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Independent work (thesis), 15 hp, for
bachelor's degree in public health pedagogical programme VT 2022
Faculty for Public health

"Vietnamese people would rather stop eating than stop smoking"

- A qualitative interview study about smoking in relation to health in Northern Vietnam.

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Författare

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Titel

Uppfattningar och erfarenheter kring rökning i relation till hälsa i norra Vietnam.

- En kvalitativ intervjustudie

Engelsk titel

"Vietnameser skulle hellre sluta äta än att sluta röka"

- En kvalitativ intervjustudie om rökning i relation till hälsa i norra Vietnam.

Handledare

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Sammanfattning

Bakgrund: Tidigare forskning visar att rökning är ett stort globalt folkhälsoproblem. Vietnam är ett av de länder i världen som har den högsta andelen rökare i sin befolkning, och de har också en lång kulturhistoria förknippat till tobak. Rökning bidrar till kroniska sjukdomar, luftföroreningar och förtidig död. Därför anses rökning vara ett hinder för att uppnå de Globala Målen. **Syfte:** Syftet var att undersöka uppfattningar och upplevelser kring rökning med särskilt fokus på hälsoaspekter bland studenter och lärare vid ett universitet i norra Vietnam. **Metod:** Studien genomfördes med en kvalitativ metod i form av semistrukturerade intervjuer, där sju lärare och fem elever deltog. En induktiv innehållsanalys användes, koder togs fram som sedan bildade kategorier och subkategorier. **Resultat:** Respondenterna var medvetna om farorna med såväl rökning som passiv

rökning, och hur det påverkar vår hälsa. Information om rökning påverkar inte den vietnamesiska rökkulturen. Människor röker på grund av en stressig livsstil och för att koppla av. Socioekonomisk status påverkade inte förekomsten av rökare men påverkade vilken typ av cigaretter köparna hade råd med. Majoriteten av rökarna i Vietnam är män på grund av historiska och kulturella värderingar **Konklusion:** Resultatet visar att rökning upplevs ha en negativ effekt på människors hälsa, miljö och ekonomi. Den djupt rotade rökkulturen medför svårigheter att minska tobaksanvändningen. Framtida forskning behöver bedrivas med fokus på kulturella aspekter av rökning för att ge nya initiativ bästa möjliga resultat till minskad rökprevalens.

Ämnesord

Vietnam, Rökning, Hälsa, Kulturella faktorer, Hälsans bestämningsfaktorer, Socialt fenomen.

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Title

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Abstract

Background: Previous research shows that smoking is a major global public health issue. Vietnam is one of the countries in the world that has the highest percentage of smokers in its population, and they also have a long cultural history linked to tobacco. Smoking contributes to chronic diseases, air pollution, and premature death. Therefore, smoking is an obstacle to achieve the SDGs. **Aim:** The aim was to explore the conceptions and experiences regarding smoking with a specific focus on health aspects among university students and teachers in Northern Vietnam. **Method:** The study was conducted with a qualitative method in the form of semi-structured interviews**,** where seven teachers and five students participated. An inductive content analysis was used, codes were produced which then formed categories and subcategories. **Result:** The respondents were aware of the dangers of smoking as well as second-hand smoking, and how it affects our health. Information about smoking does not affect the Vietnamese smoking culture. People smoke because of a stressful lifestyle and as a way to relax. Socio-economic status did not affect the prevalence of smokers but did affect what type of cigarettes the buyers could afford. The majority of smokers in Vietnam is men because of historical and cultural values. **Conclusion:** The results show that smoking is perceived to have a negative effect on people’s health, the environment, and the

economy. The deep-rooted smoking culture causes difficulties in reducing tobacco use. Future research needs to be carried out with a focus on cultural aspects of smoking to provide new initiatives with the best possible result of decreased smoking prevalence.

Keywords

Vietnam, Smoking, Health, Cultural aspects, Determinants of health, Social Phenomenon.

