GATS | GLOBAL ADULT TOBACCO

COMPARISON FACT SHEET
VIET NAM 2010 & 2015

BACKGROUND

The Global Adult Tobacco Survey (GATS) is a global standard protocol for systematically monitoring adult tobacco use (smoked and smokeless) and tracking key tobacco control indicators. This household survey collects data on persons 15 years of age and older. In Viet Nam, GATS was conducted by the Ministry of Health in collaboration with Hanoi Medical University, and General Statistics Office of Viet Nam. In Viet Nam, GATS was first conducted in 2010 and repeated in 2015. Both surveys used similar multistage stratified cluster sample designs to produce nationally representative data. There were 9,925 interviews conducted in the 2010 survey, resulting in an overall response rate of 92.8%. There were 8,996 interviews conducted in the 2015 survey, resulting in an overall response rate of 95.8%.

GATS enhances countries' capacity to design, implement, and evaluate tobacco control programs. It also helps assist countries in fulfilling their obligations under the World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC) to generate comparable data within and across countries. WHO has developed MPOWER, a package of six evidence-based demand reduction measures contained in the WHO FCTC.

Monitor tobacco use and prevention policies

Protect people from tobacco smoke

Offer help to quit tobacco use

Warn about the dangers of tobacco

Enforce bans on tobacco advertising, promotion and sponsorship

Raise taxes on tobacco

HIGHLIGHTS

- The smoking prevalence tended to be lower compared with 2010 for overall (23.8% in 2010 vs 22.5% in 2015) and among men (47.4% vs 45.3%) and among women (1.4% vs 1.1%).
  - The smoking prevalence of any cigarette significantly declined for overall from 19.9% in 2010 to 18.2% in 2015
  - The overall smoking prevalence of any smoked tobacco product in urban area significantly decline from 23.3% in 2010 to 20.6% in 2015. In which, this prevalence in men was 47.7% in 2010 and 42.7% in 2015.
  - The smoking prevalence of any cigarette among men in urban significantly decline from 45.2% in 2010 to 38.7% in 2015.
- The prevalence of indoor secondhand smoke (SHS) exposure in most places significantly declined from 2010 to 2015, including in the home (73.1% to 59.9%), workplace (55.9% to 42.6%), universities (54.3% to 37.9%), public transportation (34.4% to 19.4%), and schools (22.3% to 16.1%).
- The proportion of current smokers who received advice to quit by a healthcare provider when visiting health facilities increased from 29.7% in 2010 to 40.5% in 2015.
- There was no increase in quitting smoking as the proportion of former smokers among ever smokers remained unchanged from 2010 to 2015 (29.3% and 29.0%, respectively).
- There was an increase in the public's awareness about the harmful health effects of smoking and exposure to SHS between 2010 and 2015.
  - The proportion who believed smoking causes stroke, heart attack, and lung cancer significantly increased from 2010 to 2015 (55.5% to 61.2%).
  - The proportion who believed SHS causes serious illness to non-smokers significantly increased from 2010 to 2015 (87.0% to 90.3%).
- The percentage of persons aged 15-24 years who reported noticing cigarette advertising and promotions significantly declined between 2010 and 2015 (25.3% to 19.8%).
- The average amount paid for 20 manufactured cigarettes tended to be lower (12,700 VND in 2010 after adjusting for inflation; 11,800 VND in 2015).

