JOINT NATIONAL CAPACITY ASSESSMENT
ON THE IMPLEMENTATION OF
EFFECTIVE TOBACCO CONTROL POLICIES IN

Viet Nam
Joint national capacity assessment on the implementation of effective tobacco control policies in Viet Nam
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<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<td>CATS</td>
<td>Core Adult Tobacco Survey</td>
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<td>CIF</td>
<td>cost, insurance, freight</td>
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<td>COP</td>
<td>Conference of the Parties</td>
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<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
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<td>DALY</td>
<td>disability-adjusted life years</td>
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<td>FTE</td>
<td>full-time equivalent</td>
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<td>GATS</td>
<td>Global Adult Tobacco Survey</td>
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<td>GHPSS</td>
<td>Global Health Professionals Student Survey</td>
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<td>GSO</td>
<td>General Statistics Office</td>
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<td>GTSS</td>
<td>Global Tobacco Surveillance System</td>
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<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
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<td>HMU</td>
<td>Harbin Medical University</td>
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<td>HPF</td>
<td>Health Promotion Foundation</td>
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<td>IEC</td>
<td>information, education and communication</td>
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<td>INB</td>
<td>Intergovernmental Negotiating Body</td>
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<td>MOCST</td>
<td>Ministry of Culture, Sports and Tourism</td>
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<td>MOF</td>
<td>Ministry of Finance</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOIC</td>
<td>Ministry of Information and Communication</td>
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<td>NCDs</td>
<td>Noncommunicable diseases</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<td>NRT</td>
<td>nicotine replacement therapy</td>
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<td>point of sale</td>
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<td>PPP</td>
<td>purchasing power parity</td>
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<td>second-hand smoke</td>
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<td>tobacco advertising, promotion and sponsorship</td>
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<td>Law on prevention and control of tobacco harms</td>
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<td>TFI</td>
<td>Tobacco Free Initiative</td>
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<td>value-added tax</td>
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<td>Viet Nam Public Health Association</td>
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<td>WHO FCTC</td>
<td>WHO Framework Convention on Tobacco Control</td>
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<td>WPRO</td>
<td>WHO’s Regional Office for the Western Pacific</td>
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<td>WTO</td>
<td>World Trade Organization</td>
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Executive summary

INTRODUCTION

Tobacco imposes a significant health and economic burden in the Socialist Republic of Viet Nam. Tobacco use is estimated to be responsible for up to 90% of lung cancers, 30% of all cancers, 75% of chronic obstructive pulmonary disease (COPD) and 25% of ischemic heart diseases. Noncommunicable diseases (NCDs) are increasing rapidly in Viet Nam, accounting for more than 62% of all hospital deaths and cases.

Viet Nam has a large population, ranking thirteenth in the world. More than 15 million Vietnamese adults are currently tobacco smokers. Among these, 13 million smoke cigarettes, and 4 million smoke water pipes. The total and per capita cigarette consumption in Viet Nam almost doubled between 2000 and 2010. Today, 47% of adult males smoke. In addition, 33 million adults are exposed to second-hand smoke (SHS) at home, and 5 million more are exposed at the workplace. Tobacco causes more than 40,000 deaths per year, three times more than the number caused by traffic injuries and more than the total deaths caused by HIV/AIDS up to 2008. Furthermore, it is estimated that 10% of the total disability-adjusted life years (DALY)1 among men result from tobacco use.

Additionally, while tobacco farming, manufacturing and trading have been praised as contributors to the GDP in Viet Nam, it is now evident that tobacco-related diseases and mortality impose a very significant burden on the economy of the country. In 2007 alone, VND 2304 billion was spent on treatment for only three of the more than 25 tobacco-related diseases, in addition to many other direct costs and all of the indirect costs. International research indicates that the sum of these costs is much greater than the taxes generated by tobacco use and any other economic effects of tobacco farming, trade and manufacturing. In summary, tobacco use perpetuates poverty, impacting negatively the health of individuals and the well-being of households, as well as the economy of the country.

Recognizing the persistent increase of the health and economic burden posed by tobacco, Viet Nam’s government has made progressive efforts to reduce the use of tobacco and is tackling its serious consequences. The benefits of the National Tobacco Control Programme’s commitment to curbing the tobacco epidemic can already be observed. Government efforts started with the establishment of the Steering Committee on Tobacco Control at the Ministry of Health (MOH) in 1989. Many tobacco control actions were subsequently undertaken, as shown in Figure 1. Major milestones include the adoption in 2000 of a Resolution of the Government on National Tobacco Control Policies for the following ten years, the establishment in 2001 of the Steering Committee of National Tobacco Control Program and the ratification in 2004 of the WHO Framework Convention on Tobacco Control (WHO FCTC). Three years later, in 2007, the government established at the MOH the standing office of the Viet Nam Steering Committee on Smoking and Health (VINACOSH), and in 2009, the Prime Minister issued Decision No. 1315, which introduced a series of measures aimed at the implementation of the WHO FCTC. Recently, the government decided to scale up its efforts through a new tobacco control law (LPCTH), and it established a drafting committee to prepare the text. The draft LPCTH is still in the review process within the government and most likely will be sent to the National Assembly, with a first reading in October 2011, to be followed by a second reading in May or June 2012.

1 DALY is the sum of the years of potential life lost due to premature mortality and the years of productive life lost due to disability.
Despite significant progress, Viet Nam still faces numerous challenges in tobacco control. The high rate of smoking among adult males and the social acceptability of tobacco hinders tobacco control efforts and has been well documented as a key factor leading to the high prevalence of exposure to SHS of non-smokers, particularly women and children. In addition, the current size and operations of the tobacco industry pose a challenging environment for the introduction of tobacco control measures. Further progress is both necessary and possible, and it is the responsibility of the Vietnamese government to strengthen the implementation of policies, programs and services to curb the tobacco epidemic in the country.

**METHODOLOGY**

In August 2011, at the request of the MOH of Viet Nam, a mission led by WHO performed an assessment of the national capacity of Viet Nam to implement the WHO FCTC, with special emphasis on the WHO MPOWER package of demand reduction policies (Monitor tobacco use and interventions, 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). WHO, through its country office in Viet Nam and the WHO Western Pacific Regional Office, worked together with the MOH to organize and conduct the joint capacity assessment. A group of 18 national, international and WHO health experts interviewed 69 individuals representing 54 institutions involved in tobacco control in the country and reviewed tobacco epidemiologic and other data, as well as the status and present development efforts of key tobacco control measures undertaken by the government in collaboration with other sectors. The experts were divided into eight teams that worked in Ha Noi, Ho Chi Minh City and Ha Long. The key informant institutions included the majority of the tobacco control stakeholders in the country, including central and local governmental agencies with regulating roles or implementing responsibilities, civil society and academia.

The health experts also examined, where appropriate, the underlying capacities for policy implementation, including leadership and commitment to tobacco control; programme management and coordination; intersectoral and intrasectoral partnerships and networks; and human and financial resources and infrastructure. Finally, the expert group made recommendations based on the key findings of its analysis to further the development of the MPOWER demand reduction policies of the WHO FCTC, and also to promote the control of illicit trade and, most importantly, the establishment of a National Fund for Prevention and Control of Tobacco Harms.
RECOMMENDATIONS TO FACE KEY CHALLENGES

To reduce the NCD burden in Viet Nam in the near future, tobacco use must be controlled now. Comprehensive and effective implementation of the WHO FCTC provisions will effectively reduce tobacco use and its burden in the country. In light of the most significant and immediate challenges to continued progress of tobacco control in Viet Nam, the following recommendations are considered to be critical and to have the greatest potential for success in the short term in ensuring the sustainability of current initiatives and making further progress. These recommendations should be implemented by the government in collaboration with relevant stakeholders (with the exception of the tobacco industry and its front groups and allies) within the next 12 to 18 months.

1. Funding for tobacco control

Challenge: Currently, tobacco control in Viet Nam is underfunded, endangering the successful implementation of tobacco control measures.

Although the benefits of promoting health and reducing the harmful health effects of tobacco use are recognized in Viet Nam, tobacco control is still underfunded. Funding relies heavily on international donors (90%), while contributions from the government are limited (10%). Not all ministries at the central level with assigned responsibilities in tobacco control have been allocated sufficient budget, and the majority of the provincial governments, which are at the front line for enforcing various decisions on tobacco control and mobilizing public support, either have not allocated a tobacco control budget at all or have funded some project-based work with limited life and lack of long-term effectiveness. This effort is neither sustainable nor sufficient. Therefore, the government is considering the establishment of a National Fund for Prevention and Control of Tobacco Harms. However, it appears that ongoing discussions on what kind of mechanism should be used for managing the fund seem to distract attention from the main aspects of the debate, namely, the urgent need to establish the fund and make it available for the tobacco control efforts in the country.

Recommendation: The National Fund for Prevention and Control of Tobacco Harms urgently needs to be established, as described in the draft LPCTH.

It is critical that Viet Nam has adequate and sustainable funding for averting the tobacco epidemic. Hence the proposal under the current draft LPCTH in Article 28, National Fund for Prevention and Control of Tobacco Harms, should be approved and implemented without delay. The funds should come from tobacco users, collected through tobacco companies, as proposed in the draft LPCTH. The MOH and Ministry of Finance (MOF) should eventually ensure effective administration and distribution of funds to implement a wide range of tobacco control initiatives across the country. With this funding mechanism, the government can finance, among other things, relevant tobacco control programmes for all involved ministries and at all levels, particularly public education and communication. Tobacco control and health-promotion funds have been introduced in other parts of the world, including Asian countries such as Korea, Singapore, Malaysia and Thailand. Such funds have effectively strengthened the implementation and enforcement of tobacco control and efficiently enabled mass media communication to raise public awareness of the harm caused by tobacco use.

2. Protection from second-hand smoke

Challenge: The new LPCTH, as drafted, fails to protect non-smokers from exposure to SHS in the hospitality sector (bars and restaurants) and in selected means of transportation.

Almost 90% of non-smokers are exposed to SHS in bars, cafes and tea shops, and 81% are exposed to SHS in restaurants. The latest version of the draft LPCTH fails to provide the effective protection measures specified by the WHO FCTC Article 8 guidelines by allowing smoking or designated
smoking rooms in public places and workplaces such as restaurants, bars, karaoke lounges, hotels and discos and on public transport such as ships and trains. These are workplaces for many, and their right to live and work in 100% smoke-free environments should be upheld.

**Recommendation:** Improve the wording of Article 10 of the draft LPCTH by removing the option of smoking areas to protect the health of all, in line with the WHO FCTC Article 8 guidelines. Smoking indoors should not be allowed, and therefore there should be no indoor smoking areas. If removal of all indoor smoking areas is not possible now, the following changes should be made to Article 10 of the draft LPCTH:

a. Article 10 should have a road-map provision to introduce a total smoking ban in the public places mentioned in the article, with a clearly specified deadline. This deadline should be as soon as possible but not later than three to five years after the approval of this law.

b. Elaborate the requirements of smoking areas; at a minimum,
   b.1. The smoking area in restaurants, bars, karaoke lounges and discos should be one single room completely enclosed and physically separate from the non-smoking area, with a ventilation system separate from that of the non-smoking area and with a surface no larger than 25% of the total surface area accessible to the public.
   b.2. On ships, smoking areas should always be located in clearly signalled open areas. No designated smoking areas should be permitted on trains that do not have open areas, and trains should be covered under Article 9.
   b.3. Smoking should be allowed in only a limited number of contiguous hotel guest rooms located on floors where smoking is permitted, not to exceed 25% of the total number of guest rooms of the entire hotel complex.
   b.4. The Minister of Health should be given the authority to specify further requirements for smoking areas, such as not allowing the provision of service at any time by workers or volunteers, to avoid exposing them to SHS.

3. **Warning about the harms of tobacco: packaging and labelling**

**Challenge:** The current text-based health warnings have low impact and effectiveness and are not in line with WHO FCTC Article 11 guidelines or the regional and global trend of applying effective pictorial health warnings.

Good research evidence shows the low impact of text-based warnings and the potential effectiveness of using pictorial health warnings in Viet Nam. In a study conducted by CDS and VINACOSH in 2009, the majority of smokers (60%) in Viet Nam said that the current text-based health warnings did not make them want to quit, and the great majority (82%) thought that pictorial health warnings on cigarette packs should cover 50% of the main surfaces of each pack. Furthermore, a study based on a tobacco control policy-simulation model conducted by Levy et al. in 2006 showed that implementing pictorial health warnings in Viet Nam would help to avoid between 300 and 700 premature deaths each year for many decades to come. In addition, a study on the cost-effectiveness of pictorial health warnings in Viet Nam conducted by the Health Policy and Strategy Institute in 2011 concluded that pictorial warnings would be extremely cost-effective, with a cost to the government of only VND 500 for each additional DALY saved.

WHO FCTC Article 11 guidelines recommend that (1) health warnings on packages of tobacco products should use coloured pictures together with text, because pictures are much more effective than text alone; (2) health warnings should be printed on the principal display areas in the front and back of the
packs; (3) the size of health warnings should occupy 50% or more of the principal display areas of the packs—the larger the health warnings, the more effective they are; (4) health warnings that are printed on the top part of the display area of the packs are more effective than those printed on the lower parts; (5) packs should carry a variety of warnings to communicate different aspects of the harms of tobacco and SHS; and (6) health warnings must be renewed periodically, ideally every one or two years, to make them fresh to viewers. Worldwide, more than 40 countries have applied pictorial health warnings, including four ASEAN countries: Brunei, Malaysia, Singapore and Thailand.

Misperceptions about the consequences of introducing pictorial health warnings are still part of the debate: Some people believe that pictorial health warnings will cause an increase in the smuggling of tobacco products. This belief is not supported by the evidence. In all countries that have implemented pictorial health warnings, there has been no increase of smuggling. Moreover, the presence of pictures on the packages makes it easier for authorities to differentiate between legal and illegal products and therefore assists in the control of smuggled tobacco products. There is also a fear that the use of shocking pictures is inappropriate for an Asian country like Viet Nam. This fear is not realistic; all countries that have applied pictorial health warnings have used shocking pictures, including many countries in Asia such as Thailand, Singapore, Malaysia, Brunei, India, Iran and Mongolia.

Recommendation: Viet Nam should take a firm position to implement coloured pictorial health warnings that occupy 50% of the front and rear of cigarette packs.

Given international evidence on the effectiveness and cost-effectiveness of pictorial health warnings demonstrated by research in Viet Nam and other countries, the WHO FCTC Article 11 guidelines, the world and regional trend on using pictorial health warnings and the other findings from interviews, it is recommended that

a. Coloured pictorial health warnings should occupy 50% or more of the principal display areas of cigarette packs and be located on the upper part of the display surfaces.

b. There should be a set of 6 to 10 health warnings with strong images of harmful consequences of smoking, to be used at the same time on the packages of different cigarette brands.

c. Health warnings should be renewed every one or two years to avoid decreasing their educational effect on viewers.

d. Article 13.4 of the draft TCL should be revised to read: “The government is to decide on further increases on the size of the health warnings in the future based on the requirement of prevention and control of tobacco harms and per the proposal from Minister of Health”. The part mentioning “depending on situation of smuggling control” should be deleted.2

4. Ban on tobacco advertising, promotion and sponsorship

Challenge: Although both the existing legislation and the draft law have strong provisions to protect people from tobacco advertising, promotion and sponsorship (TAPS), there are still remaining gaps in comparison with the requirements of WHO FCTC Articles 13 and 16.

So-called “kiddie packs” (packages with fewer than 20 cigarettes) not only are allowed according to circular 78 (packs of 10, 12, and 20 cigarettes) but are also ubiquitous. According to a study done by the Hanoi School of Public Health in 2010, 28% of retail outlets sold kiddie packs, which increases access to and use of tobacco products by minors and makes pictorial health warnings less effective because of the small size of display areas.

Tobacco sponsorship of philanthropic work is allowed, ongoing and in conflict with the obligations of the WHO FCTC. The Vietnamese government has restricted promotion by the tobacco industry in the current

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2 Further drafting work has taken place on the draft LPCTH between the in-country Capacity Assessment and the production of the report. The specific recommendation for Article 13.4 has been addressed by the 5th draft dated 21/11/2011.
draft of the law, stating that the industry itself cannot publicize its support in mass media. However, there are limitless possibilities for the industry to promote itself through communications by its allies and others and thus continue building legitimacy at various levels of government and society.

