Smoking in girls and young women in Vietnam*. Bangkok: SEATCA 2008.  Two urban and two rural districts Vietnam. | 2007-2008 | Combination cross sectional survey and qualitative focus group discussion; representative sample; 2,951 students 13-25 years. | Socio-demographic characteristics; smoking behavior; exposure to advertising and promotion and anti-smoking campaigns; attitudes toward tobacco control policies; knowledge of the harms of smoking; beliefs and attitudes about tobacco industry. | Never smokers: never smoked during lifetime;  ever smoker: had tried a cigarette; current smoker: smoked in the past 30 days. | 4.5% young females had ever smoked; proportion higher in urban areas and increased by age; few are current smokers; half of ever smokers initiated at age 13; majority has negative attitudes toward smoking. | Deterring smoking initiation rites among youth females should be included in TC programs |
| Hoang VM, et al. Prevalence of and susceptibility to cigarette smoking among female students aged 13 to 15 years in Vietnam, 2007. *Prev Chronic Dis* 2010;**7**(1) <http://www.cdc.gov/pcd/issues/2010/jan/09_0023.htm>  Vietnam | 2007 | Representative sample; 8,391 female secondary school students 13-15 years taken from 2007 Global Youth Tobacco Survey. | Dependent variables: smoking status and susceptibility to smoking; independent variables: age; perception of smoking habit; knowledge of harmful effects of smoking; parents' and friends’ smoking status; education on harmful effects of smoking; access to antismoking media; exposure to billboard cigarette advertising. | NA | Prevalence of cigarette smoking 1.2% (0.9-1.5); 1.5% (95% CI, 1.2-1.9) susceptible to smoking; smoking friends strongest predictor of smoking status and susceptibility; exposure to anti-smoking lectures significantly reduced cigarette use; exposure to billboard cigarette advertising increased susceptibility. | Need to pursue school-based intervention programs and to counter tobacco advertising and marketing practices that target young women. |
| Le TP. Tobacco use and related factors in Raglai ethnic women, Khanh Hoa province. *Med Prac Jour* 2006;**533**(Monograph of Research on Tobacco Control for period 1999-2005): 48-56.  Khanh Hoa province, Vietnam | 2003 | Cross sectional survey; representative sample; 342 Raglai ethnic women 15- 49 years. | Smoking characteristics; age at smoking initiation; KAP towards smoking. | NA | Smoking prevalence 55% among Raglai women; hand-rolled cigarette use most common; 53% of smokers had smoked for more than 10 years; smokers faced 3-fold risk of chronic energy deficiency; 47% of smokers wished to quit; knowledge of harms of smoking limited. | Prevalence of smoking among this group of women extremely high; possible bias in recording smoking status. |
| Nguyen DS. Situation of tobacco use in transportation workers and the relationship with the change of respiratory function in workers with silicosis. In: *Study reports on tobacco smoking prevalence and related disease in Vietnam*. Hanoi: VINACOSH 1999:61-64.  Vietnam | 1998 | Cross sectional survey of 2,000 road traffic workers; retrospective investigation of 200 workers diagnosed with silicosis. | Description of smoking and quitting characteristics among road traffic workers and workers with silicosis. | NA | Smoking prevalence 58.4% among male workers, 6.6% among female workers and 62.2% among workers diagnosed with silicosis. | Smoking prevalence among workers high; radiography of workers diagnosed with silicosis shows worse disease conditions among smokers. |
| Le T et al. Tobacco smoking and impact on respiratory function in workers exposed to dust and development of occupational diseases. In: *Study reports on tobacco smoking prevalence and related disease in Vietnam*. Hanoi: VINACOSH 1999:55-60.  Vietnam | 1998 | Cross sectional survey; 446 workers at three companies; sampling method not described. | Socio-demographic characteristics; level of dust pollutions at workplaces; smoking characteristics of workers; rate of silicosis (based on radiographic examination); physiological respiratory function; signs of upper AD tract infection. | NA | Level of dust pollution in all factories exceeded regulated limits; smoking prevalence 66-76.5% among males; most smokers aware of harms of smoking and wanted to quit but could not; prevalence rates of silicosis and of limited or obstructed respiration significantly higher among smokers. | Prevalence of smoking in male workers high; smoking has a negative impact on the progress of occupational pathogenesis; limitation: no clear smoking definition given. |