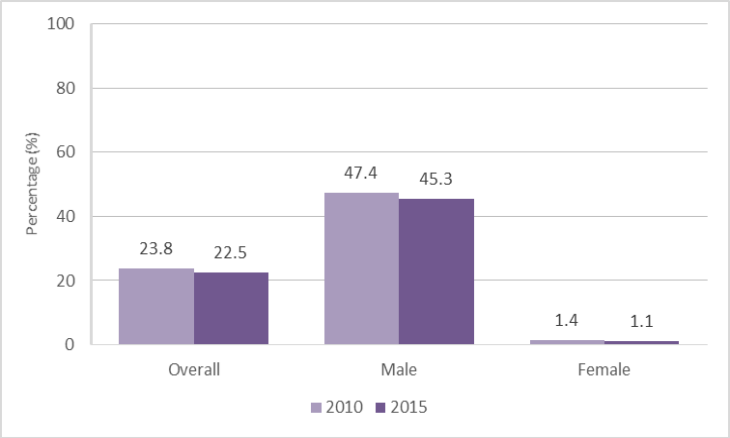
KEY MESSAGES

- Progress has been made in implementing smoke-free policies resulting in the reduction of SHS exposure in Viet Nam. However, exposure to SHS remains high in homes, at workplaces, and in public places, especially inside restaurants (80.7%). 100% smoke-free policies and enforcement in public areas such as restaurants, bars, and coffee/tea shops, can reduce involuntary SHS exposure indoors.
- Continuously implementing comprehensive tobacco control efforts can significantly reduce the tobacco smoking prevalence.
- Increasing the tax and price of tobacco products is an evidence-based strategy proven to reduce consumption. Because the tobacco tax has only been increased slightly, it has not impacted the overall price of tobacco. Increasing the tax high enough will assist in reducing the affordability of tobacco.
- Monitoring and enforcing comprehensive prohibitions on tobacco advertising, promotion, and sponsorship (TAPS) can help protect youth from TAPS exposure, especially at points-of-sale.
- It is important for communication activities to continue to be strengthened in order to sustain and increase public awareness about the dangers of tobacco use and toward changing smoking behaviors.
- Implementation of cessation services or programs can encourage and support smokers to quit.

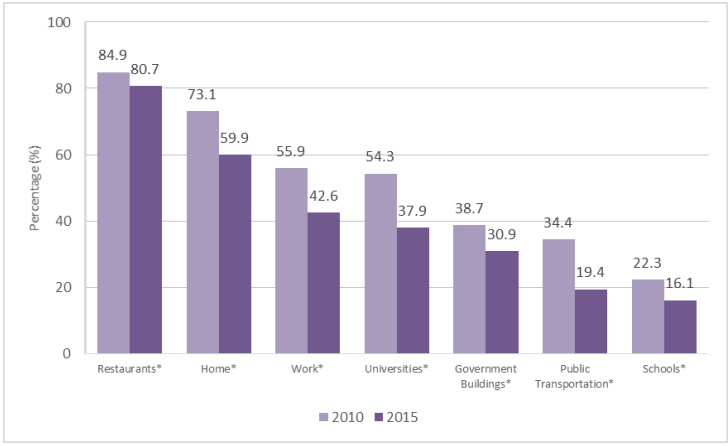
GATS | GLOBAL ADULT TOBACCO

COMPARISON FACT SHEET
VIET NAM 2010 & 2015

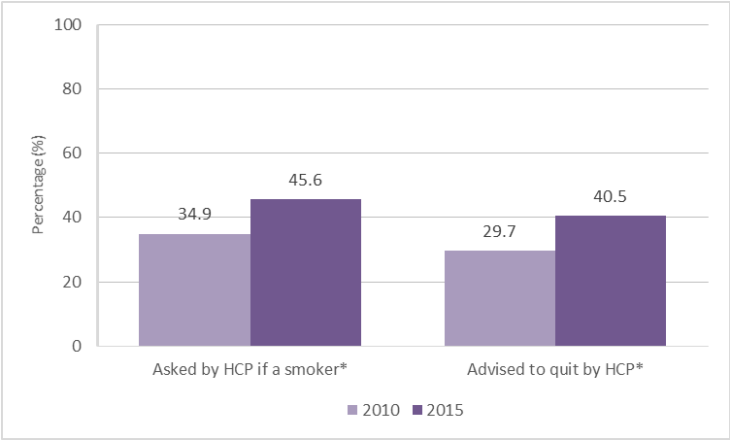
Prevalence of Current Tobacco Smoking, by Gender, 2010 and 2015