The enforcement of provisions regarding advertising at the point of sale (POS) is challenging. The Hanoi School of Public Health study shows that in 2010, 93% of the retail stores selling tobacco products violated the provisions restricting the display at POS to one pack or one carton per brand name, resulting in unlimited visibility of tobacco. The new draft law substantially weakens the existing provision by allowing display of one pack per product per brand. This will severely undermine public health.

The use of colour schemes imitating tobacco products and depicting brand images is not restricted by the current legislation. (Circular 19/2005/TT-BVHTT restricted the use of colours, but circular 78/2008/TT-BVHTTDL further allowed it.) The use of colours is not addressed in the current draft LPCTH, and this omission is widely exploited by the industry for surrogate advertising.

Recommendation: The government should address the remaining gaps within existing legislation and draft LPCTH regarding the ban on TAPS, as required by WHO FCTC Articles 13 and 16.

a. Implement the ban on kiddie packs defined in Article 23, clause 2, of the draft LPCTH as soon as possible but no later than three years after approval of this law.

b. Article 15 of the current draft LPCTH, which restricts announcements of sponsorship of philanthropic work by the tobacco industry representatives themselves, should be revised to reflect restriction on any mass media announcement of sponsorship. The industry currently has limitless possibilities for promoting itself on mass media through announcements made by others and thus can continue building legitimacy at various levels of government and society. 3

c. Article 25.1 (b) of the draft LPCTH should be revised to correspond, at a minimum, with the existing legislation that allows for display of only one pack or one carton per brand.

d. Circular 78/2008/TT-BVHTTDL, which allows for the display of colours imitating tobacco products at POS, should be revised. The preceding circular (19/2005/TT-BVHHTT) restricted such displays, but it was revoked in 2008.

5. Preventing tobacco industry interference

Challenge: The tobacco industry is reported to have undue influence over Viet Nam’s tobacco control policy.

Article 5.3 of the WHO FCTC mandates that its Parties protect public health policies from commercial and other vested interests of the tobacco industry, because there is a fundamental and irreconcilable conflict between the tobacco industry’s interests and public health policy interests. However, the tobacco industry of Viet Nam – including the Viet Nam Tobacco Association – influences tobacco control policies to the detriment of the people’s health. Examples of such presence and influence include reports of the tobacco industry bringing officials of the Government and other institutions on study tours around the world, as well as presence in discussions and decisions regarding tobacco control measures. Finally, provisions on tobacco production and trade are mixed with tobacco control provisions in the current draft of the LPCTH, leaving no clear message on whether tobacco control is a priority.

Recommendation: The Vietnamese government should take appropriate measures to prevent the undue influence of the tobacco industry.

Viet Nam should ensure compliance with WHO FCTC Article 5.3 and its guidelines for implementation. In this regard, the country should consider mechanisms to prevent potential interference from the

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3 Further drafting work has taken place on the draft LPCTH between the in-country Capacity Assessment and the production of the report. The specific recommendation for Article 15 has been addressed by the 5th draft dated 21/11/2011.
tobacco industry in all levels of decision making decisions on tobacco control matters. Advocacy to raise awareness and support of policy makers on the implementation of Article 5.3 is key, along with means to eliminate tobacco industry participation in tobacco control meetings, discussions and decision forums for regulation and legislation. Finally, issues related to tobacco control should not be part of the same regulations that address trade, manufacture, growing and production. Vietnamese officials would benefit from learning from the experiences of other countries, such as Thailand, in addressing Article 5.3 and its guidelines.

6. Warning about the harms of tobacco: mass media communication

Challenge: Current mass media communication efforts in Viet Nam are inadequate in intensity and limit effectively informing the population about the harms of tobacco.

Evaluation of two research-based mass media campaigns conducted in Viet Nam showed that such campaigns can be effective not only in increasing awareness of the harms of tobacco and of exposure to SHS but also in making smokers more likely to quit and to stop exposing others to their smoke. VINACOSH and a number of agencies at national and provincial levels have produced a significant quantity of information, education and communication (IEC) materials. However, the level of exposure of the population to well-researched, effective tobacco control campaigns is currently insufficient to significantly contribute to reducing smoking prevalence in Viet Nam. Global Adult Tobacco Survey (GATS) 2010 found that only 50% of male smokers and 27% of female smokers believe that smoking causes stroke, heart attack and lung cancer. In addition, only 60% of male non-smokers and 56% of female non-smokers believe this, indicating that the level of knowledge about smoking-related harm is not high among non-smokers either. Part of the problem is that commitment of human and financial resources for tobacco control communication and education is inadequate, and mass media campaigns must rely on continued financial contributions from international organizations.

Recommendation: Dedicate sufficient funding to ensure sustainable, comprehensive tobacco control mass media campaigns of adequate intensity and content. Further tobacco control campaigns should be designed to support and reinforce policy implementation in the draft LPCTH and other NCD strategies, and prime-time broadcast spots on national and provincial television and radio channels should be committed for tobacco control communication. Dedicated funding for national tobacco control IEC is required to enable further ongoing, comprehensive, research-based mass media campaigns to be developed and implemented, coordinated at the national and provincial level and supported and reinforced though community-level education activities and resources.

It is recommended that the draft LPCTH be amended to include a provision that Ministry of Information and Communication (MOIC) will direct provincial television and radio channels to allocate a concrete amount of free airtime in prime-time period to broadcast spots for tobacco control public service announcements.

7. Increasing tobacco taxes and prices

Challenge: The current excise tax on tobacco and prices are too low, according to best practice standards. In addition, the current excise tax structure presents opportunities for tax evasion and avoidance and keeps a wide gap between cheap and expensive products.

Despite a statutory excise rate of 65% of the ex-factory price, the actual excise tax rate (not including the value-added tax [VAT]) as a percentage of the retail price of the most sold brand is about 32%. This rate is very far from the WHO recommendation that the excise tax rate should be at least 70% of the retail price. Adding the VAT rate, the total tax rate is about 41%, which is below the global average (52%) and lower than the rate in neighbouring countries such as Indonesia (54%), Singapore (67%), Thailand (69%), Myanmar (50%) and Malaysia (52%).
In addition, the price of a pack of the most popular brand of cigarettes is low in Viet Nam (US$ 1.29 PPP [purchasing power parity]) compared with the prices in neighbouring countries such as Thailand (US$ 3.38 PPP), Indonesia (US$ 2.14 PPP) or Malaysia (US$ 5.54 PPP). Evidence also shows that the real price of cigarettes (adjusted for inflation) in Viet Nam has been decreasing in recent years, while per capita income has risen significantly, making tobacco products more affordable with time.

The ad valorem rate is imposed on the ex-factory price (or producer price), which is reported by the tobacco industry, making it easy for the industry to underreport the true price in order to reduce its tax burden.

**Recommendation:** Tobacco excise taxes should be increased in order to increase prices and make tobacco products less affordable, and they should be restructured to make them more effective in increasing revenues and reducing consumption.

This is the right time for the government to increase tobacco excise taxes in a sustainable way and not be reliant on a one-time increase; taxes are low, and there are a number of opportunities to move this issue forward. Prime Minister Directive 12/2007 and Decision 1315/2009 laid the groundwork for the justification of a tax increase. And Prime Minister Decision 732/2011, which approves the strategy for reforming the tax system, provides a concrete path for putting the tobacco tax revision on the table.

To avoid increasing the price gaps between cigarette brands following a tax increase and subsequent substitution in consumption, the government could consider introducing a specific tax amount in addition to the ad valorem rate. This would keep a balance between imposing a higher tax rate on more expensive products and at the same time reducing the price gap. Alternatively, the government could choose to impose an ad valorem tax with a minimum specific excise tax. This change could also be added in the proposed revised Special Consumption Tax Law.

### 8. Control of tobacco smuggling

**Challenge:** There is no independent and reliable source of information on the level of smuggling of cigarettes in Viet Nam, but evidence shows that, in any case, the tax level does not affect smuggling. Because few research studies on cigarette smuggling have been conducted in Viet Nam, there is little evidence for strategy and policy development and ineffective enforcement of cigarette smuggling in the country. Licensing has not been applied to cigarette retailers, so it is difficult for the government to monitor and enforce regulations on smuggled cigarette sales and consumption. GATS 2010 indicated that the average prices of Jet and Hero cigarettes, which account for more than 90% of the total smuggled cigarette market, were approximately 60% and 30% higher, respectively, than the average price of all other cigarette brands.

**Recommendation:** The government should strengthen smuggling control by establishing a system to track cigarette manufacturing distribution and retail and by requesting an independent assessment of the level of smuggling.

Prices of the most popular smuggled brands are already higher than the average price of all other cigarettes. The argument that raising the excise tax will cause higher prices of legal products and make consumers switch to smuggled products is not valid. The government should increase the tobacco excise tax now to reduce consumption without worrying about increasing smuggling.
Research on the current situation, investigation of lessons from other countries on this issue and development of a retail management model need to be conducted to step-by-step manage cigarette retailers. This will also be beneficial in addressing other tobacco control and trade violations at POS, such as advertising and promotion and selling cigarettes to minors. Seeking regional cooperation while waiting for the WHO Illicit Trade Protocol to be finalized and approved is a creative step taken by the country, and time and efforts should be invested in this. Any involvement of the tobacco industry in the process, including funding for smuggling control, should be rejected.

In any case, the government and public health organizations should invest efforts and resources in research to better understand the level, causes and features of cigarette smuggling, although such research is difficult because of the illegal nature of the activity. Sound scientific-based evidence for smuggling control policy development can improve the effectiveness of cigarette smuggling control.

Other recommendations offered by the team of experts for each of the tobacco control policies assessed are included in this final report.

WHO is grateful to the government of Viet Nam, VINACOSH, nongovernmental organizations (NGOs) and other organizations concerned with tobacco control in the country for leading the joint national tobacco control capacity assessment. Many other WHO Member States will follow and will benefit from the lessons learned during this assessment.
1. Introduction

The Socialist Republic of Viet Nam has a total population of 85.5 million people (2009), ranking third in Southeast Asia and thirteenth in the world in population size. It has 63 provinces, 54 ethnic groups and one official language (Kinh), which is spoken by 87% of the population.

Viet Nam has a number of public health challenges, including injuries, HIV/AIDS and lung diseases. Noncommunicable diseases (NCDs) such as acute myocardial infarction and stroke have increasingly become a concern in the country and are attributed to changes in social economic development and lifestyles. It is estimated that tobacco use causes about 40,000 deaths per year – more than the total deaths cause by HIV/AIDS up to 2008 (38,648) and three times the number caused by transportation injuries in 2007 (13,200) (Levy, 2006). Tobacco use and exposure to second-hand smoke (SHS) are thus major public health problems in Viet Nam. The numbers speak for themselves:

1. 47.4% of adult males in Viet Nam currently use tobacco products, primarily cigarettes and water pipes (GATS, 2010); adult women smoke much less, with a prevalence rate of 1.4%.

2. 5.9% of boys and 1.2% of girls are current smokers (GYTS, 2007), resulting in different ratios when compared with the adult population.

3. 20.7% of male and 2.7% of female medical students are current smokers (GHPSS, 2006); only 27.4% of the individuals in this group report receiving information on cessation approaches to use with patients.

4. 67.6% of non-smokers (33 million people) are exposed to SHS at home, and 49% of non-smokers are exposed in the workplace (GATS, 2010).

Viet Nam has a long-time commitment to curbing the tobacco epidemic, and the results of the National Tobacco Control Programme can already be seen. Government efforts started in 1989 with the establishment of the Steering Committee on Tobacco Control at the Ministry of Health (MOH). Many tobacco control actions were subsequently undertaken, as shown in Figure 1.1. Major achievements include the following:

- In 2001, the Steering Committee of the National Tobacco Control Program was established under Prime Minister Decision No. 467/QDTTg.
- In 2004, Viet Nam ratified the WHO FCTC.
- In 2007, Viet Nam Steering Committee on Smoking and Health (VINACOSH) was established under Minister of Health Decision No. 2830/QD-BYT.
- In 2007, Prime Minister Directive No12/CT-Ttg on strengthening tobacco control was issued.
- In 2009, Prime Minister Decision 1315 established the National Plan for WHO FCTC implementation.
- Recently, the government of Viet Nam established a drafting committee to prepare a new tobacco control law (LPCTH). The draft LPCTH was submitted to the government in July 2011 for review. It was to be submitted to the Social Affairs Committee of the National Assembly for review in September before being brought to a hearing at the plenary meeting of the National Assembly in November 2011.
Despite major progress in tobacco control, Viet Nam still faces numerous challenges. The long-term tradition of males smoking and the social acceptability of tobacco use leading to the high prevalence of exposure of women and children to SHS have been well documented and hinder tobacco control efforts.

Additionally, while tobacco farming, manufacturing and trading have been praised as activities that contributed in the past to 2% of the GDP in Viet Nam, it is now evident that tobacco-related diseases and mortality impose a very significant burden on the economy of the country. In 2007, VND 2304 billion was spent on treatment for only three of the more than 25 tobacco-related diseases (Hanoi Medical University, 2010). Introduction of a comprehensive set of effective tobacco control measures to reduce smoking in Viet Nam will contribute not only to improving the health and welfare of the people but also to reducing this significant economic burden on the country. However, the current size and operations of the industry pose a challenging environment for the introduction of such measures.

Figure 1.1. Tobacco control milestones in Viet Nam
The Viet Nam MOH, through VINACOSH leadership, is essential to strengthening the implementation of policies, programs and services to halt the tobacco epidemic. A mission led by WHO performed a joint assessment of the national capacity of Viet Nam to implement the WHO FCTC, with special emphasis on the WHO MPOWER package (Monitor tobacco use and interventions, 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 and the control of Illicit trade) of effective tobacco control policies in support of the implementation of the treaty. At the request of the Viet Nam government, WHO, through its country office in Hanoi and the WHO Western Pacific Regional Office, worked together with the MOH to organize and conduct the joint capacity assessment.

Between 15 and 22 August 2011, a group of 18 national and international experts, in collaboration with teams from the MOH and WHO, reviewed the status of present efforts, laws and activities for implementing the WHO FCTC, as well as the level of the existing capacity for tobacco control work, with emphasis on the WHO MPOWER package. The assessment team was divided into eight subteams that went into the capital city of Hanoi and travelled to Ho Chi Minh and Ha Long City to undertake key informant interviews with preselected groups, key governmental agencies, research institutions and academia, municipality officials or individuals that represented sectorwide stakeholders on tobacco control and representatives of the civil society organizations. The team also used relevant documents and background materials with information on the country. The team conducted 69 interviews with individuals from 54 institutions from various departments and institutions relevant to the tobacco control work in the country.

The group also examined, where appropriate, the underlying capacities for policy implementation, including leadership and commitment to tobacco control; programme management and coordination; intersectoral and intrasectoral partnerships and networks; and human and financial resources and infrastructure. Finally, the expert group made recommendations based on the key findings of its analysis to further the development of the demand reduction tobacco control policies of the WHO FCTC. The group also analysed issues related to the proposal of the establishment of the National Fund for Prevention and Control of Tobacco Harms.

For each policy, this report presents the following:

- **Policy status and development.** A brief introduction on the present status and future development of the policy in question, based on a thorough review of all documents made available by the coordinating team of the capacity assessment prior to the country visit (the tobacco control country profile, the WHO Report on the Global Tobacco Epidemic 2010, legislation in force, results and conclusions of previous studies and reports, etc.) and interviews with key informants.

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4 MPOWER is a WHO technical assistance package to help countries implement some provisions of the WHO FCTC. The package is an integral part of the WHO Action Plan for the Global Strategy for the Prevention and Control of Nontuberculosis Diseases, endorsed at the 61st World Health Assembly in 2008.

5 Participating institutions and key informants are listed in Annex 1.
• **Key findings.** A summary of the most important facts obtained by the assessment team in the visits and interviews. The findings are based on an analysis of key factors for success in implementing present policies and developing future ones, such as political will, programme management and coordination, partnerships and networks for implementation, provision of funds and human resources.