| Tran VD. Smoking in farmers in Vietnam. In: *Study reports on tobacco smoking prevalence and related disease in Vietnam*. Hanoi: VINACOSH 1999:24-29.  Four Vietnamese provinces. | 1999 | Qualitative survey; 1,920 farmers and fishermen; sampling method not described. | Demographic characteristics; smoking status; knowledge of smoking harms; sources of information; attitudes/beliefs about smoking; types of cigarettes used; amount consumed and expenditure; barriers to quitting and reasons for failed quit attempts. | NA | Smoking prevalence 63% among males; good knowledge about harms of smoking; waterpipe use popular; smokers spent 10,000- 100,000 VND per month on cigarettes. | Prevalence of smoking in this group high; limitation: no clear smoking definition given. |
| Ngo QC et al. Smoking behaviors, knowledge and attitude of health professionals in Bach Mai Hospital. *Med Prac Jour* 2006;**533**(Monograph of Research on Tobacco Control for period 1999-2005):65-73.  Hanoi, Vietnam | 2004 | Cross sectional survey; convenient sample; 590 medical professionals; questionnaire from Global Health Professional Survey. | Demographic characteristics; smoking status; age at initiation; quit attempts; knowledge and attitude of: the harms of smoking, model role of medical professionals, and tobacco control policies. | NA | Smoking prevalence 40.7% among male health professionals; no interviewed women smoked; Vinataba most used cigarette brand; 75% started smoking before age 20; among current smokers, only 34% planned to quit. | Prevalence of smoking among health professionals lower than among the general public and prevalence of quitting also higher. However, smoking rates among this group remain high. |
| Ly NK, Phan TH, Nguyen TK, et al. *Tobacco use among school children age 13-15 in five provinces in Vietnam: results of GYTS 2002*. Hanoi: Vietnam Ministry of Health 2005.  Five Vietnamese provinces. | 2002 | Survey; representative sample; 13,000 schoolchildren 13-15 years. | Smoking status; age at initiation; exposure to tobacco advertisements and/or information about the harms of smoking through school and media education programs; KAP related to smoking and passive smoking. | NA | 26.5% of schoolboys and 8.5% of schoolgirls had ever tried cigarettes; current prevalence 10% and 1.9%; most students exposed to information about smoking harms but received very little information about skills to refuse/avoid smoking; 50% exposed to cigarette advertising and 20% to tobacco promotion. | Tobacco education program should be strengthened with a more attractive format; TAPS ban should be strongly enforced |
| Ministry of Health, General Statistics Office, UNICEF, and WHO. *Survey assessment of Vietnam youth*. Hanoi: Ministry of Health 2005.  42 Vietnamese provinces | 2002 | National survey; representative sample; 7,584 youth 14-25 years; based on 2002 VLSS sample. | Education, work and employment; KAP of reproductive health, HIV, and health risk behaviors, including drug, alcohol, and tobacco use; injuries and mental health. | NA | 43.6% of young males smoked at some time; of those, 77% are current smokers; prevalence increased with age; average age at initiation was 16.9 years; peer pressure the most common cause of smoking (54%). | NA |
| *Studies on economic burden of tobacco use and production* | | | | | | |
| Efroymson D et al. 2001[2]  Bangladesh | 1999 | Combination secondary data analysis and survey; 123 smoking rickshaw pullers 15-70 years; qualitative study on poor households. | Cost of tobacco to the national economy; daily income; consumption of and daily expenditures on tobacco; opportunity cost of tobacco use. | NA | Tobacco expenditure major burden for the poor; average male smokers spent more than twice as much on cigarettes as per capita expenditure on clothing, housing, health and education combined; typical poor smoker could add 500+ calories to diet of one or two children with daily tobacco expenditure; estimated 10.5 million currently malnourished people could have adequate diet if tobacco expenditure directed to food. | Higher taxes would increase prices and prevent smoking among the poor and youth. |