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Preface

Having received the opportunity to write about smoking as a social phenomenon in Vietnam has been very interesting. This has led to a greater understanding of how the Vietnamese people perceive smoking and how it is affected by the culture in a way that we did not have prior knowledge of. We also have a better understanding of how important it is with continued public health work to reduce the consequences caused by smoking.

The work process has been carried out jointly all the way from start to finish. We decided that we would conduct every other interview, but both were present during all interviews. The analysis and writing process has since been carried out jointly and the same with all the reworking that needed to be done.

Acknowledgement

We have a number of people we want to thank who have made it possible for us to experience the greatest academic achievement during our time as students. First of all, Kristianstad University and the assessor group that granted our MFS-scholarship so we could carry out our study in Vietnam. Many thanks to Anna-Karin Sjödal who guided and supported us through the application process and was very helpful all the way to departure. Without her help and contacts, this would never have been possible. We would like to thank our supervisor Åsa Bringsén, who has been there as support, and who has guided us in the right direction. With all her experience and knowledge, we have received lots of wise input.

We would like to thank the University in Vietnam for welcoming us with open arms. Thanks to Đỗ Hoài and Do Thi Ninh, who not only helped us find respondents to our study, but also took their time outside of work hours to make us feel at home. We would like to thank all the students and teachers who participated in the study. We want to thank you for allowing us to take part in your opinions and experiences, which has been very educational.

Cecilia Boberg Malmö 2022-05-02

Josefine Tuvesson Kristianstad 2022-05-02

1. Introduction

The use of tobacco causes approximately six million deaths globally each year and every other tobacco user dies prematurely (Gilljam 2015). If the ongoing trend continues, the numbers of yearly deaths will be up to 8 million in the year of 2030 (Abd Al-Badri, Muna Atallah, Ali & Sahib 2017). Tobacco is the leading preventable cause of inferior health and premature death, and it is known to be highly addictive and most of its users will develop an addiction (Pellmer Wramner, Wramner & Wramner 2017). The drug is not solely harmful to users' wellbeing since the smoke also causes negative health effects on people who inhale it. (Gilljam 2015). The term smoking in this context means any type of tobacco products which can be smoked. Annually about 1.2 million second-hand smokers, referring to those who are exposed to tobacco smoke, die due to the exposure of the polluted air (World Health Organisation [WHO] 2021). Moreover, according to the WHO (2021) the use of tobacco increases the risk of non-communicable diseases, for example different types of cancer, Chronic obstructive pulmonary disease (COPD), cardiovascular diseases, and respiratory issues (Gilljam 2015). COPD is the third leading cause of death and primarily induced by smoking (WHO 2022). Cancer and cardiovascular diseases are the two major causes of premature deaths globally, and tobacco users have a three times higher risk of developing them (Gilljam 2015). Due to diseases and premature deaths, tobacco use entails immensely high costs because of production loss for the national economy. This is particularly severe in developing countries with large populations. It is also shown that tobacco use is high in countries that has extensive groups with lower social status. The high tobacco usage differs in various countries, but it varies more due to inequality than poverty (WHO 2014). Therefore, it is considered essential to reduce the use of tobacco and this is a high priority in global health matters (Huang et al. 2021).

One of the goals within public health is to create an equal and sustainable world. By working to meet the Sustainable development goals [SDGs], it is a step in the right direction (UNDP n.d). The fourth WHO tobacco trend report, shows that sixty countries are now on the right track to reach the global goal of reducing the use of

tobacco by 30 percent (WHO 2021). The report also states that both African and East-Asian regions have now joined in to try and reduce their tobacco usage. This is a big step forward as East-Asia is the region with the highest percentage of smokers, 29 percent of the entire population. The report also states that even though the high percentages of smokers, the tobacco use is declining fast (ibid.).