• **Key recommendations.** The recommendations made by the assessment team address the actions required, in line with the WHO FCTC and its guidelines and considering the legally binding obligation of the country as a Party to the WHO FCTC, to improve the design, implementation and enforcement of the tobacco control policy. Unless otherwise noted, the suggested time for implementing the recommendations is 12 months.

WHO is grateful to the government of Viet Nam and the nongovernmental organizations (NGOs) involved in tobacco control in Viet Nam for leading the way by carrying out the joint national tobacco control capacity assessment. Many other WHO Member States will follow and will benefit from the lessons learnt during this joint work.
2. Coordination and implementation of tobacco control interventions

2.1. POLICY STATUS AND DEVELOPMENT

2.1.1. Tobacco control

2.1.1.1. Policies

Viet Nam has a number of tobacco control regulations. Policy status, implementation and enforcement of regulations and laws will be discussed in the respective chapters. The main instruments are listed in Table 2.1.

Table 2.1 Viet Nam Legal Framework for Tobacco Control

<table>
<thead>
<tr>
<th>Year</th>
<th>Instrument</th>
<th>Relevant Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>Law on the Protection of People’s Health No. 21-LCT/HĐNN8</td>
<td>Banned smoking in designated public places (halls, cinemas and theatres). The law was reinforced in 1991 by a government decree.</td>
</tr>
<tr>
<td>1990</td>
<td>The Council of Ministers bans the import of cigarettes, Circular 278/1990/-CT</td>
<td>Import bans remained in place until January 2007, when Viet Nam officially joined the World Trade Organization.</td>
</tr>
<tr>
<td>1992</td>
<td>Prime Minister Directive No. 13/TTG to ban tobacco advertising</td>
<td>Banned tobacco advertising.</td>
</tr>
<tr>
<td>2000</td>
<td>Prime Minister Decision No. 175/1999/QÐ-TTg on using duty stamps on cigarette packs</td>
<td>Introduced a duty stamp to hinder smuggling and tax evasion.</td>
</tr>
<tr>
<td>2000</td>
<td>Government Resolution No. 12/2000/NQ-CP</td>
<td>Created the National Tobacco Control Policy for 2000-2010, with the overall objective of reducing the male smoking rate from 50% to 20% and maintaining the female smoking rate below 2%. The policy set out various measures including smoke-free areas, a complete ban on tobacco advertising and limitations on sponsorship.</td>
</tr>
<tr>
<td>2002</td>
<td>Advertising Ordinance No. 39/2001/PL-UBTVQH10</td>
<td>Prohibited all advertising for commodities and services that are banned or discouraged by the law (including tobacco, which falls under the category of discouraged products).</td>
</tr>
<tr>
<td>2004</td>
<td>WHO Framework Convention for Tobacco Control (WHO FCTC)</td>
<td>Viet Nam became a Party to the treaty, making the country legally bound by its provisions.</td>
</tr>
<tr>
<td>2005</td>
<td>Circular 19/2005/TT-BVHTTence Treatment</td>
<td>Provided guidance on the tobacco advertising ban.</td>
</tr>
<tr>
<td>2005</td>
<td>Revised Special Consumption Tax Law No. 57/2005/QH11</td>
<td>Unified the tax rate at 55% of the ex-factory price in 2006 and 2007 and further increased it to 65% in 2008.</td>
</tr>
<tr>
<td>2006</td>
<td>Revised Trade Law No. 36/2005/QH11</td>
<td>Banned tobacco advertising and promotion.</td>
</tr>
</tbody>
</table>
2.1.1.2. Structure, governance and key players

2.1.1.2.1. Government agencies

Viet Nam’s tobacco control activities are coordinated by a multisectoral committee, VINACOSH. The Committee is chaired by the Minister of Health and vice-chaired by the Minister of Culture, Sports and Tourism. It comprises managers of about 13 ministries who are committee members; about seven ministries assign one staff member to be part of the operational Secretariat of the Committee. VINACOSH’s Secretariat Group includes tobacco control focal points from the MOH, MOF, MOIT, the Ministry of Culture, Sports and Tourism (MOCST), the Ministry of Education and Training, the Ministry of Information and Communication (MOIC), the Labour Union, Ho Chi Minh Youth’s Union and Women’s Union (Figure 2.1).

The VINACOSH standing office coordinates the implementation of tobacco control measures in the country (Figure II.1). The MOH tobacco control focal point is the head of the VINACOSH standing office (The Director of Medical Service Administration). The VINACOSH standing office consists of 12 staff (one director, 15%; one vice director, 50%; one chief accountant, 50%; and nine full-time staff: two civil servants, four administrative staff and three project staff). The VINACOSH Committee is mandated to coordinate the implementation of the WHO FCTC in Prime Minister Decision No. 1315/QD-TTg, which approves the plan for WHO FCTC Implementation.

### Year Instrument Relevant Action

<table>
<thead>
<tr>
<th>Year</th>
<th>Instrument</th>
<th>Relevant Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Decision No. 02/2007/QD-BYT</td>
<td>Mandated health warnings on cigarette packs; moved the location of warnings from the side of the packs to the front and back, covering 30% of the display areas with two new messages.</td>
</tr>
<tr>
<td>2009</td>
<td>Decision No. 1315/QD-TTg</td>
<td>The Prime Minister issued the National Plan for WHO FCTC implementation.</td>
</tr>
<tr>
<td>2010</td>
<td>Decree No. 75/2010/ND-CP</td>
<td>Placed regulations on fines for administrative violations in cultural activities, including tobacco advertising.</td>
</tr>
<tr>
<td>2011</td>
<td>Resolution No. 07/2011/QH13</td>
<td>Required that the draft LPCTH be considered and approved by the National Assembly in May 2012.</td>
</tr>
</tbody>
</table>

Figure 2.1 VINACOSH and supporting tobacco control structure at the MOH
### Table 2.2 Key government stakeholders and their responsibilities in tobacco control (according to Decision No. 1315/QD-TTg and Decree 45/2005/ND-CP)

<table>
<thead>
<tr>
<th>Ministry / Governmental Agency</th>
<th>Tobacco Control Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At central level</strong></td>
<td></td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Organizes, directs and coordinates intersectoral programmes and prepares national tobacco control plan, implementation, monitoring and evaluation.</td>
</tr>
<tr>
<td>Ministry of Culture, Sports and Tourism</td>
<td>Directs education and communication activities and implements the ban on tobacco advertising, promotion and sponsorship (TAPS) (except mass media and publications).</td>
</tr>
<tr>
<td>Ministry of Industry and Trade</td>
<td>Directs the activities of the tobacco industry and provides studies for alternative livelihoods; combats illicit trade; implements ban of TAPS with MOCST; manages tobacco joint ventures; combats domestic smuggling.</td>
</tr>
<tr>
<td>Ministry of Finance</td>
<td>In charge of tax policy development. Directs implementation of tax policies; allocates financial resources from state budget to annual budget from ministries, sectors and provinces; monitors the application of stamps; in charge of submitting protocol for the Fund for prevention and control of tobacco harms in Viet Nam.</td>
</tr>
<tr>
<td>Ministry of Education and Training (includes universities)</td>
<td>Directs tobacco control activities among students and the teaching staff and integrates tobacco control content into school curricula.</td>
</tr>
<tr>
<td>Ministry of Planning and Investment</td>
<td>Collaborates with the MOF to ensure allocation of the budget for tobacco control nationally; controls the investments of the tobacco industry; policy development.</td>
</tr>
<tr>
<td>Ministry of Agriculture and Rural Development</td>
<td>Designs measures to promote alternative crops.</td>
</tr>
<tr>
<td>Ministry of Public Security</td>
<td>Enforces the prohibition of smoking in public places by policemen on duty; controls smuggling control; enforces fines on violations (criminal cases).</td>
</tr>
<tr>
<td>Ministry of National Defence</td>
<td>Participates in smuggling control.</td>
</tr>
<tr>
<td>Ministry of Information and Communication</td>
<td>Directs the communication and propaganda for tobacco control; enforces the ban on TAPS in mass media and publications.</td>
</tr>
<tr>
<td><strong>At local level</strong></td>
<td></td>
</tr>
<tr>
<td>Provincial People’s Committee</td>
<td>Directs implementation of tobacco control activities at the provincial level; develops annual plans and allocates budget for tobacco control activities. The Chairman of the Provincial People’s Committee has the power to sanction those who violate the law.</td>
</tr>
<tr>
<td>District and Commune People’s Committee</td>
<td>The Chairman of the District/Commune People’s Committee has the power to sanction those who violate the law.</td>
</tr>
</tbody>
</table>
2.1.1.2. Socio-political and mass organizations, intergovernmental organizations and civil society

In Viet Nam, many socio-political and mass organizations support society in improving social, economic, health and wealth status, and many of them are involved officially through VINACOSH in tobacco control activities.

Table 2.3 Some Viet Nam social organizations and their responsibilities in tobacco control

<table>
<thead>
<tr>
<th>Social Organization</th>
<th>Brief Description of Tobacco Control Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Committee of Viet Nam Fatherland Front</td>
<td>Mobilizes members; monitors compliance with smoking ban; provides education and information.</td>
</tr>
<tr>
<td>Viet Nam Farmers’ Union</td>
<td>Mobilizes members; monitors compliance with smoking ban; provides education and information.</td>
</tr>
<tr>
<td>Viet Nam Women’s Union</td>
<td>Mobilizes members; monitors compliance with smoking ban; provides education and information.</td>
</tr>
<tr>
<td>Viet Nam General Confederation of Labour</td>
<td>Mobilizes members; monitors compliance with smoking ban; provides education and information.</td>
</tr>
<tr>
<td>Ho Chi Minh Youth's Union</td>
<td>Mobilizes members; monitors compliance with smoking ban; provides education and information.</td>
</tr>
</tbody>
</table>

Some NGOs are also very active in tobacco control and work on a project basis, usually with support from international organizations. The WHO country office also participates in regular activities with VINACOSH and other implementing groups (Table 2.4).

Table 2.4 Some Viet Nam NGOs and their responsibilities in tobacco control

<table>
<thead>
<tr>
<th>NGO</th>
<th>Brief Description of Tobacco Control Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthBridge Canada in Viet Nam</td>
<td>Involved in policy communication; coordinates and conducts policy-relevant research, advocacy and capacity building, public education and support for smoke-free implementation.</td>
</tr>
<tr>
<td>Center for Research and Community Development</td>
<td>Conducts tobacco control studies; raises public awareness and supports smoke-free partnership (SFP) projects.</td>
</tr>
<tr>
<td>Viet Nam Public Health Association</td>
<td>Supports smoke-free policy implementation, policy advocacy and research.</td>
</tr>
<tr>
<td>Family Health International</td>
<td>Provides education and communication on youth and tobacco.</td>
</tr>
</tbody>
</table>

Some academic institutions, including Ha Noi Medical University, Ha Noi School of Public Health, the Institute of Public Health of Ho Chi Minh and Viet Nam University of Commerce, also participate actively in conducting research, surveillance and other tobacco control activities.
2.1.1.3. Coordinating mechanisms

2.1.1.3.1. Coordination within the government
The coordination of activities within the government falls under the VINACOSH mandate. Regular meetings are organized to coordinate initiatives among VINACOSH Steering Committee members, the secretary and the standing office. The VINACOSH Standing Committee has to submit an annual report of activities to the MOH and the Ministry of Planning and Investment. A national tobacco control plan of action was developed by Viet Nam for 2000–2010, and a second plan is being finalized for 2011–2020.

2.1.1.3.2. Coordination within the health sector
VINACOSH collaborates with different sectors of the MOH, especially with the Department of Legislation, Department of Training and Science and Department of Food Safety. In addition the Viet Nam General Labour Federation and the Health Trade Union, a close partner of VINACOSH, are involved in supervising smoke-free health-care facilities, and the Center of Health Communication and Education is designing training and communication materials and building capacity through training workshops.

2.1.1.3.3. Coordination of activities in provinces and districts
In about 10 project provinces that receive support from the Bloomberg Initiative and AP to implement smoke-free environments, steering committees have been officially established from provincial to district and commune level to coordinate tobacco control actions. Tobacco control activities are reported annually by the Provincial People’s Committee to VINACOSH.

2.1.1.3.4. Coordination with mass organizations, civil society and other sectors
Apart from the organizations that are members of VINACOSH, the Committee works with different groups of the civil society and mass organizations in communication issues, primarily with funds from international organizations. Some of these groups are contacted on a project needs basis.

Coordination of activities includes regular meetings among the tobacco control group consisting of the Viet Nam Public Health Association, HealthBridge, CDS, the Hanoi School of Public Health, Family Health International, the WHO and other partners to share information and to collaborate on implementation when appropriate. There is good collaboration with the media.

2.1.1.4. Funding
VINACOSH receives limited funds directly from the MOH from the regular budget of the government. Some cities, such as Ho Chi Minh City, allocate funds from city and district budgets for tobacco control activities. VINACOSH and other implementing agencies rely primarily on other sources of funds, including intergovernmental organizations [e.g., WHO], development agencies [Sweden SIDA, IDRC/RITC, Netherlands NEDA], NGOs [the American Cancer Society, SEATCA] and philanthropies [Bloomberg Initiative, Rockefeller Foundation and Atlantic Philanthropies].

2.1.1.4.1. Sustainable funding for tobacco control: the National Fund for Prevention and Control of Tobacco Harms
The government of Viet Nam is committed to implementing the WHO FCTC and recognizes the need to provide sustainable funding for tobacco control. According to Decision No. 1315/Qd-TTg on the national plan of WHO FCTC implementation issued by the Prime Minister on 21 August 2009, the MOF is to take prime responsibility and collaborate with MOH and related ministries and sectors to study and recommend the establishment of the National Fund for Prevention and Control of Tobacco Harms.
Following the road map under Prime Minister Decision No. 1315/Qd-TTg on the national plan for WHO FCTC Implementation, the MOF issued an action plan on implementing the decision. The action plan aims to develop a suitable model for the National Fund for Prevention and Control of Tobacco Harms and a circular on managing and cost norms for tobacco control activities. Also, the MOF assigned the Tax Policy Department (DoTP) to work with VINACOSH to develop the model. The following activities have been completed:

1. Update estimates of treatment costs of three tobacco-related diseases (Hanoi Medical University [HMU])
2. Review impacts of active and passive smoking on human health (HMU)
3. Review impacts of the social and economic costs of tobacco use National Economic University (NEU)
4. Review research on impacts/potential impacts of tobacco control measures (DoTP)
5. Review models of sustainable funds in Viet Nam and the HPF in the world (DoTP)
6. Analyse strengths/weaknesses of the current funding mechanism for tobacco control in Viet Nam (DoTP and VINACOSH)
7. Estimate the necessary budget to implement the national plan of WHO FCTC implementation (DoTP and VINACOSH)
8. Invite international experts’ input to the HPF model development (VINACOSH).

After many studies and meetings by the MOF and MOH on the source of money for the National Fund for Prevention and Control of Tobacco Harms, the tobacco control draft committee has proposed in the draft LPCTH under Article 28-29 that the funding should come from:

- A compulsory contribution by tobacco users, to be collected by manufacturers or importers, calculated as a percentage of the sale price inclusive of import tax, if there is one, but without excise tax and VAT, and with the maximum amount not exceeding 2% of the sales price
- Voluntary contributions from national and international organizations and individuals
- Income from tobacco control related services organized by the fund
- Other legal sources of funding.

2.1.2. TOBACCO INDUSTRY

The tobacco industry in Viet Nam is largely under government control, with a renewed commitment of continuity expressed in a recent government decree. There are a few trademark licensing agreements with multinational companies involved in all stages of production, from tobacco growing and processing (British American Tobacco, Japan Tobacco and Imperial Tobacco) to join venture agreements for cigarette manufacturing (Philip Morris, formerly with Sampoerna and Imperial Tobacco) and for accessory production (New Toyo).