| Baquilod M. 2006[3]  Philippines | 2000-2003 | Secondary analyses of national surveys on prevalence of tobacco use and on household income and expenditure. | Descriptive and econometric estimation of impact of price increases and taxation on tobacco consumption. | NA | Among poor households, tobacco spending higher than expenditure on education or health, and same as on clothing. | Study was one component of larger tobacco and poverty study. |
| SEATCA 2008[4]  Southeast Asia | 2002-2007 | Data review; tobacco cultivation studies conducted in ASEAN countries. | Link between tobacco use, poverty, and tobacco farming. | NA | The poor consume more tobacco and face higher risk of premature death; tobacco workers in developing countries not benefit from high value-added; tobacco control would not result in net job loss; revenue from and costs of tobacco production high relative to other crops; tobacco growing worsens deforestation and environmental damage. | A review of secondary data, but useful for advocacy. |
| Efroymson D and FitzGerald S eds. 2003[5]  Bangladesh and India | 2000-2002 | Literature review; secondary data analysis; case studies of farmers, leaf pickers, bidi rollers, and managers; survey of 400 street children and families in Mumbai. | Conditions and livelihood of tobacco growers; various tobacco cultivation and production-related issues of farmers, workers, and environment; benefit of alternative crops. | NA | Tobacco cultivation does not benefit economic development; Mumbai street children spent more on tobacco than on food. | Investing in tobacco maintains cycle of poverty and misery. |
| Sung H-Y et al. 2006[7]  China | 2000 | Prevalence-based, disease-specific approach estimate of smoking-related burden. | Smoking-attributable costs; indirect morbidities cost; costs of premature deaths caused by smoking-related diseases. | NA | Economic cost of smoking was 5.0 billion USD; direct costs were $1.7 billion (34%), indirect morbidity costs were $0.4 billion (8%), and indirect mortality costs were $2.9 billion (58%). | Adverse health effects of smoking constitute huge economic burden to China. |
| WHO 2004[8]  Bangladesh | 2003-2004 | Cost of Illness (COI) approach; data from tertiary hospital survey, experts survey, and household survey. | Tobacco-related diseases; tobacco-attributable disabilities; deaths and direct and indirect costs. | Costs of tobacco use included i) private patient medical expenditure; ii) public health infrastructure; and iii) loss of potential income due to illness and disability. | Total annual cost of tobacco-related illnesses estimated at 66.9 billion taka (46 billion taka in of lost income from premature death and disability and 20.8 billion taka in direct health care cost). | Cost of tobacco use outweighs benefit from revenue and wages by 2.6 billion taka. |
| Bales S and Hoang VK 2003[16]  Vietnam | 1992-1993 and 1997-1998 | Secondary data analysis of two VLSS; 1992-1993 (nationwide representative sample of 4,800 households with 23,839 individuals); 1997-1998 (6,000 households with 28,518 individuals). | Tobacco use prevalence; various forms of tobacco use and relationship of tobacco use to SE factors such as residential setting, geographical region, education, income, occupation (multivariable analysis); smoking trends over time and quit behaviors. | History of tobacco use assumed that cigarette users had smoked for more than 6 months. | Poorest group spent 2.6 times more on tobacco than on education for small children. | Risk of underestimation due inconsistency of questionnaires used in two different survey years. |
| Hoang VK et al. 2006[17]  Vietnam | 1997-1998 | Secondary data and regression analysis of 1997-09 VLSS; nationwide representative sample; 6,000 households with 28,518 individuals. | Preferred types of cigarette by income group; impact of multi-level tobacco tax policy on low-price cigarette smokers; price elasticity of smoking participation and quantity smoked by income group; effect of single uniform 65% tax on consumption and government revenue. | History of tobacco use assumed that cigarette users had smoked for more than 6 months. | Most low- priced cigarettes consumers were rural poor; low income households' tobacco spending equal to 1.5 times educational spending and equal to health care spending; ratio of expenditures for tobacco/ education, tobacco/food, and tobacco/health higher among rural population ; imposing uniform tobacco 65% tax would result in 32% price increase for low-priced cigarettes and 16% increase for domestic filtered cigarettes; tobacco consumption would decrease by 25% and tax revenue would increase by 11%. | Data on income may be incorrect; potential shift to pipe smoking taken into account by using expenditures rather than price, creating the possibility that price data may not be representative; impact of smuggling not examined. |