1.2. Current health situation in Vietnam

Vietnam has a long history of using tobacco, from the old traditional, chewing on tobacco leafs, until today's cigarettes. They also have a traditional bamboo pipe, Điếu Cày, used to smoke hand-picked tobacco, Thuốc lào. This tobacco has a nicotine content of about 9 percent, which is significantly higher than normal cigarettes with a nicotine content of 1 – 3 percent (Nguyen 2019). Vietnam is now home to 15 million users and is one of the top 15 countries with the highest consumption of tobacco globally (Minh Dao et al 2019). Smoking related diseases, cause about 40 000 deaths annually in Vietnam alone, due to the high percentages of tobacco users. Statistics show that almost 43 percent of the adult male population in Vietnam are smokers, and approximately 34.5 million non-users are considered second-hand smokers (WHO 2018a). It has been estimated that the immediate cost of healthcare, related to smoking in Vietnam, is roughly around $592.4 million. The money spent on tobacco and the cost of its consequences would be of greater value spent on improving the country's education system and health care (Ngo et al. 2019a).

Recent studies demonstrate that the high usage of tobacco is caused by the population's poor knowledge of the harmful effects related to tobacco (Hinh & Minh 2013). Only about 51.5 percent of the population were aware about the high risk of developing lung cancer, cardiovascular diseases and respiratory diseases caused by smoking or second-hand smoking (Minh Dao et al 2019). Although the knowledge of negative health consequences between second-hand and active smoking has increased, there is still a high misconception in the Vietnamese population, saying that only active smoking is a contributing factor for the sequelae (ibid.).

According to already conducted studies smoking is seen as both a health hazard and a global issue for the individual as well as entire countries, leading to huge costs for health care and decreased use for agricultural lands. Even though this worldwide problem is one of the most preventable ones, people still choose to smoke. That is why this study wants to analyse possible relations between Vietnamese adults and their conception and experiences regarding smoking.

2. Literature review

2.1. Public health

In the public health perspective, health is considered to be defined by two different perspectives, the biomedical and the holistic. The biomedical perspective is based on the absence of disease. While the holistic one is considered that health is a more multidimensional perspective, which incorporates both mental, physical, and spiritual dimensions (Misselbrook 2014). The definition of health is very complex, with a lot of components and the term cannot be used the same way in every context (Larsson 1999). With the holistic perspective there is room for both the pathogenic and salutogenic dimensions, which incorporate the use of health prevention as well as health promotion. This may also mean a more people-centred health care where the health care users' resources and needs will be incorporated in the decision making (WHO 2007). As the holistic perspective gains more ground in the health care industry it might contribute to a more balanced health care where both perspectives can be combined (ibid.).

In recent years, the concept of health has developed dramatically and the traditional way of thinking that health is only defined as the absence of disease is now longer the dominant approach (Larsson 1999). The World Health Organization's definition of health is "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO 1986). Health is not an unchanging state but a mobile process that is created in the relationship between the individual, its environment and society (Larsson 1999). Though it is dependent on the three dimensions, which are environment, economy, and society. These dimensions inhabit the social determinants of health and is therefore seen as a

starting point for both the SDGs and many public health interventions (Solar & Irwin 2010). A global health convention, formed by the WHO (2005), points out that the tobacco epidemic is affecting the individuals as well as the global society. By forming a global health convention, the WHO has produced a framework that is aimed towards the 40 participating states, which on many levels will help the individual form healthier and more sustainable habits (ibid.).

2.1.1. Determinants of health

The determinants of health can be described as factors in which the individual can influence to some extent, but not all, such as gender or inheritance (Dahlgren & Whitehead 2007). Some of the most significant lifestyle habits related to health, are individuals' diets, physical activity, tobacco, and alcohol use. These habits are not only affected by our own choices but also by our living conditions (Folkhälsomyndigheten 2020). These health aspects are based on a person’s life situation, and it differs in different groups depending on education, socio-economic status, or gender. Because of these factors, those with the lower status have a harder time to live as healthy compared to those with higher status (ibid.). Further, circumstances that come with the different socio-economic groups are that the knowledge differs depending on the status. Some are more limited due to poverty and poorer education (Hai, Hai, Dung & Hens 2010). It is thus important to analyse the connection between the individual's choice, the influence of society and also health literacy when studying people’s health aspects.