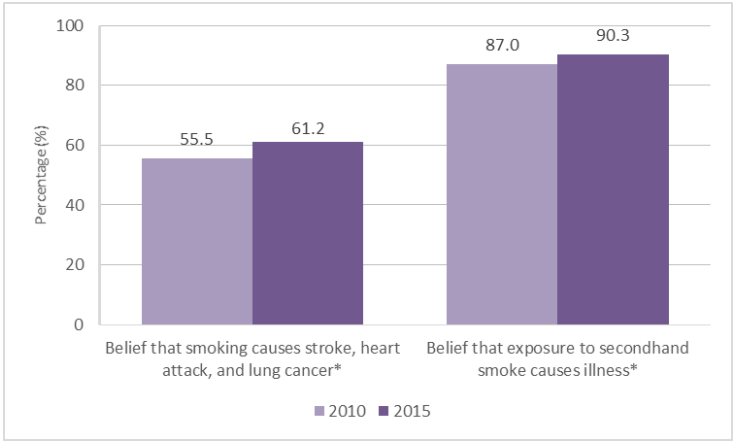
Exposure to Secondhand Smoke Inside Various Places in the Past 30 Days, 2010 and 2015



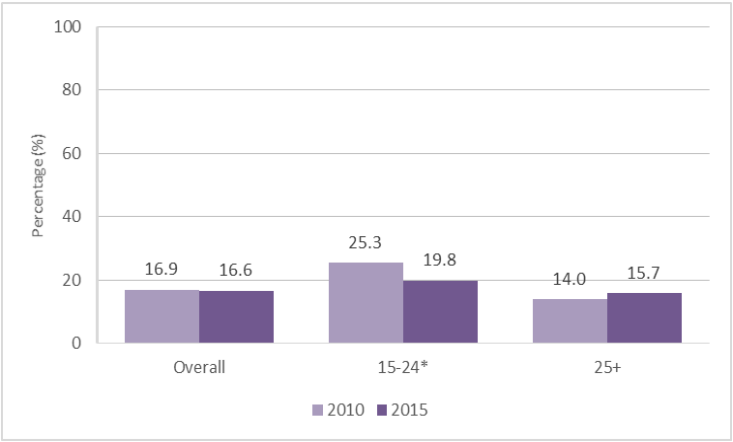
Smokers who Received Healthcare Provider Advice in the Past 12 Months, 2010 and 2015



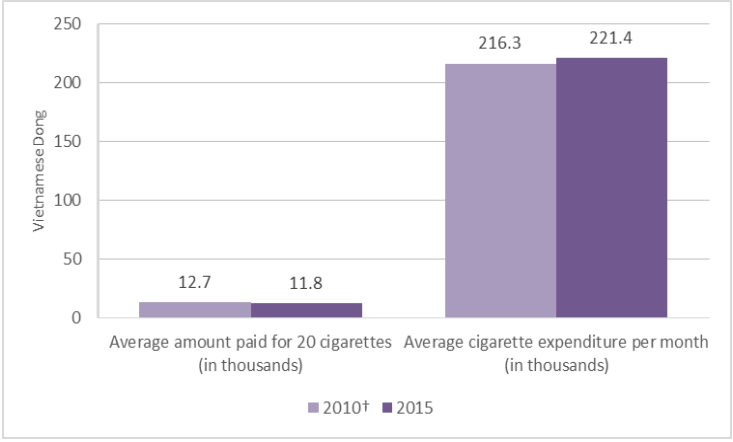
Belief that smoking and exposure to secondhand smoke exposure causes illness, 2010 and 2015



Noticing any Cigarette Advertisement, Sponsorship, or Promotion in the Past 30 Days by Age, 2010 and 2015



Average Amount Paid for 20 Manufactured Cigarettes and Average Cigarette Expenditure per Month, 2010 and 2015



NOTE: Current use refers to daily and less than daily use. Adults refer to persons aged 15 years and older. Data have been weighted to be nationally representative of all non-institutionalized men and women aged 15 years and older. Percentages reflect the prevalence of each indicator in each group, not the distribution across groups. * Indicates comparison is statistically significant at p<0.05. † GATS Viet Nam 2010 cost data were adjusted for inflation for direct comparison to 2015.

Financial support was provided by the Bloomberg Initiative to Reduce Tobacco Use through the CDC Foundation with a grant from Bloomberg Philanthropies and the Bill & Melinda Gates Foundation. Technical assistance was provided by the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), and RTI International. Program support was provided by the CDC Foundation.