| Hoang M et al. 2004[18]  Five provinces in Vietnam | 2003 | Cross sectional survey; representative sample; 5,611 persons in 1,158 households (680 with smokers and 478 without smokers) | Prevalence of tobacco use and type of tobacco used by demographic and SE factors (age, gender, education level, ethnic, occupation, income); household tobacco expenditures versus other needs. | NA | * 54%of adult males smoked; annual per household tobacco expenditure 40 USD; poorest smoking households spent 2.3 times more on tobacco than education. | * NA |
| Ross H et al. 2007[19]  Hanoi, Vietnam | 2005 | Record review of 390 patients at three major hospitals; focus on three major smoking-related diseases (lung cancer, ischemic heart disease and COPD); combined with prevalence-based approach. | Smoking status; unit cost of direct and some indirect health care expenditures; RR adopted from similar Chinese and US studies; cost share of individual, government, and insurance companies. | NA | 72.5% of social costs related to treatment of three smoking-related diseases; represents 4.3% of total healthcare expenditures and 0.22% of GDP; government bears 51% of cost; families and insurance sector bear 34% and 15%, respectively. | Outpatient care and self treatment costs not included; small sample size in limited number of hospitals; number of smoking-related diseases not addressed. Validation of self reporting on expenditure also questionable. |
| Hoang VM et al. 2009[21]  Two tobacco-growing and two non-tobacco-growing communes Vietnam | 2007 | Cross sectional household survey combined with qualitative interviews; 980 farmers from 480 households. | Revenue, expenditure and self-reported illness during past six months; tobacco growing and non-growing communes. | * NA | Growing tobacco no benefit after discounting family labour costs; tobacco growers had higher risk of illness than other crop growers; tobacco growing child- and women- labour abusing; contributes to deforestation. | Small sample size and limited by retrospective self-reporting survey (recall bias, underreporting, especially related to income); unknown variation of recall bias among different groups of responders. |
| Tran DH 2004[22]  Phong Lai province, Vietnam | 2004 | Qualitative case study. | Labour allocation; alternative crops; SE benefits. | NA | Incentives shift led to decline in tobacco cultivation; even where tobacco cultivation is profitable, other alternatives may be more so. | No comparison (control) or quantitative corroboration. |
| Nguyen TM et al. 2004[31]  Vietnam | December 1997- December 1998  and 2002 | Secondary data analysis; 1997-98 VLSS (nationwide survey of representative sample of 6,000 households with 28,518 inhabitants) and 2002 NHS (nationwide survey of representative sample of 36,000 households). | Average cigarette prices; estimated number of cigarettes produced and imported; prevalence of tobacco use and expenditures on tobacco and other goods per income group. | NHS: users smoked 100+ lifetime cigarettes.  VLSS: users smoked for more than 6 months.  World Bank: food poverty = 1.287 million VND or less per person per year (amount of required to ensure 2100 Kcalo/day). | Amount spent on tobacco could purchase 1.6 million tonnes of rice and feed 10.6 million people annually; 1.5% of population below poverty line due to tobacco expenditures; tobacco use widens inequality; prevalence of smoking higher in poorer groups who started smoking earlier and were less likely to quit; poorest group spent 1.5 times more on tobacco than education. | Underestimates tobacco consumption due to underestimation of smuggled cigarettes use; inconsistencies in the definition of “tobacco use.” |