However, the effect of limited health knowledge has shown a negative impact on lower socio-economic and minority groups. Though individuals' understanding of health literacy is important it is not the only crucial part. Health literacy is also how society, media, organizations, and professionals present health information in an easy and understanding way (U.S. Department of Health and Human Services 2010). The term health literacy stands for people's cognitive and social skills which are crucial for individuals’ motivation, understanding and use of information in a way that both promotes and maintains good quality of health. Health information is often quite technical and complicated even for highly educated individuals, which affects the dissemination of information to the entire population (ibid.).

2.1.2. The global goals for sustainable development (SDGs)

In 2015, the United Nations (UN) 193 member states and world leaders agreed to 17 global goals that are now officially known as the sustainable development goals (UNDP n.d). These goals were set to end poverty and hunger, fight inequality creating a more sustainable world, which is to be achieved by the year 2030 (ibid.). Tobacco consumption is seen as a major obstacle to achieve the SDGs. *Goal 1* is aimed to end poverty of all forms globally (UNDP n.d.). The non-communicable diseases caused by smoking entails high costs both by production loss and the direct cost of healthcare (Unfair tobacco 2016). *Goal 2* is aimed to end world hunger and to promote sustainable farming (UNDP n.d.). The tobacco industry occupied approximately 3.8 million hectares of land. If the agricultural lands that are used in tobacco cultivation were used in growing crops, more than 10 million of people could be fed (Unfair tobacco 2016). *Goal 3* is aimed for good health and wellbeing (UNDP n.d.). Tobacco is one of the main factors behind non-communicable diseases (WHO 2018a). *Goal 11* is aimed to create sustainable cities and communities (UNDP n.d.). Second-hand smoking caused by breathing in polluted air is a big issue and is as harmful as active smoking. By making public places, schools, and workplaces smoke free areas, it can save lives (Tobaksfakta 2016).

2.2. Smoking

The consequences of smoking affecting the individual can be anything from minor health risks, tooth decay or stomach ulcers. It may also cause different types of cancers or other non-communicable diseases, such as heart failure, stroke, or pneumonia (Socialstyrelsen 2014). These diseases have skyrocketed and thus become an economic burden for the health care system across the globe, with an estimated cost of $1436 billion. The cost due to the diseases' factors in both the direct medical costs regarding treatment at a medical centre and the indirect costs of productivity loss due to death or disability (Goodchild, Nargis & Tursan d'Espaignet 2017). Thus, the cost of smoking and its related diseases has been proven to be a challenge for creating a sustainable world as smoking entails high costs for both health care, agriculture, and the individual itself. This means that money spent on all things related to smoking could be used for other, more

sustainable, things such as improving healthcare facilities, growing crops which could be used to feed millions of people or restoring ecosystems (Unfair tobacco 2016). Smoking is considered a major risk for both the environment and the human health. Nevertheless, the relationship between pollution, non-communicable diseases and smoking is more well-known than how smoking affects people's wellbeing and mental health (Degenhardt & Hall 2001).

Even though people of today's society have a greater understanding of the relationship between smoking and diseases, the reasons for smoking have changed throughout the years. Through a more historical point of view smoking has been around for thousands of years, starting as a form of healing ritual that later became a cure for most things (Gilman & Zhou 2004). These things could be anything from medical to intoxicant use, and were promoted to everyone, but it was mostly used by the upper class. As time goes on, smoking made its way through the socio-economic groups and is now used by people all over the world (Gilman & Zhou 2004). As of 2019, there were about 1.14 billion smokers globally and they consume roughly around 41 trillion of cigarette-like products. Even though 1.14 billion sounds like a lot, the prevalence has decreased since the 1990s. This is because of an increase in the world population, which also entails a higher number of smokers in total (GBD 2019 Tobacco Collaborators 2021). Due to that smoking is still popular with many different uses, it also causes a lot of disastrous effects on both the world and the human being (WHO 2021).