2.2. KEY FINDINGS

2.2.1. The tobacco industry has a strong presence in Viet Nam, with consequent influence on tobacco control policies.

This was acknowledged by most interviewees. Examples of where the industry presence and influence are felt are instances of the industry taking government officials and other institutions on study tours around the world and direct involvement in and funding of combatting illicit trade. The tobacco industry is also present in discussions and decisions regarding tobacco control measures, and their interests do not match public health concerns. Finally, regulations on tobacco production and trade are mixed with tobacco control regulations, leaving no clear message on whether tobacco control is a priority.
2.2.2. Despite VINACOSH’s key role and successes in coordinating national tobacco control efforts in Viet Nam among its members, opportunities for more active work by ministries and mass associations are not yet optimal.

VINACOSH’s importance is fully recognized by interviewees from all sectors, at all levels. A well-known multisectoral steering committee, VINACOSH also works with nonmember agencies and mass media organizations, spearheading tobacco control activities. Some of the organizations operate under the umbrella of the Tobacco Control Working Group; they include VINACOSH, WHO, the Viet Nam Public Health Association, HealthBridge, CDS, the Hanoi School of Public Health and other partners. In monitoring the tobacco epidemic and responding to it, VINACOSH has also collaborated with Ha Noi Medical University, the Ministry of Education and Training and General Statistics Office (in the Global Tobacco Surveillance System [GTSS]: Global Youth Tobacco Survey [GYTS], the Global Health Professionals Student Survey [GHPSS], GATS) and relevant ministries/agencies (on the WHO FCTC implementation report). By interviewing many of VINACOSH’s members and partners, the assessment team found that communication and support to some sectors of society are still not considered strong enough. Moreover, there was no evidence of a clear strategy that would promote the integration of VINACOSH members and partners, ensuring regular communication and support.

Furthermore, coordination of multisectoral activities is not benefiting from the full involvement of the MOH in the discussions and decisions regarding some tobacco control policies in Viet Nam, especially in non-health sectors. This includes MOH participation in the discussions and decisions on taxes and prices, alternative livelihoods and illicit trade and in the preparations of Viet Nam positions for the negotiations of the WHO FCTC Illicit Trade protocol. This prevents a more effective use of public health arguments in the discussions of different aspects of tobacco control.

At the subnational level, provincial reports submitted annually to VINACOSH show irregular progress in implementation of tobacco control measures, limited by availability of funds and the lack of commitment of provincial leaders. However, in some provinces such as Thai Binh and Hai Duong and cities such as Ha Long, Hue and HCM city, there is strong commitment on the part of the provincial leaders and very good coordination among people’s committees, health departments and other sectors in planning, implementation and reporting to VINACOSH.

2.2.3. VINACOSH’s human resources, i.e., the VINACOSH Standing Office focal point have insufficient time allocated for coordinating tobacco control work.

The VINACOSH standing office team is funded primarily by external sources and has limited capacity for undertaking the tasks necessary for the sustainability of the tobacco control agenda. Identified training needs include foreign language skills, advocacy abilities and programme management. At the subnational level, focal points to ensure regular communication and implementation are missing.

Moreover, the staff working on tobacco control is insufficient in all ministries, sectors and provinces, preventing a better multisectoral approach, outreach and sustainability of effective tobacco control measures. Very few organizations can have full-time working staff, and part-time staff is limited in both quantity and quality.

2.2.4. Tobacco control has inadequate funding: VINACOSH has very limited funding available from governmental sources, much less than the annual budget required for planned activities.

Major financial sources include international organizations and philanthropies, but their contributions are irregular and do not ensure sustainability and infrastructure.
Despite government recognition of the benefit of promoting health and reducing the harmful health effects of tobacco use, tobacco control in Viet Nam is still underfunded. Currently, 90% of the funding for tobacco control in Viet Nam comes from International donors, and less than 10% comes from the state budget. Having to compete with other health issues, tobacco control receives minimal funding from the state budget.

There is insufficient funding allocated to the ministries that are assigned roles and responsibility for tobacco control by Decision No. 1315. At the provincial level, which is the front line for implementing various decisions on tobacco control – in particular, organizing IEC activities on tobacco harm prevention and control in their respective localities – most of the provinces have not allocated a budget for tobacco control, according to provinces’ reports on implementing the National Tobacco Control Policy in 2000-2010. Only Ho Chi Minh City has allocated some amount for tobacco control activities, approximately US$ 50 000 in 2000–2010. Finally, some provinces have received funding for tobacco control from projects, which each last only two to three years.

### 2.2.5. An effective managing mechanism for the National Fund for Prevention and Control of Tobacco Harms is under discussion.

Currently, the kind of mechanism that would most effectively manage the fund is still being debated. The major concerns are efficiency and accountability. Various types of funds have been established in Viet Nam, some of which are set up within government departments, while others are created for charity. There are issues concerning transparency in the use and administration of many of the existing funds.

### 2.3. KEY RECOMMENDATIONS

#### 2.3.1. Viet Nam should take appropriate measures to prevent the undue influence of the tobacco industry.

Viet Nam should ensure compliance with Article 5.3 of the WHO FCTC and its guidelines for implementation. The country should consider mechanisms to prevent potential interference from the tobacco industry at all levels of decision-making on tobacco control matters in the government. Advocacy to raise awareness and support of policy makers on the implementation of Article 5.3 is key, along with means to eliminate industry participation in tobacco control meetings, discussions and decision forums for regulation and legislation. Finally, issues related to tobacco control should not be part of the same regulations that address tobacco trade, manufacture, growing and production. In this regard, the country would benefit from examining the experiences of other countries in addressing Article 5.3 and its guidelines, such as Thailand.

#### 2.3.2. A strategic plan for communication between VINACOSH and relevant ministries and sectors should be established to increase tobacco control presence on the public agenda.

This recommendation includes but is not limited to strengthening regular information, communication and coordination of activities among VINACOSH members. It also includes broader participation of VINACOSH members in providing regular technical assistance to relevant ministries in developing training materials and education activities. Such activities would be instrumental in guaranteeing a strong presence of the MOH in discussions and decisions on tobacco control policies that fall within the health sector.
As a forum that involves different players in tobacco control, particularly WHO, the academia and civil society, the Tobacco Control Working Group should be strengthened by regular meetings, sharing of information, training and collaboration in implementation; participation could be expanded to incorporate additional partners.

Local authorities from provincial to district level should set up tobacco control steering committees with clear functions and coordination mechanisms among people’s committees, departments and sectors. The Health Department or Health Center for Education and Communication should be the focal organization for providing technical advice and monitoring implementation. Advocacy activities should also target provincial people’s committees and provincial health departments to promote their commitment to tobacco control.

2.3.3. Strengthening VINACOSH’s human resources capacity is vital to ensure the smooth implementation of tobacco control activities in Viet Nam.

This can be achieved by ensuring that VINACOSH’s focal point is a full-time tobacco control staff member and by increasing the number of full-time staff in the VINACOSH standing office, funded by regular budget.

Local authorities from provincial to lower levels and organizations should assign full-time and part-time staff to work on tobacco control, ensuring clear coordination within and between sectors.

Staff from both national and provincial levels should receive regular and adequate training on required areas.

2.3.4. A National Fund for Prevention and Control of Tobacco Harms urgently needs to be established to ensure sustainable and adequate funding for strengthening VINACOSH’s human resources and its capacity to coordinate tobacco control.

This action would ensure the promotion of smooth implementation of tobacco control activities from centre to local levels. The Vietnamese government should consider approving tobacco control and health promotion funds with the appropriate funding mechanism, as recommended by the WHO FCTC.

Article 26 of the WHO FCTC requires all Parties to secure and provide financial support for the implementation of various tobacco control programmes and activities to meet the objectives of the Convention. Best practices in many other countries should be shared with policy makers to improve awareness, support and commitment and to address concerns regarding the establishment and smooth operation of the funds.

Advocating local authorities to enhance awareness and support for tobacco control in order to mobilize funding at provincial and lower levels is recommended. Learning from the experiences of cities such as Ho Chi Minh City can be useful in this regard.

It is critical that Viet Nam has adequate and sustainable funding for tobacco control. Since tobacco control programmes need long-term efforts, funding from international donors is not sustainable and sufficient to implement Directive No. 1315 or the draft LPCTH, which is scheduled to be approved soon. The establishment of a National Fund for Prevention and Control of Tobacco Harms would ensure the continued implementation of Decision No. 1315.
Tobacco use perpetuates poverty, which affects the health of individuals, the well-being of households and the economy of the country. In 2007, VND 1160 Billion (US$110 million) was spent on inpatient treatment of smoking-related cases of lung cancer, chronic obstructive pulmonary disease (COPD) and ischemic heart disease alone, accounting for about 4.3% of all health-care expenditures and 0.22% of Viet Nam’s GDP. The Vietnamese government is burdened with 51% of smoking-related costs. The availability of a National Fund for Prevention and Control of Tobacco Harms could help significantly reduce tobacco use in the country, and the funding should come from tobacco companies, as proposed in the draft LPCTH.

Proposals in Article 28-29 of the current draft LPCTH, National Fund for Prevention and Control of Tobacco Harms, should be considered and implemented without delay. However, there should be clear guidance for implementation. Also, funding from the state budget should continue to be allocated for tobacco control, while other sources of funding as proposed in the draft LPCTH should be mobilized.

The government will not lose but will gain by introducing a tobacco control fund, which will enable it to finance relevant tobacco control programmes at all levels and in all relevant ministries. Moreover, it will create supportive environments to promote healthy behaviour and improve the quality of life and well-being of all of society.

2.3.5. An autonomous agency and efficient mechanism are needed to manage the National Fund for Prevention and Control of Tobacco Harms.

To overcome concerns about accountability and efficiency, the MOF and MOH need to further develop detailed guidance on how the fund will be managed, utilized and evaluated.

Tobacco control and health promotion funds have been introduced in many parts of the world, including Australia, Switzerland, Austria and South-East Asian countries such as Singapore, Malaysia and Thailand. The experience from many countries has shown that having an autonomous government agency manage the fund provides the advantage of flexibility in management and support activities that are unlikely to exist or difficult to conduct under national health budgets. Moreover, an autonomous agency can operate openly, equitably and accountably and can react quickly to emerging needs without bureaucratic constraints. This type of organization can also cement multisectoral collaboration across a range of government departments and nongovernmental and community-based organizations from different sectors, including health, sports and education.
3. Monitoring and evaluation

3.1. POLICY STATUS AND DEVELOPMENT

Monitoring and evaluating programmes must provide both overarching and specific information on the tobacco epidemic and the response to it (tobacco policies and programmes). Effective surveillance and monitoring systems must track several components, including (i) prevalence of tobacco use; (ii) impact of policy interventions; and (iii) tobacco industry marketing, promotion, public relations strategies and lobbying. These components were examined by the assessment team.

3.1.1. Surveillance of tobacco prevalence and the impact of policy interventions.
Tobacco surveillance is being conducted in Viet Nam, and the MOH is deeply involved in this effort. The structure at the MOH responsible for tobacco surveillance is VINACOSH.

The following tobacco surveys have been conducted:
- Viet Nam National Health Survey 2002: MOH
- GYTS 2003, 2007: VINACOSH
- GSPSS 2003: VINACOSH
- GHPPS 2007: VINACOSH
- GATS 2010: WHO, General Statistics Office (GSO), VINACOSH, HMU
- SAVY 2003, 2007: Youth’s Union, MOH, GSO, UNICEF, WHO
- Smoke-free implementation: Viet Nam Public Health Association (VPHA) network in 12 provinces, VINACOSH in three provinces, HealthBridge in Hanoi, CDS in Ha Long, Labour Union, Trade Union in the health sector
- Pack warning implementation: CDS, VINACOSH
- WHO FCTC implementation: Annual reports from ministries and provinces

3.1.2. Tobacco industry monitoring
TAPS violations at POS were monitored by the Harvard School of Public Health, HealthBridge, Hanoi Medical University, VINACOSH and the MOCST.

3.2. KEY FINDINGS

3.2.1. Viet Nam has recent, representative and periodic tobacco surveillance data for both adults and youth. However, sustainability is a challenge.
There are two main challenges to the sustainability of prevalence surveillance:
- Although the MOH contributes some funds for some tobacco-specific surveys, funding for tobacco surveillance is still largely dependent on external sources. This is relevant especially in the case of GATS, which in its present form is expensive.
• Adult prevalence data are key to monitoring the tobacco epidemic; however, the existing surveys measuring adult prevalence use methodologies that produce noncomparable data. GATS, an internationally validated survey, is not sustainable. The complete GATS survey cannot be integrated in full into other adult surveys. A core set of questions from GATS has been developed by WHO’s Regional Office for the Western Pacific (WPRO), the Core Adult Tobacco Survey (CATS), to facilitate its integration in adult surveillance efforts.

3.2.2. Efforts to translate surveillance findings into policy actions are insufficient.
Although VINACOSH and other agencies are producing some tobacco surveillance data, there are few efforts to translate the data into information for action and policy-making.

3.2.3. Efforts to monitor strategies and actions of the tobacco industry to undermine tobacco control efforts are insufficient.
Although some activities by government organizations and civil society are geared towards development of a database to monitor some of the tobacco industry actions to undermine public health, these efforts are limited and not part of an overall surveillance plan.

3.3. KEY RECOMMENDATIONS

3.3.1. Ensure sustainability of existing surveillance efforts by integrating a core set of questions and methods from GATS into ongoing surveys.
GATS is a very important effort to measure prevalence and other indicators. To guarantee sustainability, VINACOSH needs to integrate CATS into ongoing large-scale national surveys.

3.3.2. Better utilize the existing surveillance data by ensuring translation into actionable items for policy makers.
VINACOSH needs to take the lead in ensuring that data are interpreted for decision-making and that the messages are disseminated in a timely way to all relevant stakeholders.

3.3.3. Build up and systematize tobacco industry monitoring activities.
Each country needs to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and must be informed of industry activities that have a negative impact on tobacco control efforts. The guidelines of WHO FCTC Article 5.3 recommend a series of activities to prevent the influence of the tobacco industry in public health. Monitoring the implementation of Article 5.3 and Article 13 and these guidelines is essential for ensuring the introduction and implementation of efficient tobacco control policies. Existing models and resources for monitoring tobacco industry strategies and activities should be used, such as those outlined by the WHO Tobacco Free Initiative (TFI) in its reports and publications.7

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4. Protect people from tobacco smoke

4.1. POLICY STATUS AND DEVELOPMENT

Presently, Viet Nam’s legislation and regulations\(^8\) ban smoking in the enclosed spaces of the health and education sectors, public transport (except ships and trains) and all government offices and workplaces, except in the hospitality sector and a few public places. However, it is anticipated that this legislation will soon be replaced by a LPCTH that is in draft form and will be voted on at the end of the second semester of 2012. Articles 9 to 12 of the draft LPCTH address smoke-free public places. In its version dated 19.07.2011, the draft LPCTH stipulates that

- Smoking is totally prohibited in the indoor areas and outdoor grounds of the following facilities: medical examination and treatment facilities; kindergartens; primary, secondary and high schools; continuing education facilities; entertainment areas specially designated for children; areas with high risk of fire and explosion.
- Smoking is prohibited in the indoor areas of workplaces; in other public places, barring those that follow; on public transport, barring those that follow.
- Designated smoking areas (DSAs) are allowed in airport segregation areas; restaurants, bars, karaoke lounges, hotels and discos; public transport means that are ships and trains; “other places as regulated by law”.\(^9\)

Furthermore, Article 10 states that DSAs must satisfy the following conditions:

- DSAs must have a space or\(^10\) ventilation system separate from that of the no-smoking area.
- DSAs must have tools to contain cigarette ends and ashes and must have signs at suitable and easy-to-see locations.
- DSAs must be equipped with fire-extinguisher devices.

In addition, the “heads of public places where regulation on smoking bans is applied” are responsible for the violations committed by smokers in their premises.