| Nguyen TL et al. 2004[32]  Vietnam | 1997-1998 | Secondary data analysis of 1997-1998 VLSS (nationwide representative sample of 6,000 households with 28,518 inhabitants). | Smoking prevalence and patterns of tobacco use by expenditure group; share of tobacco expenditure in total expenditure; expenditure on tobacco versus expenditure on other needs (education, health care and food) per expenditure group. | History of tobacco use assumed cigarette users had smoked for more than 6 months. | 1/3 of poor households consume tobacco; expenditure on tobacco a large percentage of total expenditure; poorest households spent 2.2 times more on cigarettes than on education and 1.6 times than on health care. | NA |
| *Studies investigating the environmental impact of tobacco production* | | | | | | |
| Geist H 1999[23]  Global | 1990-1995 | Global secondary data analysis. | Global amount of forest and woodland consumed annually for curing tobacco; tobacco industry’s share of deforestation; rank of countries by degree of tobacco deforestation. | NA | Vietnam ranks among the countries with “heavy to medium level of deforestation due to tobacco.” | NA |
| *Studies investigating the impact of tax and tobacco control policies on tobacco consumption and its consequences* | | | | | | |
| Guindon E et al. 2010[24]  Vietnam | 2009-2010 | Literature review. | * Tobacco use and prevalence; tobacco policies; price and tax structure; affordability; impact of tax; modeling analysis; prediction of the impact of tax increase on deaths and tax revenue up to 2050. | NA | * Vietnam has high prevalence of smoking in males; significant public exposure to secondhand smoke; the poor spend larger share of total income on tobacco; tobacco taxes and prices are low; tax increase will reduce smoking. | NA |
| Nguyen TTH et al. 2008[25]  Vietnam | 2008 | Secondary analysis of macroeconomic data and contents of the Input – Output Table of the National Economy Report 2000. | Macroeconomic data; smoking prevalence; employment in tobacco industries. | NA | 10% decline in tobacco consumption would cause 11.18% decline in tobacco manufacturing employment but increase in *national* employment of 0.058%; 100% increase in excise taxes with tobacco control policies would increase national output by 0.07% and employment by 0.399%. | NA |
| Eozenou P and Fishburn B. 2009[26]  Vietnam | 1998 | Cross-sectional household survey and spatial price variation. | Value of cigarette consumption; model of simultaneous choice of quantity and quality; spatial variations in price and quantity demand used to estimate “Almost Ideal Demand System.” | NA | Price elasticity of cigarette demand is −0.53; introduction of cigarette taxation would generate additional government revenue. | NA |
| Laxminarayan R and Deolaikar A. 2004[27]  Vietnam | 1992-1993 and 1997-1998 | Secondary data analysis of two VLSS; 1992-1993 (nationwide representative sample of 4,800 households with 23,839 individuals) and 1997-1998 (6,000 households with 28,518 individuals). | NA | NA | Poor and low price cigarette users more sensitive to price changes; waterpipe tobacco price increases have less impact on initiation; cigarettes price changes significantly and positively associated with switch to waterpipe smoking. | NA |
| PATH Canada. *Cigarette smuggling in Viet Nam: problems and solutions (final project report)*. Ottawa: HealthBridge Canada 2005.  Vietnam | 2005 | Qualitative study combining site observation, in-depth interview of government officers/ custom officers, secondary data analysis, and a literature review. | Description of recent situation of cigarette smuggling in Vietnam; scale, causes, major routes, and people involved in the smuggling; present policies/regulations and implementation and enforcement. | NA | 10% of Vietnamese cigarette market smuggled; 555, JET, HERO, MARLBORO and DUNHIL most commonly smuggled brands; multiple routes and means of infiltration; most carriers of smuggled goods are poor people. | Cigarette smuggling is a serious issue in Vietnam; high benefits, consumer brand preference, and loopholes in policy definitions and enforcement identified as major causes of smuggling. |
| Le VA, Le TTH, Tran TTH, et al. *Preliminary investigation of tobacco advertisement, promotion and sponsorship in Vietnam*. Hanoi: Hanoi School of Public Health 2010.  Vietnam | 2009 | Combined qualitative study and quantitative survey; 1530 points of sale; some secondary data used. | Forms of TAPS violation; types of shops violating ban; brands involved. | NA | 95.4% of POS violated ban; most common violations were product displays (91.2%) and use of brand colors/logos (41.5%); other violations included sale of kiddy packs and sponsorships. | POS still an issue in Vietnam |