As of today, smoking is not as common in all parts of the world as it once was. This is because of the knowledge that smoking causes cancer and how it contributes to other non-communicable diseases (WHO 2021). However, as many other things in our society, smoking can be seen as a societal phenomenon, something that is affected by popular trends, human influence and other circumstantial factors which changes over time (Markey 1926). The smoking culture may have changed in many parts of the world, but it is still a problem in many low- and middle-income countries. This may be because of the stress that comes with living with a low income, or it could be because of different genders, as there are many more smokers who are male (Le et al. 2018; Stubbs et al. 2017).

Since smoking is dependent on both cultural and economic factors there is a parallel to be drawn between smoking and lifestyle factors. Due to smoking being a large income factor because of high sales of cigarettes as well as a coping mechanism for perceived stress within individuals in low-income countries. There is not a clear way on how to proceed with the widespread problem (Barbeau, Leavy-Sperounis, Balbach 2004). Even though there are more restrictions regarding where and what you are allowed to smoke, it does not seem to matter to the ones who smoke the most. In South Korea the implementation of an outdoor smoking ban, which means that it is not allowed to smoke in public places outdoors, did not affect the prevalence of smoking but did affect the prevalence of attempts of smoking cessation by a few percent (Ko 2020).

One of the big benefits of implementing an outdoor smoking ban is that the air quality will improve, and this is something that the SDGs are working towards since goal 11 is aimed at creating more sustainable cities (UNDP 2021). Regarding the individuals smoking cessation, it may be promoted with the help of education, social support, and healthcare providers (Huang et al. 2021). Another thing that might influence the individual's decision to smoke is their health literacy which affects the individual's understanding of perceived health risks with smoking (U.S. Department of Health and Human Services 2010).

2.2.1. Smoking in Vietnam

Vietnam has over 15 million smokers and is one of the top 15 countries in the world with the highest consumption of tobacco. There are several reasons why people smoke, one of them being education level, but it can also depend on cultural context. For example, in Vietnam the male population consists of almost 43 percent active smokers (Hinh & Minh 2013; Minh Dao et al 2019). This is mostly dependent on sociocultural factors as tobacco is seen as a highly valued gift, a symbol of unity or a traditional part of manhood (Burgess et al. 2014). Le et al. (2018) explains not only, that men were overrepresented smokers in Vietnam, they also demonstrated that men who had a poorer self-rated health were more likely to smoke.

Tobacco and cigarettes are not only seen as a gift or a symbol, but the Vietnamese people also commonly smoke in social contexts or as a companion to drinking beer or coffee (Burgess et al. 2014). Vietnam has a very long history with the usages of different types of tobacco products, and even though the concerns around negative health effects caused by smoking and a decline in sales, the consumption is still very high (Minh Dao et al 2019). Due to more information about the health risks of smoking, the tobacco industry has evolved. They have developed other variants of cigarettes such as e-cigarettes marketed as healthier and with less tar, but these alternatives do not reduce the risk of sequelae (ibid.).

As previously stated, the male population in Vietnam are overrepresented smokers but that does not exclude the high risk for women and children posed by second-hand smoking (Le et al. 2018). Approximately 69.2 percent of women and 47.7 percent of children are considered second-hand smokers due to family members who are active smokers. Studies have also shown that about 92.6 percent of pregnant Vietnamese women had been exposed to second-hand smoking throughout their lifetime (Ngo et al. 2019b). With the high number of second-hand smokers and active smokers in Vietnam there is a public health concern that the knowledge around non-communicable diseases that can come from smoking are still quite low. Minh An et al. (2013) highlights that the general knowledge surrounding the harmful effects caused by active- and second-hand smoking was surprisingly high, with numbers at 90 and 83 percent. While the knowledge concerning the non-communicable diseases were only at 51.1 percent.