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\(^8\) Resolution 12/2000/NQ-CP of 14 August 2000 ratified National policies on Tobacco Control for 2000–2010: This policy requires a strictly implemented smoking ban inside workplaces and public places. Decree No. 45/2005/ND-CP dated 6 April 2005 refers to the administrative punishment in health sector. Article 16, provision 1, refers to fine level for the violation of smoke-free regulations. Directive No. 12/2007/CT-TTg of 10 May 2007 by the Prime Minister regarding the strengthening tobacco control activities strictly implements smoke-free regulations inside workplaces and public places (Article 2 provision 1). Decision No. 1315/QD-TTg dated 21 August 2009 by the Prime Minister approving the plan for WHO FCTC Implementation: According to this decision, smoking is fully banned in classrooms, kindergartens, health facilities, libraries, cinemas, theatres, cultural houses, indoor working spaces and places at high risk of explosion and fire; on public means of transport; sporting event halls; roofed stadiums; exhibition centres; waiting rooms at railway stations and bus interchanges; airports, seaports and ferry landings; and bars and karaoke bars must be partially smoke-free. Decision No. 1315/QD-TTg on the plan for WHO FCTC Implementation, issued in August 2009: At the ministerial level, each ministry has issued legal documents to implement the smoke-free policies of the government. A policy to implement the decrees exists at the city, department and grassroots levels.

\(^9\) Further drafting work has taken place on the draft LPCTH between the In-country Capacity Assessment and the production of the report. The section related to “other places as regulated by law” has been removed within the 5th draft dated 21/11/2011.

\(^10\) The version dated 21/11/2011 replaced “or” with “and”.
4.2. KEY FINDINGS

4.2.1. The draft of the new LPCTH, which allows DSAs in the hospitality sector and selected transportation means, fails to protect non-smokers from SHS.

In 2004, the Vietnamese government ratified the WHO FCTC and in doing so accepted its duty to protect its citizens from exposure to tobacco smoke in workplaces and public places and on means of public transportation, as mandated by Article 8. Later, in 2007, Viet Nam voted in favour of the approval of Article 8 guidelines that indicate that no level of exposure to tobacco smoke is safe and that “approaches other than 100% smoke-free environments, including ventilation, air filtration and the use of designated smoking areas [whether with separate ventilation systems or not], have repeatedly been shown to be ineffective and there is conclusive evidence, scientific and otherwise, that engineering approaches do not protect against exposure to tobacco smoke.” Article 8 also stipulates that effective measures to protect people from exposure to tobacco smoke should cover (1) indoor workplaces, (2) indoor public places, (3) public transport, and (4) “as appropriate”, “other public places”.

The possibility of a new LPCTH being enacted next year presents a key opportunity for the government to meet its international legal commitment. However, the assessment team found that the third version of the draft LPCTH (dated 19/07/2011) fails to provide the effective protection measures specified by the WHO FCTC Article 8 guidelines by allowing DSAs in several public places, including:

- Airport segregation areas
- Restaurants, bars, karaoke lounges, hotels, discos
- Public transport means that are ships and trains.
- Other places as regulated by law.

The above places are workplaces for many, and their right to employment in 100% smoke-free environments should also be upheld.

DSAs are contrary to best practice and have been proven to be incapable of providing the effective protection specified by WHO FCTC Article 8 guidelines; thus, they should be avoided. The assessment team also found that the proposed draft LPCTH is vague and incomplete in its description of the requirements for DSAs. It states that there must be a “separate space or ventilation system from the no-smoking area”, implying there could be a common space for non-smokers and smokers, provided it has some form of ventilation system, or that separate spaces without separate ventilation systems are acceptable.

4.2.2. 56% of workers are exposed to SHS in workplaces that are theoretically 100% smoke-free, indicating poor compliance with the existing law.

Poor compliance with the existing law seems to be due to limited enforcement efforts by local and central authorities, with some exceptions. The commitment of the MOH reflected in basic policy documents on smoke-free environments, as well as technical and financial support from international organizations, has resulted in certain achievements regarding smoke-free environments. VINACOSH has worked closely with the Viet Nam Labour Federation and the Health Trade Union in recent years to enforce smoke-free implementation, and its annual report shows a decreasing trend in smoking prevalence among workers, as well as better compliance at workplaces. The same positive changes were also observed at more than 10 project provinces, including Ha Long, Hue, Thai Binh and Ho Chi Minh City.

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11 The version dated 21/11/2011 replaced “or” with “and”.
12 Compliance is an outcome, and enforcement is the process leading to that outcome, characterized as being a governmental activity that has three components: awareness of the law by potential violators, inspection of establishments to issue warnings/sanctions when a violation is found and documentation/evaluation of the impact of the law.
There appear to be several reasons for the limited efforts:

- **The subjects of sanctions.** The present legislation recognizes only the smoker as a potential violator of the law and therefore subject to sanction; it does not sanction the owner or manager of the facility where the violation occurs. Interviewees mentioned that the smoker often is not carrying any money at the time of the sanction and is therefore released.

- **Lack of guidelines for implementing Decree 45.** This decree regulates the regimen of sanctions to be applied to violators of the smoke-free law and regulations. However, it lacks guidelines as to which agency should issue the ticket, which agency should collect the fine and how the funds should be used. This lack of clarity has paralysed enforcement efforts.

- **Implementing the smoke-free legislation is not a priority for authorities and leaders.** Although authorities and leaders generally understand the harms of SHS and generally support the implementation of the smoke-free legislation, they have not adequately prioritized actions to implement these commitments. In addition, some leaders still smoke indoors in workplaces. The following two issues could be a direct consequence of the lack of priority.

- **Lack of coordination among enforcing agencies.** Authorities of sectors other than the health sector also have the responsibility of enforcing the smoke-free legislation in their areas. However, many non-health agencies do not consider enforcing health legislation to be a priority.

- **Limited and overloaded health inspection staff.** Inspectors working for the MOH at central, provincial and district levels have a mandate to implement the smoke-free legislation. However, inspectors are limited in number, generally not trained on the topic and already overloaded with other competing activities and demands.

- **Lack of public-awareness activities to improve compliance.** Activities to raise public awareness of the harms of SHS are conducted regularly and have resulted in 87% of the people thinking SHS causes serious illness. However, very few activities have been carried out to transform this knowledge into an active engagement of the population with the enforcement of and compliance with the law.

- **Lack of sufficient incentives to comply with the law.** Although complying with the smoke-free legislation may grant an establishment the honour of being declared of good culture, compliance is generally not an important criterion for facility/staff evaluation, nor is it a criterion for individual promotion.

### 4.3. KEY RECOMMENDATIONS

4.3.1. **Improve the wording of Article 10 of the draft LPCTH by removing the option of smoking areas, to protect the health of all, in line with WHO FCTC Article 8 guidelines.**

Smoking areas should not be allowed for airport segregation areas; restaurants, bars, karaoke lounges, hotels and discos; or public transport means that are ships and trains. Where denial of smoking areas is not possible now,

a. Article 10 should have a road map provision to introduce a total smoking ban, with a clearly specified deadline. The deadline should be as soon as possible but never later than three to five years after the approval of the law.
b. The requirements of DSAs should be elaborated. At a minimum,
- The smoking areas in restaurants, bars, karaoke lounges and discos should
  - be completely enclosed and separate from the non-smoking area
  - have a ventilation system separate from the non-smoking area
  - be one room no larger than 25% of the total surface area accessible to the public.
- In the case of hotels, smoking should not be allowed in working areas or public areas such as lobbies, except restaurants and bars, as indicated above. Further, the law should designate a maximum number of contiguous hotel rooms on floors where smoking is permitted, not exceeding 25% of the total number of rooms.
- In the case of trains and ships, smoking areas should always be located in clearly indicated open areas.
- The Minister of Health should be given the authority to specify further requirements for smoking areas, such as not allowing the provision of service at any time by workers or volunteers to avoid their exposure to SHS.

4.3.2. Improve enforcement of the smoke-free legislation by:
- Issuing guidelines for implementing Decree 45 or any other regulation developed in accordance with the new LPCTH indicating which agencies should issue penalty tickets, which agency should collect the fines and how the funds should be used.
- Making the owners or managers of the facility where the violation occurs the subject of sanctions, as indicated in the draft LPCTH, including loss of business licensure for repeat violations, in addition to fines and other possible sanctions such as public notice of violations.
- Communicating to authorities and leaders the need to raise the priority of enforcement efforts, including efforts leading to the creation of active mechanisms of coordination among enforcing agencies and to the assignment of a critical mass of inspectors to enforcement activities during a significant but limited time during which inspections and sanctions could be given a high public profile for education purposes.
- Implementing communication activities to raise public awareness about the need to comply with the smoke-free law.
- Creating additional incentives to comply with the law, such as including smoke-free compliance as a criterion for facility/staff evaluation within the health sector and for individual job promotion.
- Building the necessary capacity among the existing enforcement staff.
5. Offer help to quit tobacco use

5.1. POLICY STATUS AND DEVELOPMENT

Tobacco use can lead to nicotine dependence, which is a chronic condition that often requires repeated interventions. However, effective treatments and helpful resources exist, and cessation can significantly reduce the risk of contracting smoking-related diseases.\(^\text{13}\) Although most of the smokers who want to quit eventually do so without intervention, assistance greatly increases quit rates.

WHO FCTC Article 14 requires Parties to develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and to take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence. Consistent with other provisions of the WHO FCTC and the intentions of the Conference of the Parties (COP) to the Convention, Viet Nam (along with the other Parties) adopted specific guidelines to assist in meeting their obligations under Article 14.\(^\text{14}\)

First steps in adopting specific measures to help people in Viet Nam to quit tobacco use were taken in 2000 through the Government Resolution on National Tobacco Control Policy 2000, which included measures for supporting smoking cessation.\(^\text{15}\) Following ratification of the WHO FCTC, the Prime Minister issued Directive No. 12/2007CT-TTg (in 2007) and Decision No. 1315/QD-TTg (in 2009) on the plan of WHO FCTC implementation, which also included measures to support tobacco cessation.

Further policy development is included in the current draft LPCTH (Articles 17 and 18). This draft assigns further roles and responsibilities in smoking cessation at various levels of the governmental and nongovernmental sectors (the MOH, people’s committees, organizations, schools and families).

5.2. KEY FINDINGS

5.2.1. Although VINACOSH has already taken useful steps towards building support for quitting tobacco, a systematic, easily accessible, low-cost service is still not available.

There is still no national, easily accessible quitline. Although VINACOSH is currently implementing a pilot project that provides tobacco cessation counselling via telephone, the number is not toll-free and therefore not usable by a large portion of the population.

There are no national guidelines for the treatment of tobacco dependence. In 2009, VINACOSH, in cooperation with medical institutions, developed a set of materials that could serve as national guidelines on tobacco cessation counselling/treatment; however, these guidelines have not been formally approved by the MOH.

\(^{13}\) http://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/ quitting/index.htm.

\(^{14}\) Guidelines for implementation of Article 14 of the WHO FCTC. Available at: http://www.who.int/fctc/guidelines/article_14.pdf.

\(^{15}\) http://www.vinacosh.gov.vn/?mPage=06P20F01, accessed 17.08.2011.
Generic pharmaceuticals are not included in the National List of Essential Drugs. Pharmacological treatment for tobacco dependence was not on the market in Viet Nam until recently, when the MOH specifically approved importation of nicotine replacement therapy (NRT). However, even if they are now legally present on the market in Viet Nam, the NRT drugs are not yet included in the list.

5.2.2. The health system is not fully committed to responding to the current demand for quitting tobacco use in Viet Nam.

No systematic tobacco cessation advice is offered in primary health-care services. There is no broad understanding of the ICD-9 F17 diagnosis (tobacco dependence) as a condition requiring treatment and therefore needing to be integrated as a medical act (i.e. within routine medical practice). This is partially due to the absence of undergraduate or postgraduate training on treatment of tobacco dependence. There is low awareness among medical professionals of the need for providing advice/diagnosis and treatment of tobacco dependence to patients and their role in it. In 2006, according to the GHPSS conducted in Viet Nam, 20.7% of male and 2.7% of female medical students were current smokers [GHPSS, 2006]. Only 27.4% of this group reported receiving information on cessation approaches to use with patients.

No behavioural or pharmacological treatment for tobacco dependence is currently approved for reimbursement under the health insurance scheme. The health-care system gives no incentive to provide brief advice or further treatment.

General information on quitting, and specifically on quitting services, is not widely available to the public.

5.3. KEY RECOMMENDATIONS

5.3.1. On a short-term basis, VINACOSH should expand existing piloted services to sustainable, nationwide, available and easily accessible quitting services. Options for implementation could include the following:

- The current quitline should be developed into a national, toll-free, easily accessible and well-staffed quitline. The quitline number should be widely disseminated, using media and health warnings on cigarette packs. Quitlines are inexpensive to operate, confidential and can be staffed for long hours, so they can reach people who are unable to call during business hours or who live in remote places. A national quitline in Viet Nam would help introduce tobacco users to tobacco-dependence treatments, such as counselling and NRT. A quitline would also provide tangible support to smokers who want to quit as a result of the implementation of the smoke-free places law in Viet Nam.

- National guidelines for the treatment of tobacco dependence should be approved by the MOH, widely disseminated and implemented. These guidelines should promote the role of brief advice in primary health-care services.

- Generic cessation drugs (NRT in the form of gums, patches, lozenges and nasal sprays) should be included in the National List of Essential Drugs.
5.3.2. The health system should build a sustainable medium- and long-term response that meets the demands of the population seeking support for quitting tobacco. Options for implementation include the following:

- Provision of systematic brief advice should be mandatory for all primary health-care professionals, and eventually for all medical professionals. The MOH should formally recognize diagnosis and treatment of tobacco dependence as a medical act (i.e. within routine medical practice) and, in collaboration with the Ministry of Education and Training, should develop and implement appropriate curriculum and training materials on tobacco cessation for medical schools. Integrating tobacco cessation into primary health care and other routine medical visits would provide the health-care system with opportunities to remind users that tobacco harms their health and that of others around them. Repeated advice at every medical visit reinforces the need to stop using tobacco, and advice from health-care practitioners can greatly increase abstinence rates. This intervention is relatively inexpensive, because it is part of an existing service that most people use at least occasionally. It can be particularly effective because it is provided by well-respected health professionals with whom tobacco users may have good relationships.

- Behavioural or pharmacological treatment for tobacco dependence should be covered by the national health insurance scheme.

- Information for smokers on quitting services should be made widely available and should explore all potential creative and powerful approaches. Viet Nam has very high rate of Internet access among young people, so the Internet could be a powerful channel for providing the information. The MOH, in collaboration with governmental and nongovernmental partners, should explore creative methodologies to inform the public about the effects of tobacco use and to provide advice on quitting, e.g., by expanding the use of mobile communication technology to a more systematic approach.
6. Warn people about the dangers of tobacco

6.1. PACKAGING AND LABELLING

6.1.1. POLICY STATUS AND DEVELOPMENT

The first health warning on cigarette packs was implemented in Viet Nam in 2001. That warning had only the text “Smoking is harmful to health” on the sides of the packs, in very small letters and difficult to read.

In 2007, the MOH conducted a research project on designing and testing of pictorial health warnings. After the testing, the five most effective samples (as rated by the interviewees) were selected and approved by the scientific committee of the MOH. The five samples then were adopted for use in Minister of Health Decision No. 02/2007/QĐ-BYT, but the use was optional. The MOH was to consider issuing a further decision to make the pictorial health warnings compulsory after 2010, but that decision has not been issued, because a government decree issued in 2008 (Decree No. 119/2007NĐ-CP) stated that starting 1 April 2008, health warnings should cover 30% of the surface of the packs with one of two health messages: “Smoking can cause lung cancer” or “Smoking can cause Chronic Obstructive Pulmonary Disease (COPD)”. To date, health warnings are applied based on Decree No. 119/2007NĐ-CP.

In 2011, VINACOSH commissioned further research to develop and test more samples of pictorial health warnings to be ready for use once the LPCTH is approved and comes into effect. Ten further samples were developed, and the six rated most highly on effectiveness were selected and approved by the VINACOSH standing office.

The current draft LPCTH states: Packages of tobacco products produced in Viet Nam or imported for domestic consumption shall print pictorial health warnings in text and pictures. Health warnings shall occupy at least 50% of the principal areas on the front and back of all tobacco packages, ensuring that those words and pictures are clear, legible. Samples of the health warnings shall periodically change at the interval of every two years.