| **Authors, year and location** | **Year of Assessment** | **Nature of report** | **Key findings related to this paper** | |
| --- | --- | --- | --- | --- |
| *General publications* | | | | |
| Shafey O et al. 2009[1]  Global | 2006-2008 | International atlas mapping history, documenting current situation, and predicting future of epidemic of tobacco use. | In Vietnam, 42.9% of males and 2.2% of females smoke; 55.3% of youth live in homes with smokers;  45% of total cigarette price is tax. | |
| World Bank 2007[9]  Vietnam | 2006-2007 | World Bank’s annual country update on Vietnam’s socio-economic situation. | Vietnam is one of best performing economies over past decade; success made in reducing poverty, with the general poverty rate falling from 58.1% in 1993 to 16% in 2006. | |
| World Bank 1999[10]  Global | 1997-1999 | Examined economic aspects of tobacco control; assessed expected consequences of tobacco control for health, for economies, and for individuals. | Policies that reduce demand for tobacco would not cause long-term job losses; higher tax would not reduce government revenue but would increase it in the short and medium terms. | |
| WHO 2002[33] Global | 2001-2002 | Global annual estimate of burden of disease. | Number of deaths in Vietnam due to chronic diseases was 66% of total deaths in 2002. | |
| International Agency for Research on Cancer 2002[34] Global | 2002 | Database providing an estimate of cancer morbidity and mortality globally and by region and country. | In Vietnam in 2002, 75,150 cancer cases newly detected, of which lung cancer was the most prevalent; 54,642 cancer deaths predicted, with about 9,500 due to lung cancer. | |
| *Vietnamese Policy and Statistical Documents* | | | | |
| Ministry of Health 1998[28]  Vietnam | 1997 | Annual MOH report on national health indicators, public health service system (including budget, staffing at all levels and disaggregated by province), national health focus programs (such as reproductive health and family planning, tuberculosis, and EPI). Hospital-based morbidity and mortality data using ICD10 also provided. | Proportion of hospital admissions attributable to chronic diseases 39% in 1997. | |
| Ministry of Health 2003[29]  Vietnam | 2003 | Annual MOH report on national health indicators, public health service system (including budget, staffing at all levels and disaggregated by province), national health focus programs (such as reproductive health and family planning, tuberculosis, and EPI). Hospital-based morbidity and mortality data using ICD10 also provided. | Proportion of hospital admissions attributable to chronic diseases 68% in 2003. | |
| General Statistics Office 2007[30]  Vietnam | 2006 | National annual database on national demographics and economic and social development. Major findings of national surveys also provided on the GSO website. | Between 2000 and 2005, Vietnam produced between 23,000 and 33,000 tonnes of tobacco leaves annually. | |
| Government of Vietnam, Office of the Prime Minister. *Decision # 1315/QD-TTG: “decision on approval of plan for FCTC implementation*.” Hanoi 21 August 2009. | 2009 | Vietnam Government’s plan for FCTC implementation signed by Prime Minister on 21 Aug, 2009. Key milestones included: road map for tobacco tax increases; minimum tobacco prices and control of sale of cigarettes at duty free outlets; smoking strictly prohibited in class rooms, children’s gardens, health facilities, libraries, cinemas, theatres, work sites and offices, and on public transportation; other public places to have separated areas for smokers; pictorial health warnings to be included on cigarette products; comprehensive ban on all forms of tobacco advertisement, promotion and sponsorship. | NA |
| Government of Vietnam, Ministry of Culture, Sport and Tourism. *Circular # 78/2008/TT-BVHTTDL*. Hanoi 29 August 2008. | 2008 | Through Circular # 19/2005/TT-BVHTT of 12 May 2005, the government had had guidelines for the implementation of a comprehensive ban on tobacco advertisement, promotion, and sponsorship. However there were loopholes on points-of-sale advertising and products display, while the ban of sponsorship was only partial (only those sponsorships directly related to advertisement were banned). The 2008 Circular provided supplements to Circular 19 on the products display issue. | NA |