To conclude, previous research shows that smoking accounts for millions of deaths annually and is seen as an obstacle to achieve the SDGs. And to break the ongoing tobacco epidemic, public health efforts are required to contribute to a better global health. Even though there are many studies on the subject made throughout Vietnam, the majority of them are aimed towards the society, the negative outcomes in form of diseases and the costs of the matter in question. Therefore, further qualitative studies are necessary to increase the awareness of how Vietnamese people addresses smoking as a social phenomenon in relation to health and how it is portrayed in the Vietnamese culture to gain a deeper understanding.

3. Aim

The aim was to explore the conceptions and experiences regarding smoking with a specific focus on health aspects among university students and teachers in Northern Vietnam.

4. Method

4.1. Choice of method

Since the aim was to explore the conceptions and experiences regarding smoking with a specific focus on health aspects among university students and teachers in Northern Vietnam, the method of choice was a qualitative one. This is because a qualitative approach allows for a deeper understanding of the respondents' experiences which then could be analysed for a broader perspective on the subject (Patel & Davidsson 2019).

4.2. Study design

Considering the qualitative study design, semi-structured interviews were conducted as the data collection method. The choice of method was although mostly dependent on the selected topic. Also because of the previous studies that has been conducted, most of them have had a quantitative approach and did not provide the more comprehensive depth that this study will bring. By the using semi-structured interviews there was room for structure provided by the interview guide (See appendix 1), also room for situation-based follow-up questions that brought some more depth into the conversation. This doesn't mean in-depth interviews, which aims for a much deeper and broader perspective than what could be accomplished with semi-structured interviews (Patel & Davidsson 2019).

4.3. Selection

The selection of this study has been carried out with various aspects in mind. The purpose of the study was to focus on adults from a University in Northern Vietnam, due to the specific age group 20 – 35, who are more likely to speak English, are found in that arena. The reason for choosing the specific age range was due to the

younger individuals, under 20, do not smoke to the same extent (Huang et. al 2021). Kien et. al (2017) implies that the hard-core smokers in the age group 25 – 29 have gone up by five percentage points, which also strengthens the choice for the age range. Both men and women, as well as smokers and non-smokers were selected to be interviewed for the study. The choice to include both men and women as well as smokers and non-smokers, was to explore conceptions from a broader perspective. By including individuals with different lifestyle habits, it contributed to a more nuanced picture, as their perceptions may differ (Denscombe 2018). As the interview study was not linked to any specific arena or organization, a teacher at the university was contacted. Through the now existing contact person, both additional teachers and students who were suitable for the study were introduced. Since each respondent recommended additional people to partake in the study, a snowball selection was carried out (Patel & Davidsson 2019). Based on the snowball selection, 12 respondents were interviewed, of which five were students and seven were teachers.

The respondents had to match the inclusion criteria, which are listed below. When they matched, there was a discussion when and where the interview would take place. The study required approximately 10 – 12 interviews, to make sure that there was enough data for the thesis, which also gave some room for any dropouts or other errors that could occur (Denscombe 2018).

Inclusion criteria

- Age range 20 – 35
- Smoker or non-smoker
- Born in Vietnam and understanding of Vietnamese culture
- Preferably English speaking but an interpreter was used if needed

4.4. Implementation

Before the actual interviews took place, two pilot interviews were conducted to discover potential errors or other inaccuracies that could occur. The respondents that participated in the pilot interviews were selected due to them being Vietnamese and understanding the Vietnamese smoking culture. This also provided some sort

of time frame which was used to notify the respondents beforehand and it also strengthened the study's reliability (Patel & Davidsson 2019). The pilot studies answered the purpose of the study, but some questions were perceived as superfluous, and the interview guide contained too many knowledge questions. As a result, the interview guide was reworked and obtained fewer questions, but which provided more depth and ability to bring additional nuanced answers (ibid.). The material of the pilot studies were not included in the final result. The interview guide acted as a tool and helped to establish a better structure for the interview guide as well as the interviews by sectioning different questions into different themes. The themes were also useful in the analysing process, as a part of the operationalization (Patel & Davidsson 2019). In total the interview guide consisted of three themes, *smoking and health aspects; smoking as a societal phenomenon; information and understanding.*