Internationally, pictorial health warnings have proved to be effective in reducing smoking. Canada was the first country to introduce large, graphic health warning labels on cigarette packages in 2001, and a study found that smokers who had read, thought about and discussed the labels were more likely to have quit, to have made a quit attempt or to have reduced their smoking. About one-third of the former smokers reported that the labels had motivated them to quit, and more than one-quarter said that labels helped them remain abstinent. In another Canadian study, about one-fifth of the smokers reported reducing their consumption as a result of seeing the warning labels.
Australia introduced graphic health warning labels in 2006, causing more than half of the smokers to believe that they had an increased risk of dying from smoking-related illness, with 38% feeling motivated to quit. Other countries that use pictorial warning labels, including Brazil, Singapore and Thailand, report similar effects on smoking-related behaviour. Graphic warnings also persuade smokers to protect the health of non-smokers by smoking less inside their homes and avoiding smoking near children.

The WHO FCTC Article 11 guidelines recommend that:
1. Health warnings should be printed on the principal display areas in front and back of the packs and in the upper part of the principal display areas.
2. Health warnings on packages of tobacco products should use colour pictures together with text, because the use of pictures is much more effective than using text alone.
3. The health warnings should cover 50% or more of the pack’s surface. The larger the size of health warnings, the more effective they are.
4. Health warnings that are printed on the top of packs are more effective than those printed on the lower parts.
5. Many different warnings should be used to communicate different aspects of the consequence of smoking on health.
6. It is important to change the design at a certain time interval, ideally every one or two years, to keep the warnings fresh to viewers.

6.1.2. KEY FINDINGS

6.1.2.1. There is a strong need to move from text-only warnings to pictorial health warnings.
A survey on current text-based warnings conducted by CDS and VINACOSH in 2009 showed that
• Only 39% of smokers remembered the message “Smoking can cause lung cancer”, and only 6% remembered the message “Smoking can cause COPD”.
• More than half of the respondents thought that the current health warnings had not warned enough about the harms of tobacco.
• About 60% of the smokers said that the current health warnings did not make them want to quit.
• Four-fifths (82%) of the respondents thought that pictorial health warnings on cigarette packs should account for 50% of the main surfaces of the packet, and half (52%) said that pictorial health warnings should make up 70% of the main surfaces to create the necessary impression.

A study on a tobacco control policy simulation model conducted by Levy et al. in 2006 found that implementing pictorial health warnings in Viet Nam will help avert between 300 and 700 early deaths each year for many decades to come.

In addition, a study on the cost-effectiveness of pictorial health warnings in Viet Nam conducted by the Health Policy and Strategy Institute in 2011 concluded that printing pictorial health warnings will significantly increase cessation and reduce the rate of youth uptake of smoking. This intervention measure will also be extremely cost-effective, with each additional DALY saved costing the government only about VND 500.

The majority of people from ministries and related agencies, including those who were interviewed during the assessment, support using pictorial health warnings that cover 50% of the principal displayed areas of the cigarette packs.
6.1.2.2. There are some misperceptions about the consequences of introducing graphic health warnings:

- **Pictorial health warnings will cause increased smuggling of tobacco products.**
  In all countries that have implemented pictorial health warnings, there is no scientific evidence of increased smuggling. Smokers tend to stick to the same brand of cigarettes, because they get used to a certain taste, and in Viet Nam, the smuggled tobacco products are more expensive than the legal products, making it even more difficult for smokers to switch from legal brands to smuggled brands. The implementation of pictorial health warnings will, in fact, make it easier for authorities to differentiate between legal and illegal products and therefore will result in better control of smuggled tobacco products.

- **Using large pictorial health warnings covering 50% of principal displayed areas is not the right approach.**
  A minority of people favour using a gradual-steps approach, starting with pictorial health warnings covering 30% or 40% of the pack and then moving to 50% after two years. However, the large majority of countries that have implemented pictorial health warnings (30 out of 40) have required the warnings to occupy at least 50% of the principal displayed areas. Smaller warnings are more difficult to see and read. Therefore, the WHO FCTC Article 11 guidelines recommend that health warnings should use pictures and should occupy 50% or more of the principal display areas.

- **The use of shocking pictures is inappropriate for an Asian country.**
  All of the countries that have implemented pictorial health warnings use strong and shocking images. Pictorial warnings are used in many countries in Asia, including Thailand, Singapore, Malaysia, Brunei, India, Iran and Mongolia. In addition, during testing of the samples in Viet Nam, the majority of interviewees supported strong pictorial health warnings.

6.1.3. KEY RECOMMENDATIONS

6.1.3.1. Communicate about the effectiveness of graphic health warnings.
Further efforts should be made to communicate and raise the awareness of the public and policy makers of:

- The effectiveness, cost-effectiveness and benefits of pictorial health warnings in reducing smoking and saving lives.
- The misconceptions about a link between smuggling and the use of pictorial health warnings.

This effort should be undertaken through workshops, newspaper articles, TV coverage and other forms of communication.

6.1.3.2. Strong graphic health warnings that occupy 50% of the front and rear of cigarette packs should be introduced.
Given international evidence on the effectiveness and cost-effectiveness of pictorial health warnings, the guidelines on Article 11, the world and regional trend towards using pictorial health warnings and the other findings from interviews, it is recommended that:

- Viet Nam should take a firm position on implementing pictorial health warnings that occupy 50% or more of the principal displayed areas and are placed on the upper part of the packs.
- Article 13.4 of the draft LPCTH should be revised to read: “The government is to decide on further increasing on the size of the health warnings in the future, based on the requirement to prevent and control tobacco harms and per the proposal from Minister of Health”. The text that refers to “depending on situation of smuggling control” should be deleted.16

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16 Further drafting work has taken place on the draft LPCTH between the in-country Capacity Assessment and the production of the report. The specific recommendation for Article 13.4 has been addressed by the 5th draft dated 21/11/2011.
Six to 10 samples of health warnings with strong images of the harmful consequences of smoking should be used at the same time on the packages of different cigarette brands. A new set of images should be introduced every one or two years to refresh the warnings.

6.2. PUBLIC AWARENESS AND MASS-MEDIA CAMPAIGNS

6.2.1. POLICY STATUS AND DEVELOPMENT

Article 12 of the WHO FCTC emphasizes the critical role of communication and education in tobacco control. The guidelines for implementation of Article 12 include developing or adapting existing communication tools and activities, such as campaigns, according to the needs, knowledge, attitudes and behaviours of each target population, to ensure that they:

- Are appropriate to the target audience
- Are of high frequency and long duration
- Contain refreshed and targeted messages
- Use a variety of methods and media vehicles
- Use lessons learnt from other successful campaigns
- Use integrated evaluation.

The guidelines also suggest supplementing mass media with community-based (including traditional) communication approaches where appropriate.

In Viet Nam, the role and contribution of communication and education on tobacco control has been emphasized in national policies, including Directive No. 12/2007/ CT-TTg by the Prime Minister on strengthening tobacco control activities and Decision No. 1315/2009/QĐ-TTg by the Prime Minister on implementing the WHO FCTC in Viet Nam. At the sectoral level, around 50 provinces, ministries and mass organizations have developed action plans to implement Decision No. 1315, including communication and education as a key component.

In the current draft LPCTH, Article 8 focuses on the role of IEC in tobacco harm prevention and control. Article 8 also provides requirements regarding the responsibilities of corresponding ministries and sectors for communication activities. The MOH will be responsible for organizing and providing scientific information on tobacco harms and will assume prime responsibility for collaborating with relevant ministries and agencies to organize IEC on tobacco harm prevention and control. The MOIC will be responsible for organizing and directing communication agencies to carry out IEC on tobacco harm prevention and control.

To date, a variety of communication and education activities on tobacco control have been undertaken in Viet Nam, and they have contributed to increasing awareness of the health effects of smoking and exposure to SHS. The activities have included meetings, parades, press conferences and production and distribution of IEC materials. Activities at the national and provincial levels have been primarily focussed around World No Tobacco Day each year, and information and education materials have been produced and distributed by VINACOSH. Ongoing earned media activities undertaken by HealthBridge Canada include the development of a network of journalists who are regularly briefed on tobacco control issues. In addition, VINACOSH has worked with the American Cancer Society to present a series of training workshops for journalists on tobacco control and to promote a competition among journalists to publish media articles on tobacco control issues.
In addition, two coordinated mass media campaigns have been developed, implemented and evaluated in Viet Nam in recent years. In collaboration with the VPHA, HealthBridge Canada conducted a project in 2005–2007 titled “Reducing the Social Acceptability of Smoking in Viet Nam”, which included a mass media campaign supplemented by community-based activities. The campaign was conducted in three provinces (Da Nang, Thai Binh and Ben Tre) and specifically targeted women about the harms of SHS.

During December 2009 and January 2010, a mass media campaign titled “Cigarettes Are Eating You Alive” was conducted by VINACOSH and the World Lung Foundation. The campaign aimed to increase knowledge of the harms of smoking and exposure to SHS and to encourage smoking cessation. It featured two television advertisements, which were broadcast 245 times over five weeks on national and provincial television stations.

6.2.2. KEY FINDINGS

6.2.2.1. Research-based tobacco control mass media campaigns can contribute towards reducing smoking in Viet Nam, but current levels of communication are inadequate.

Public education and communication campaigns can increase understanding of the harms of tobacco smoking and support the acceptance of tobacco control policies. Evaluation results from two mass media campaigns showed that research-based mass media campaigns can be effective in Viet Nam. An evaluation of the “Reducing the Social Acceptability of Smoking in Viet Nam” campaign showed an increase in the awareness of the harm of exposure to SHS and an increase in women objecting to being exposed to it.

The “Cigarettes Are Eating You Alive” campaign achieved high awareness among both smokers and non-smokers, and the majority of the smokers reported that the advertisements made them feel concerned about the effects of their smoking on their health and that of their family. More than three-quarters of the smokers who had seen the campaign said it made them more likely to quit and to stop exposing others to their smoke. Following the campaign, there was increased support for the introduction of a smoke-free policy in bars and drinking places and high levels of support for indoor smoke-free policies in workplaces (86%) and on public transportation (76%).

Significant production of IEC materials has been achieved by VINACOSH and a number of agencies at the national and provincial levels, but the current levels of exposure of the population to well-researched, effective tobacco control campaigns are insufficient to significantly contribute to reducing smoking prevalence in Viet Nam. GATS 2010 found that only 50% of male smokers and 27% of female smokers in Viet Nam believe that smoking causes stroke, heart attack and lung cancer, and only 60% of male non-smokers and 56% of female non-smokers believe it.

A coordinated national campaign can achieve greater cost-efficiencies in communication and education activities than a fragmented approach to developing and producing IEC materials. However, international research has shown that mass media campaigns and other communication activities must be implemented in a regular, ongoing way to have a sustained impact on knowledge and attitudes and to lead to the reduction of smoking prevalence. At present, funding for mass media tobacco control communication and education is inadequate to finance sustained campaigns, and consequently, exposure of the population to well-researched, effective tobacco control campaigns is inadequate to significantly reduce smoking prevalence in Viet Nam.

Funding for mass media campaigns cannot rely on continued financial contributions from international organizations.

6.2.2.2. Commitment of human and financial resources for tobacco control communication and education is inadequate.

Despite commitment and infrastructure for implementation of public education and communication being identified at the central and provincial level in Ho Chi Minh City, human and financial resources are currently insufficient to effectively develop and implement sustained, comprehensive, research-based tobacco control mass media campaigns.

6.2.2.3. Greater effectiveness and efficiencies in tobacco control mass media and other communications can be achieved.

The tobacco control efforts of provincial health information and education centres are guided by a national targeted programme on NCDs, but opportunities for greater strategic planning and coordination to improve effectiveness and increase efficiencies of these efforts have been identified. Developing and implementing a national research-based communication strategy could reduce duplication and overlapping of efforts to increase the effectiveness of communication and education activities.

6.2.3. KEY RECOMMENDATIONS

6.2.3.1. Dedicated funding should be committed to ensure sustainable, comprehensive tobacco control mass media campaigns and to build capacity for tobacco control education and communication. This funding could be provided by the National Fund for Prevention and Control of Tobacco Harms proposed in the draft LPCTH.

Commitment of dedicated funding for national tobacco control education and communication is required to enable ongoing, coordinated, comprehensive, research-based mass media campaigns to be developed and implemented at the national and provincial level, using paid and unpaid media and supported and reinforced through community-level education activities and resources. Additional funding is required for further training and capacity building for tobacco control education and communication staff.

6.2.3.2. Prime-time broadcast spots on national and provincial television and radio channels should be committed to tobacco control communication.

Under the draft LPCTH, the MOIC will be responsible for organizing and directing communication agencies to carry out IEC on tobacco harm prevention and control. To achieve the necessary levels of communication exposure required to educate the population and reduce smoking in Viet Nam, it is recommended that the draft LPCTH be amended to include a provision that Ministry of Information and Communication (MOIC) will direct provincial television and radio channels to allocate a concrete amount of free airtime in prime-time period to broadcast spots for tobacco control public service announcements.
6.2.3.3. An annual comprehensive, research-based national tobacco control communication strategy should be developed and implemented to increase the effectiveness and efficiency of mass media campaigns and other communication activities.

The MOH, as the coordinating agency for tobacco control communication in Viet Nam, should task the expert working group (comprising VINACOSH, WHO, HealthBridge Canada, the Hanoi School of Public Health, the VPHA and CDS) coordinated by VINACOSH to develop and implement an annual comprehensive, research-based national communication strategy. The process should include identifying priority target audiences, developing targeted strategies for these audiences, developing or adapting effective communication materials through research, achieving consistent exposure to target audiences, coordinating procedures to achieve greatest effectiveness and efficiencies in implementation at all levels and implementing monitoring and evaluation.

6.2.3.4. Further tobacco control campaigns should be designed to support and reinforce policy implementation in the LPCTH and other NCD strategies.

Development, implementation and evaluation of national and provincial tobacco control campaigns should be coordinated with and should support and reinforce other tobacco control policy measures such as the introduction of graphic health warnings on tobacco packs and compliance with smoke-free regulations, as well as linking and integrating with other NCD prevention strategies and activities.
7. Enforce bans on advertising, promotion and sponsorship

7.1. POLICY STATUS AND DEVELOPMENT

The tobacco industry engages in a comprehensive marketing strategy to create the impression that tobacco use is acceptable. Its marketing messages attach desirable qualities such as popularity, glamour, and sex appeal with tobacco use and understate the health risks. The goals of consumer-oriented tobacco marketing strategies are to recruit new tobacco users to replace those who have quit or died, to maintain or increase use among current users, to reduce a tobacco user’s willingness to quit and to encourage former users to start using tobacco again.

Comprehensive bans, which prohibit the use of all marketing strategies by the tobacco industry, reduce tobacco use among people of all income and educational levels. Partial advertising bans are less effective, in part, because the tobacco industry switches its marketing efforts to unrestricted outlets where bans are not comprehensive. WHO FCTC Article 13 requires each Party to implement and enforce a comprehensive ban on TAPS within five years of the entry into force of the Convention for that Party. Viet Nam ratified the WHO FCTC in 2005 and has introduced a number of pieces of legislation that include provisions for a ban on TAPS.

7.1.1. Existing legislation

Between 2000 and 2010, several pieces of legislation on tobacco control were introduced, including a ban on TAPS. The Ministry of Culture and Information (MOCI) was responsible for development and implementation policies related to the ban until 2007. The MOCI was divided into two ministries in 2007, and the MOCST and MOIC were assigned shared responsibilities for TAPS. The key pieces of legislation that have provisions concerning TAPS in Viet Nam are:

- Resolution No. 12/2000/NQ-CP, National Policy on Prevention and Control of Tobacco Harmful Effects During the Period from 2001 – 2010, states that tobacco advertising is banned in all forms, including the use of brand names, logos, and trademarks. Promotion of tobacco is prohibited, including through sales girls and printing of trademarks and logos in means of transportation. Tobacco industry sponsorship for cultural and sporting activities with the aim of tobacco advertising is also prohibited.
- An advertising ordinance (passed by National Assembly in November 2001 and put into effect on 1 May 2002) prohibits all advertising behaviours of commodities and services banned by the law, including tobacco.
- In 2005, Circular No. 19/2005/TT-BVHTT was enacted to implement Resolution No. 12/2000/NQ-CP and the advertising ordinance. In 2008, Circular No. 78/2008/TT-BVHTTDL was enacted, changing some of the contents of the earlier circular.