When possible, respondents were contacted, they were informed about the study and asked if they wanted to participate. If they consented to participate in the study a time and place was decided to suit both parties. This meant that the respondents contact information was collected to be able to reach them if needed (Patel & Davidsson 2019). The interviews were conducted at the end of March 2022, in Northern Vietnam. When we met for the interview, they were handed a letter of information (See appendix 4) which had information about the study, and also notified them that the thesis will be published on DiVA Portal. This gave the respondent a chance to ask questions before partaking in the interview. There was also a letter of consent (See appendix 2) that each of the respondents had to sign before the interview could begin. In the letter of consent, we also asked for permission to record the interview so that the transcription and analysis process would go smoother and be more time efficient. During the interview only one of us were the moderator and the other one acted as an observer who supported the moderator if needed. Since the interview was based on an interview guide, there were standard questions which all the respondents answered. Though there were, if deemed necessary and appropriate, follow up questions to hopefully get a deeper

understanding for their general conception about smoking and other possible experiences that related to smoking (Patel & Davidsson 2019).

The interviews differed in length, between 15 – 40 minutes with the average of 30 minutes. For most of the interviews there were no need for an interpreter. Though there was a need for an interpreter during two interviews due to the respondents' inability to express their conceptions and experiences regarding smoking in English. The interpreter was notified about the responsibility regarding the confidentiality and had to sign an agreement stating that they would not spread the information about either the interviewee or the results of the interview (See appendix 3). When the interviews were completed, the recordings were transcribed verbatim, and analysed through a content analysis (Patel & Davidsson 2019).

4.5. Analysis

The analysis began with transcribing the interviews and even though they were transcribed verbatim some of the material when the respondents pondered for the English word were left out due to its irrelevance (Denscombe 2018). This did not affect the outcome of the transcribed material, it only made it easier to read through which assisted in the content analysis (ibid.). Before the content analysis began the respondents were given a possibility to validate their own transcribed material. By doing so it enables an opportunity to discover any misinterpretations and potential errors (Patel & Davidsson 2019).

Throughout the inductive content analysis, the transcribed material was read through to uncover meaningful qualitative units, which then were compressed into condensed meaningful units and codes (Graneheim, Lindgren & Lundman 2017) (See table 1). An inductive content analysis is used to highlight similarities and differences uncovered in the material. A manifest interpretation was used to uncover subjective and hidden codes in the condensed meaningful units (ibid.). The codes were then colour-coordinated and gathered to form categories and sub-categories which will be presented in the result (See table 2).

Table 1: Showing the content analysis process.

Meaningful qualitative unit	Condensed meaningful unit	Code	Subcategory	Category
I live in a family where my parents are doctors and nurses and I go to a school where everyone studies some kind of health, so we don't promote smoking. And I also think that people who grow up in the environment where many smoke, they also smoke. The children who grow up in the family who has dad or uncle who smokes will smoke as well. If their friends smoke, they will smoke too.	People whose surroundings involve family and friends who smoke are at greater risk of starting smoking compared to people who do not.	The environment and culture influence the individual's choices	Socialization and cultural factors	**Smoking determinants**
There are affiches, government and also on the packet you see pictures and much information on these publications. And children they know that it's bad. Particularly the children of people who smoke, they know it is bad. And because they see on the tv and publication the kids know. With the information they know and remember the information.	The adults get their information about the negative effects of smoking through various publications issued by the government, while children receive it through commercials on TV	Information gathering varies depending on age	Source of knowledge	**Smoking determinants**

4.6. Ethics

Because this study needed information from an outside party the consideration for ethics is highly valued. This means that it was necessary to take the four ethical principles, *information, approval, confidentiality,* and *use*, into great consideration before the interviews, and even before asking for permission. These four principles are supposed to guide the researcher so that the study will be ethically approved from both perspectives. Through an examination of the authorities' regulations in Vietnam, no approval of them was required to carry out the study. What was required was the approval of the individuals who would participate in the study (U.S. Department of Health and Human Services n.d.).