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Decree No. 56/2006/NQ-CP, Fining Administrative Violation in Cultural and Informative Activities, states that a monetary penalty will be applied for violations of advertising regulations, including tobacco advertising.

Directive No. 12/2007/CT-TTG, Strengthening Prevention and Control of Tobacco Harmful Effect Activities, states that the ban on TAPS must be strictly monitored.

Decree No. 75/2010/NĐ-CP, on regulations on fining administrative violations in cultural activities, includes tobacco advertising. Provisions include a monetary penalty for companies/organizations violating the tobacco advertising ban. Circular No. 09/2010/TT-BVHTTDL was enacted in August 2010 as a guideline for implementing Decree No. 75.

Most importantly, the Prime Minister signed Decision No. 1315/QĐ-TTG in August 2009 on the approval of the plan for implementing the WHO FCTC, including the provision for a ban on TAPS.

### 7.1.2. Enforcement mechanism and monitoring of compliance

Monitoring of TAPS ban violations and enforcement of existing legislation is a shared responsibility of three ministries: MOCST, MOIC, and MOIT.

- **MOCST** is the central body that manages all advertising activities in Viet Nam, including strict control of tobacco advertising. All types of tobacco advertising on billboards, posters, panels, boxes, cartons and matchboxes and POS violations (if any) are under the management of this ministry.

- **MOIC** is responsible for the management of all information and communication activities, including dissemination of information on tobacco control. Violation of the tobacco advertising ban through television, radio, newspapers, magazines, websites, etc. is monitored, and penalties are enforced by the MOIC.

- The Department of Market Management (MOIT) is responsible for monitoring and supervising trading activities of all POSs, including violation of the ban on tobacco advertising and promotion.

### 7.1.3. Draft LPCTH

The current draft of the LPCTH includes provisions on TAPS: Article 7 (Tobacco advertising, promotion and marketing is strictly prohibited in all forms), Article 15 (On tobacco sponsorship), and Article 25.1 (b. Displaying cigarettes). Tobacco sponsorship is allowed only for philanthropic purposes, and announcement of the names of sponsoring tobacco companies in mass media, by themselves, is prohibited.

### 7.2. KEY FINDINGS

#### 7.2.1. Existing legislations and the draft LPCTH have strong provisions to protect people from tobacco advertising on mass media, billboards, posters, etc.

The current level of compliance with these provisions is high.

#### 7.2.2. Enforcement of the current provisions on advertising, promotion, and display at POS is weak or challenging.

- According to a study conducted by the Hanoi School of Public Health, the rate of violation of provisions regarding display at POS [only in retail outlets] in 2010 was 93%. Enforcement challenges include the following:
  - Multiple ministries (MOCST, MOIC, and MOIT) are responsible for implementation, but there is no coordination mechanism between them.

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– Strong guidelines for implementation supported by a coordinating mechanism to facilitate joint efforts are currently missing.
– Resources (both financial and human) for implementation and monitoring are scarce.
– Although the fines were increased in 2010 (Decree No. 75/2010/ND-CP), they are not high enough to deter violations.
– Street vendors, of which there are a huge number, contribute to sales and are one of the most visible outlets for display of cigarette packs.
– Penalties are imposed on retailers; no fines are imposed on the tobacco industry.

7.2.3. Tobacco sponsorship for philanthropic purposes is allowed, ongoing and in conflict with the obligations of the WHO FCTC.

The government has further restricted promotion by the industry in the current draft TCL, stating that the industry itself cannot announce its support in mass media. However, there are limitless possibilities for the industry to promote itself on mass media through announcements made by others, which continue building legitimacy at various levels of government and society.23

7.2.4. There are gaps within existing legislation and the draft LPCTH.

• Display at POS not being considered as advertising does not conform to best practices for protection from advertising. Advertising promoting and marketing of tobacco in all forms is a component of the strictly prohibited acts within the draft LPCTH. However, the draft makes provisions for display at POS, and they are in conflict with WHO FCTC Article 13, which states that display and visibility of tobacco products at POS constitute advertising and promotion and should therefore be banned.
• Existing legislation on advertising and the draft LPCTH limit POS display of products to one packet per brand, which in itself is a loophole clearly exploited by the industry. The draft LPCTH substantially weakens the existing provision by allowing display of one pack per product per brand. This will create a huge loophole for the tobacco industry to exploit.
• The use of schemes of colours imitating tobacco products and depicting brand images is not restricted by the current legislation. Circular No. 19/2005/TT-BVHTT restricted the use of colours, but Circular No. 78/2008/TT-BVHTTDL further allowed it, which creates a huge gap that is exploited by the industry for surrogate advertising.
• Kiddie packs (packs of 10, 12, and 20 cigarettes) are also allowed, according to Circular No. 78. According to a study done by the Hanoi School of Public Health in 2010, 27.7% of retail outlets carried and sold kiddie packs.

7.3. KEY RECOMMENDATIONS

7.3.1. Strengthen enforcement of the TAPS ban at the POS.

• Establish a coordinating mechanism between the three ministries responsible for implementation. Also, develop and disseminate strong guidelines for the coordination mechanism to facilitate joint efforts.
• Allocate resources (both financial and human) for implementation and monitoring.
• Recommend increasing fines. Although the fines were increased in 2010 (Decree 75/2010/ND-CP), they are not at a level high enough to deter violations.
• Impose penalties on both the retailers and the tobacco industry. This should be addressed in the implementing regulations in the draft LPCTH.

23 Further drafting work has taken place on the draft LPCTH between the in-country Capacity Assessment and the production of the report. The specific issue raised at 7.2.3. has been addressed by the 5th draft dated 21/11/2011 (Article 15).
7.3.2. Recommend revision of the provision on sponsorship in the draft LPCTH (Article 15).
The draft dated 19/07/2011 restricted announcements by the tobacco industry of its sponsorship of philanthropic work. It is recommended that this be revised to reflect restriction on any mass media announcement of sponsorship. There are limitless possibilities for the industry to promote itself on mass media through announcements made by others, continuing to build legitimacy at various levels of government and society.24

7.3.3. Address gaps within existing legislation and the draft LPCTH by:
• Revising Article 25 to, at a minimum, correspond with the existing legislation that allows for display of only one pack or one carton per brand.
• Revising Circular No. 78/2008/TT-BVHTTDL, which allows for the display of colours imitating tobacco products at POS. The preceding circular (No. 19/2005/TT-BVHTT) restricted such displays but was revoked in 2008.
• Imposing a total ban on the sale of kiddie packs in Viet Nam and removing clause 2 of Article 24. The current draft includes a provision stating that the government will develop a road map based on the status of tobacco smuggling control and the need for prevention and control of tobacco harms. The regulations on graphic health warnings will be completely ineffective if kiddie packs can be sold. Kiddie packs are very attractive to youth because of their affordability and ease of access.
• Recommending revision of the draft LPCTH to have the road map impose a “ban on any display and on the visibility of tobacco products at the point of sale, including fixed retail outlets and street vendors”. Only the textual listings of products and their prices, without any promotional elements, should be allowed. This regulation was implemented in several countries, including Thailand, to deny the tobacco industry the opportunity to exploit a loophole.

7.3.4. As Viet Nam is a Party to the WHO FCTC and has also agreed to the accompanying guidelines, it should ban TAPS.
Viet Nam has an obligation to the protection of public health and to the WHO FCTC. Therefore, it should develop plans to move towards a complete ban on TAPS at the earliest possible time.

7.3.5. Cigarette sales (by street vendors) should be managed to limit POS violations.
Development of a collaborative mechanism between the MOIT and the MOCST is recommended.

24 Further drafting work has taken place on the draft LPCTH between the in-country Capacity Assessment and the production of the report. The specific recommendation for Article 15 has been addressed by the 5th draft dated 21/11/2011.
8. Raise tobacco taxes and prices

8.1. TOBACCO TAXES

8.1.1. POLICY STATUS AND DEVELOPMENT

Since 2008, a single ad valorem excise tax rate of 65% of ex-factory price (Special Consumption Tax Law 27/2008/QH12) has been imposed on all cigarettes and other tobacco products, including water pipes – the second most popular tobacco product in Viet Nam, after cigarettes. In addition to the excise tax, a VAT rate of 10% (based on the retail price exclusive of VAT) and an import duty (140% of the cost, insurance, freight [CIF] value, applied only on imported cigarettes) are imposed. The total tax as a percentage of the retail price of a pack of cigarettes is, on average, about 41%. Before 2007, a more complex excise tax system was in place, with different rates imposed for filtered and unfiltered cigarettes and for those that contained mainly imported versus domestic materials. The revised Special Consumption Tax Law of 2007 established a single rate of 55% of ex-factory price, which was increased to 65% in 2008.

Different legislative documents on tobacco tax policy recommend considering taxation as a tobacco control measure. Prime Minister Directive No. 12/2007/CT-TTg on strengthening tobacco control activities recognizes that tobacco taxation and pricing reduce tobacco use and should be used to reduce accessibility to tobacco products. The Directive recommends evaluating the impact of the Special Consumption Law on tobacco use and on the national income and continuing research to develop a tobacco tax increase plan.

The 2009 Decision on the ratification of the plan for the implementation of the WHO FCTC (No. 1315/QĐ-TTg) agreed to develop by 2010 a price and taxation road map for tobacco products aiming to “increase taxation and prices of tobacco products; levy high tax on imported tobacco products; apply regulations on minimum price for tobacco products; and apply measures to reduce and strictly control product sales at duty free shops”.

Additionally, Prime Minister Decision No. 732/QĐ-TTg approves “the strategy of reforming the tax system during the period 2011–2015”. The strategy plans to revise, among other things, the excise tax on tobacco products to restrict consumption and fulfill international commitments.

Finally, the draft LPCTH includes a provision (Article 16) requiring that the Special Consumption Tax be at a high level to limit and reduce tobacco affordability.
8.1.2. KEY FINDINGS

8.1.2.1. The current excise tax and prices are too low, according to best practice standards.

Despite a statutory excise tax rate of 65% of the ex-factory price, the actual rate as a percentage of the retail price of the most sold brand is about 32%. This is very far from the WHO recommendation that the excise tax rate should represent at least 70% of the retail price. Adding the VAT, the total tax rate is about 41%, which is below the global average of the total tax (52%) and lower than that of a number of neighbouring countries, including Indonesia (54%), Singapore (67%), Thailand (69%), Myanmar (50%) and Malaysia (52%).

If the total tax share were to be increased to the global average (around 52% of retail price), the excise tax would need to be increased from 65% to about 100% of the ex-factory price. This would lead to an approximately 30% increase in total revenues, which is substantial.

The price of a pack of cigarettes in Viet Nam is also low (US$ 1.29$ PPP) compared with the prices in neighbouring countries Thailand (US$ 3.38 PPP), Indonesia (US$ 2.14 PPP) or Malaysia (US$ 5.54 PPP). The real price of cigarettes (adjusted for inflation) in Viet Nam has been decreasing in recent years, while per capita income has risen significantly, defeating the purpose of a tax policy that aims to make tobacco products less affordable.

Consequently, the government should increase its tax rate. However, despite policy directions to increase taxes as a means to reduce consumption (the Prime Minister’s Directives and Decisions cited above), no action has been taken. This is particularly true in relation to Decision No. 1315/QÐ-TTg, which calls for the development by 2010 of a road map for a number of actions in relation to tobacco taxation, including increasing the rate.

The process of revising the tax law is complex and requires a great deal of time to come into effect. A year before submitting any tax change proposal, the issue needs to be on the agenda of the National Assembly and to follow thorough ground preparation to convince the different government agencies about its relevancy. It is therefore very important to start taking action now to plan a tax increase that would come into effect by 2013-2014.

8.1.2.2. The current excise tax structure in Viet Nam has weaknesses that provide opportunities for tax evasion and avoidance, in addition to keeping a wide gap between cheap and expensive products.

The ad valorem rate is imposed on the ex-factory price (or producer price) reported by the tobacco industry. It is difficult for the government to know the exact price; it has to rely on the value the industry reports, without appropriate means of verification. Therefore, the industry can easily report a value far less than the real value in order to reduce its tax burden. The problem could be addressed by basing the tax rate on a value the government is able to verify.

An ad valorem rate is proportionate, leading automatically to a higher burden on expensive products than on cheaper ones. A tax increase would further increase the burden on high-priced cigarettes, widening the gap between them and lower-priced products. This might encourage consumers to switch to cheaper products, rather than reducing consumption or quitting tobacco use. A specific tax that is applied uniformly tends to reduce the gap between prices as well as incentives to switch to cheaper products.
8.1.3. KEY RECOMMENDATIONS

8.1.3.1. Tobacco excise taxes should be increased to increase prices and make tobacco products less affordable.
This is the right time to increase taxes, which are currently low. There are a number of opportunities that can move this issue forward. Prime Minister Directive No. 12 and Decision No. 1315 laid the groundwork for the justification for a tax increase. And Prime Minister Decision No. 732, which approves the strategy for reforming the tax system, provides a concrete path for putting a tobacco tax increase on the table. Given the lengthy legislative process needed to promulgate such a change, action needs to be taken as soon as possible to make sure the issue is included in the agenda of the National Assembly by fall of this year or, more realistically, next year. Concerted advocacy work is needed to provide relevant government agencies with the justification for changing the tax and to make them agree to include the issue on the agenda of the National Assembly. The government should consider revising the tax law to ensure that taxes are increased in a sustainable way, rather than relying on a one-time increase.

8.1.3.2. The tobacco tax should be restructured to make it more effective in increasing revenues and reducing consumption.
To make the tobacco industry unable to falsely report a lower producer price and to make sure that tax increases are effective, the government should change the base on which the tax is applied to the retail price of tobacco products, excluding the VAT and excise tax. The suggested base would be easier to verify and it would not need to rely on industry reporting. Tobacco could be included in the price control list in the MOF. This would require the tobacco industry to establish a distribution network giving the MOF access to information on the price at all levels of the distribution chain and, ultimately, the retail price. This retail price would need to be reported to the MOF every time it changed, providing comprehensive market data to the ministry in a sustainable manner (able to be cross-checked by verifying on a regular basis the price in the market). This could be done by including a provision in the proposed revised Special Consumption Tax Law to add tobacco in the price control list.

To avoid increasing price gaps between higher-priced and lower-priced cigarettes and subsequent substitution in consumption, the government should consider introducing a specific tax rate in addition to the ad valorem rate. This would keep a balance between imposing a higher tax rate on more expensive products and would also reduce the price gap. Alternatively, the government could choose to impose an ad valorem tax with a minimum specific excise tax. This change could also be included in the proposed revised Special Consumption Tax Law.

Joint national capacity assessment on the implementation of effective tobacco control policies in Viet Nam
8.2. ILLICIT TRADE IN TOBACCO AND TOBACCO PRODUCTS

8.2.1. POLICY STATUS AND DEVELOPMENT

Sale of foreign-manufactured cigarettes, except at duty free shops, was prohibited in Viet Nam between 1999 and 2006 as stipulated in Directive No. 278-CT of August 1990 and Decree No. 11/1999/NĐ-CP of March 1999 on goods and services banned from business, subject to business restriction or to conditional business. Cigarettes were smuggled in this period to evade the prohibition on selling foreign cigarettes in the market, as noted in British American Tobacco’s internal documents in 1991 and 1994.25

In 2006, Viet Nam joined the World Trade Organization (WTO) and was required to follow the principle of national treatment for all products, which means that imported and locally produced goods should be treated equally, at least after the foreign goods have entered the market26. Decree No. 59/2006/NĐ-CP of 12 June 2006, on banned goods and services subject to business restriction or to conditional business, moved foreign manufactured cigarettes from the list of goods prohibited to the list of goods with business restriction. This resulted in a lower management level applied to cigarettes and therefore lighter punishment for smuggling. The quantity of smuggled cigarettes increased between 2006 and 2009 because the penalty frame for smugglers was weaker than it had been in the previous period. Therefore, in Decree No. 43/2009/ND-CP of May 2009, the government added smuggled cigarettes to the list of goods prohibited from sale in Viet Nam to strengthen management and enforcement, leading to a slight reduction in cigarette smuggling. In addition, Circulars No. 75/2007/TT-BTC and 78/2009/TT-BTC, issued by the MOF in 2007 and 2009, established a fund for controlling cigarette smuggling in Viet Nam.

The Customs Office, the Border Army, the Department of Market Administration, the Ministry of Public Security, and people’s committees at province level are responsible for control of cigarette smuggling. The five sectors’ work allocation and cooperation are based on the area in which smuggling takes place and its scope. The Border Army is usually in charge of control at country borders, while the Department of Market Administration becomes involved when the smuggled cigarettes have passed into the country. The Ministry of Public Security participates in smuggling control only in cases that are serious enough to bring to court.

8.2.2. KEY FINDINGS

8.2.2.1. Poor recording of cigarette smuggling and limited research in Viet Nam have provided poor evidence for strategy and policy development and ineffective enforcement in Viet Nam.

According to some sources, the Jet and Hero brands account for more than 90% of the total smuggled cigarette market in Viet Nam.

8.2.2.2. Because licensing is not required for cigarette retailers, it is difficult for the government to monitor and control smuggled cigarette sales and consumption.27

25 K Lee et al., 2008. Gaining access to Viet Nam’s cigarette market : British American Tobacco’s strategy to enter a “huge market which will become enormous”, Global Public Health, 3 :1, 1–25.
8.2.2.3. GATS 2010 indicated that the average prices of Jet and Hero cigarettes were approximately 60% and 30% higher, respectively, than the average price of all other cigarette brands.\(^\text{28}\)

Cigarette price surveillance conducted by VINACOSH and CDS indicated that Jet and Hero are two of the four cheapest smuggled brands. This suggests that taste, rather than price, drives the market share of cigarettes in Viet Nam.

8.2.2.4. The tobacco industry directly funds the government’s smuggling control forces.

Funds provided by the tobacco industry have been used for smuggling investigation, monitoring, seizure, smuggled-cigarette destruction, professional training, review meetings, rewards for contributions to smuggling control, dissemination of legislation on smuggling control and incentives for smuggling control forces.

8.2.2.5. The government is seeking more effective solutions for cigarette smuggling control.

In its effort to reduce smuggling, the government actively participates in all Intergovernmental Negotiating Body (INB) discussions. In addition, Viet Nam initiated bilateral discussions with Cambodia and Laos and a multilateral cooperation plan with Cambodia, Laos and Myanmar, seeking solutions for the smuggling problem, including tobacco smuggling in the subregion of the Mekong River.

8.2.3. KEY RECOMMENDATIONS

8.2.3.1. More research on cigarette smuggling is needed.

The government and public health organizations should invest efforts and resources in research to better understand the size, causes and features of cigarette smuggling, although such research is difficult because of the illegal nature of the activity. Sound scientific-based evidence is needed to develop smuggling control policy and to improve the effectiveness of the control.

8.2.3.2. A system to track cigarette manufacturing, distribution and retailing should be established.

Countries with high tax rates but success in controlling smuggling, such as the United Kingdom and Japan, report that managing distribution is the key. Research on the current situation, lessons from other countries on this issue and development of a retail management model are needed to step-by-step manage cigarette retailers. This will also assist in addressing other tobacco control and trade violations at POS, such as TAPS and selling cigarettes to minors.

8.2.3.3. The government should consider raising the excise tax and not worry about increased smuggling.

Prices of the most popular smuggled brands are already higher than the average price of all other cigarettes. The argument that raising the excise tax will increase the prices of legal products and make consumers switch to smuggled products is not valid. The government should raise the tobacco excise tax now to reduce consumption.

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8.2.3.4. Support from the tobacco industry should be rejected. Legislation is needed to protect public health policies from the tobacco industry’s interference.

The tobacco industry has used tactics for years and in many countries to circumvent and undermine efforts to develop and implement public health policies. WHO FCTC Article 5.3 aims to protect public health policies relating to tobacco control from commercial and other vested interests of the tobacco industry, in accordance with national law. WHO has recommended that governmental and semi/quasi-governmental bodies reject all partnerships, as well as nonbinding and nonenforceable agreements with the tobacco industry. By directly receiving support from the Viet Nam Tobacco Association, governmental smuggling control forces and related agencies can be affected by the tobacco industry’s positions. Although the government lacks adequate funding for smuggling control, its agencies should reject funding from the tobacco industry in order to comply with the WHO FCTC. The government should pass national legislation to implement Article 5.3 and disseminate it to all governmental agencies.

8.2.3.5. Regional and international cooperation in smuggling control should be enhanced.

Seeking regional cooperation while waiting for the Illicit Trade Protocol to be finalized and approved is a creative step taken by the country, and time and efforts should be invested in it. Any involvement of the tobacco industry in the process should be prevented.

8.2.3.6. The health sector should be required to participate in developing strategy and policy with respect to tobacco control.

Cigarette smuggling seriously harms public health efforts in tobacco control, because it undermines the impacts of many tobacco control measures, including taxation and health warnings. To ensure that policy and strategy relating to smuggling control do not harm the health of society, the government should require the participation of the MOH in developing strategy and policy relating to cigarette smuggling.
9. Tobacco growing and farmers

9.1. POLICY STATUS AND DEVELOPMENT

Tobacco farmers do not make up a large portion of the workforce in Viet Nam. In 2006, tobacco cultivation accounted for only 0.2% of the workforce (0.4% of agricultural workers) or about 72,000 full-time equivalent (FTE) workers. Tobacco leaves are cultivated in 27 of 64 provinces throughout Viet Nam.

In a 2009 survey, Vietnamese tobacco farmers reported they were dissatisfied with tobacco cultivation because of the instability of tobacco prices, the labour intensity required to cultivate and the negative health effects of handling tobacco leaves. The study also reported that 17.2% and 30% of tobacco farming households in two districts, respectively, fell into debt after the tobacco harvest.

Tobacco farmers receive wide support from VINATABA (the most popular cigarette company in Viet Nam) in the form of seeds, capital and rural infrastructure. Tobacco companies are making big profits from the hard work of farmers; manufacturers’ profits are increasing, while farmers’ income is not. Child labour on tobacco farms is widespread. To lower the cost of cultivating tobacco, farmers utilize unpaid family members, including children, for production.

The government’s expansion policy for the tobacco-growing sector aims to stabilize annual production by 2010 at around 40,000 hectares under cultivation and 80,000 tonnes of processed leaf, with a stated goal of “domesticating tobacco supply” by 2015 so that all cigarette production companies will use only domestically processed tobacco.

The Ministry of Agriculture and Rural Development does not promote tobacco growing, but at the same time seems to have limited capacity to support farmers.

The following programmes benefit farmers, including but not limited to tobacco farmers:

• Planning is provided in some areas, with support to switch to priority crops.
• Contracts with industry are compulsory, which provides some protection for farmers. Support is also provided for the development of such contracts, but only in pilot centres not covering all communes and districts. However, they are present in all provinces.
9.2. KEY FINDING

9.2.1. Concern about the possible negative impact of tobacco control on tobacco farmers.
In many countries, the tobacco industry uses the plight of tobacco farmers to oppose strong tobacco control legislation. In Viet Nam, concerns have been raised by the Ministry of Industry and Trade and the Viet Nam Tobacco Association that tobacco control will threaten the livelihood of tobacco farmers by eliminating the need for tobacco leaf.

In reality, farmers tend to make a poor living from cultivating tobacco; their income is falling, and they are often trapped in a cycle of debt. Locally produced leaves meet approximately 70% of the needs of local cigarette manufacturing. Around 200,000 farmers are involved in tobacco cultivation in Viet Nam, but most of them engage in other activities as well and therefore do not rely solely on tobacco cultivation.

9.3. KEY RECOMMENDATION

9.3.1. Tobacco control policy and measures should be progressively continued, since there is no evidence that tobacco control is directly linked with a reduction in employment in farming.
Farming issues should not hinder any tobacco control work, because there is no threat in the near future that demand and production will go down, particularly since consumption is still growing. Furthermore, there is no evidence that tobacco control is directly linked with a reduction in employment in farming. In countries such as Canada and the United States of America, reduction in tobacco farming was the result of government policies to reduce tobacco subsidies rather than reduction in the prevalence of tobacco use.

Tobacco control policies such as tax increases are unlikely to have a significant negative impact on employment in the tobacco cultivation and manufacturing industries, which account for only a very small share of total employment in Viet Nam – about 0.3% of all jobs. A growing population and rising incomes are likely to sustain the absolute number of jobs in tobacco-related industries in the years to come.
### Annex 1. List of institutions and key-informants

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<td>Vice Minister of Health</td>
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<td>Nguyễn Xuân Phúc</td>
<td>Vice Chief Inspector of Ministry of Cultural, Sport and Tourism</td>
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### Joint national capacity assessment on the implementation of effective tobacco control policies in **Viet Nam**

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### Debriefing meeting of the assessment team members with national stakeholders – 22 August 2011

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Annex 2. List of assessment team members

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10. Nguyễn Thanh Hương, Senior Lecturer and Researcher; Head of Social Science, Behavior and Health Education Faculty; Chair of the Health Policy Department and Health Education Department, Hanoi School of Public Health, Viet Nam
11. Nguyễn Tuấn Lâm, National Professional Officer, WHO Viet Nam
12. Phạm Hoàng Anh, Country Director of Viet Nam Office, HealthBridge Foundation of Canada; Tobacco Control Program Manager, Ha Noi, Viet Nam
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COORDINATION AND IMPLEMENTATION OF TOBACCO CONTROL INTERVENTIONS

1. Viet Nam should take appropriate measure to prevent the undue influence of the tobacco industry.
2. A strategic plan for communication between VINACOSH and relevant ministries and sectors should be established to increase tobacco control presence on the public agenda.
3. Strengthening VINACOSH’s human resources capacity is vital to ensure the smooth implementation of tobacco control activities in Viet Nam.
4. A National Fund for Prevention and Control of Tobacco Harms urgently needs to be established to ensure sustainable and adequate funding for strengthening VINACOSH’s human resources and its capacity to coordinate tobacco control.
5. An autonomous agency and efficient mechanism are needed to manage the National fund for Tobacco Control and Community Health Promotion.

MONITORING AND EVALUATION

1. Ensure sustainability of existing surveillance efforts by integrating a core set of questions and methods from GATS into ongoing surveys
2. Better utilize the existing surveillance data by ensuring translation into actionable items for policy makers.
3. Build up and systematize the activities on tobacco industry monitoring.

PROTECT PEOPLE FROM TOBACCO SMOKE - SMOKE-FREE ENVIRONMENTS

1. Improve the wording of Article 10 of the draft LPCTH by removing the option of smoking areas, to protect the health of all, in line with WHO FCTC Article 8 guidelines.
2. Issuing guidelines for implementing Decree 45 or any other regulation developed in accordance with the new LPCTH indicating which agencies should issue penalty tickets, which agency should collect the fines and how the funds should be used.
   a. Making the owners or managers of the facility where the violation occurs the subject of sanctions, as indicated in the draft LPCTH, including loss of business licence for repeat violations, in addition to fines and other possible sanctions such as public notice of violations.
   b. Communicating to authorities and leaders the need to raise the priority of enforcement efforts, including efforts leading to the creation of active mechanisms of coordination among enforcing agencies and to the assignment of a critical mass of inspectors to enforcement activities during a significant but limited time during which inspections and sanctions could be given a high public profile for education purposes.
   c. Implementing communication activities to raise public awareness about the need to comply with the smoke-free law.
   d. Creating additional incentives to comply with the law, such as including smoke-free compliance as a criterion for facility/staff evaluation within the health sector and for individual job promotion.
   e. Building the necessary capacity among the existing enforcement staff.
OFFER HELP TO QUIT TOBACCO USE

1. On a short-term basis, VINACOSH should expand existing piloted services to sustainable, nationwide, available and easily accessible quitting services.
2. The health system should build a sustainable medium- and long-term response that meets the demands of the population seeking support for quitting tobacco.

WARN PEOPLE ABOUT THE DANGERS OF TOBACCO

1. Packaging and labelling
   1. Communicate about the effectiveness of graphic health warnings.
   2. Strong graphic health warnings that occupy 50% of the front and rear of cigarette packs should be introduced.

2. Public awareness and mass-media campaigns
   1. Dedicated funding should be committed to ensure sustainable, comprehensive tobacco control mass media campaigns and to build capacity for tobacco control education and communication. This funding could be provided by the National Fund for Prevention and Control of Tobacco Harms proposed in the draft LPCTH.
   2. Prime-time broadcast spots on national and provincial television and radio channels should be committed to tobacco control communication.
   3. An annual comprehensive, research-based national tobacco control communication strategy should be developed and implemented to increase the effectiveness and efficiency of tobacco control mass media campaigns and other communication activities.
   4. Further tobacco control campaigns should be designed to support and reinforce policy implementation in the LPCTH and other NCD strategies.

ENFORCE BANS ON ADVERTISING, PROMOTION AND SPONSORSHIP

1. Strengthen enforcement of TAPS ban at the POS.
   a. Establish a coordinating mechanism between the three ministries responsible for implementation. Also, develop and disseminate strong guidelines for the coordination mechanism to facilitate joint efforts.
   b. Allocate resources (both financial and human) for implementation and monitoring.
   c. Recommend increasing fines. Although the fines were increased in 2010 (Decree 75/2010/ND-CP), they are not at a level high enough to deter violations.
   d. Impose penalties on both the retailers and the tobacco industry. This should be addressed in the implementing regulations in the draft LPCTH.
2. Recommend revision of the provision on sponsorship in the draft TCL (Article 15).
3. Address gaps within existing legislation and the draft LPCTH by:
   a. Revising Article 25.1 (b) to, at a minimum, correspond with the existing legislation that allows for display of only one pack or one carton per brand.
   b. Revising Circular No. 78/2008/TT-BVHTTDL, which allows for the display of colours imitating tobacco products at POS.
c. Imposing a total ban on the sale of kiddie packs in Viet Nam and removing clause 2 of Article 24. The current draft includes a provision stating that the government will develop a road map based on the status of tobacco smuggling control and the need for prevention and control of tobacco harms. The regulations on graphic health warnings will be completely ineffective if kiddie packs can be sold. Kiddie packs are very attractive to youth because of their affordability and ease of access.
d. Recommending revision of the draft LPCTH to have the road map impose a “ban on any display and on the visibility of tobacco products at the point of sale, including fixed retail outlets and street vendors”. Only the textual listings of products and their prices, without any promotional elements, should be allowed.

4. As Viet Nam is Party to WHO FCTC and has also agreed to the accompanying guidelines it should ban TAPS. Therefore, it should develop plans to move towards a complete ban on TAPS at the earliest possible time.

5. Cigarette sales (by street vendors) should be managed to limit POS violations. Development of a collaborative mechanism between the MOIT and the MOCST is recommended.

**RAISE TOBACCO TAXES AND PRICES**

1. Raise tobacco taxes and prices
   1. Tobacco excise taxes should be increased to increase prices and make tobacco products less affordable.
   2. The tobacco tax should be restructured in order to make it more effective in increasing revenues and reducing consumption
      a. To make the tobacco industry unable to falsely report a lower producer price and to make sure that tax increases are effective, the government should change the base on which the tax is applied to the retail price of tobacco products, excluding the VAT and excise tax.
      b. To make the tobacco industry unable to falsely report a lower producer price and to make sure that tax increases are effective, the government should change the base on which the tax is applied to the retail price of tobacco products, excluding the VAT and excise tax.

2. Illicit trade in tobacco and tobacco products
   1. More research on cigarette smuggling is needed.
   2. A system to track cigarette manufacturing distribution and retail should be established.
   3. The government should consider raising excise tax without much worry about increased smuggling.
   4. Support from the tobacco industry should be rejected. Legislation is needed to protect public health policies from the tobacco industry’s interference.
   5. Regional and international cooperation in smuggling control should be enhanced.
   6. The health sector should be required to participate in developing strategy and policy with respect to tobacco control.

**TOBACCO GROWING AND FARMERS**

1. Tobacco control policy and measures should be progressively continued, since there is no evidence that tobacco control is directly linked with a reduction in employment in farming.
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