To meet the information principle, the potential respondents needed to be informed about the purpose of the study, this included the aim and underlying motivation for the study. If the respondents gave their verbal consent to participate, they received the letter of information. The letter stated that they had the right to cancel at any time, how long the interviews would take, how the results would be used, where the thesis will be published, when the material would be discarded of and how their participation would benefit the study (Vetenskapsrådet 2002). To make sure that the principle of approval was met, the respondents had to agree to participate, and thus they signed a letter of consent which stated the purpose of the study. This also gave them an opportunity to ask questions about their participation and about the study in general (ibid.). There was a risk that some participants did not want to sign a letter of consent because of their insecurity about signing formal documents. If this occurred a recorded verbal consent was accepted as an approval before starting the interview. If the respondents did not want to be recorded, the student who acted as an observer would also act as a secretary and a verbal consent was accepted.

Regarding confidentiality the data collected will not be spread and the same goes for the transcribed material. The respondent's identity will be kept confidential as there was no mentions of any names or extreme specifics that could possibly be linked to anyone (Vetenskapsrådet 2002). The finished product, though, will be published on DiVA Portal but since the results of the study was presented as a whole, nobody can be identified. No one will gain access to either the recordings or transcribed material, but the completed thesis is free to access online. As the need for an interpreter was necessary, it could affect the confidentiality and there was a need for an agreement between us, the respondent, and the interpreter. This is so that the interpreter does not spread any information regarding the study or the respondents. When the thesis is finished and approved, all of the material regarding the interviews will be discarded. Since this is a thesis, and the material will only be used for that specific purpose with no other intent. The material and thesis will not be used for any type of commercial purposes or non-scientific use (Vetenskapsrådet 2002).

5. Results

The results are based on 12 conducted interviews with five female and seven male respondents. Five of the respondents were students and seven were teachers at a university in Northern Vietnam. The respondents' ages varied between 20 – 35 years and approximately half of them were smokers.

The data showed that the conceptions and experiences regarding smoking fell into two categories, that is*, smoking determinants* and *effects caused by smoking*. The table below present additional subcategories and codes.

Table 2: Describes the formation of categories and subcategories.

Subcategories	**Categories**
Socialization and cultural factors	**Smoking determinants**
Source of knowledge	
Accessibility	
The impact on health and environment	**Effects caused by smoking**
Economy	

5.1. Smoking determinants

This category will present smoking determinants with a summary text reinforced with quotes. The sub-categories that will be presented below are *Socialization and cultural factors*, *source of knowledge,* and *Accessibility*.

5.1.1. Socialization and cultural factors

In general, the respondents portrayed a picture that the prevalence of smoking depended on what environment you surround yourself with. If someone's family or friends smoke, then they were more likely to smoke as well.

> *"And I also think that people who grow up in the environment where many smoke, they also smoke. The children who grow up*

in the family how has dad or uncle who smokes will smoke as well. If their friends smoke they will smoke too." (5)

However, it was not like this for everyone. Most men smoke because of their father, uncle, or other male role figures, and it is such a major part of their culture and history. The respondents described that even though everyone has the opportunity, it is generally only men who smoke.

"The typical smoker, the majority would be men. And I think every man in Vietnam smokes. (12)

They also explained that smoking is generally not something women do. The environment and family influence the men to smoke but it does the opposite for women.

"The women they never really smoke, it's just the men." (3)

There was also a difference between the age groups, where the older generation smoked because of the long history and habits and the younger generations smoked because of trend, movies, to fit in with friends or to prove a point.

"It's in the tradition of the Vietnamese, [...] Ah and people smoke because they get influenced by the films. They look very cool, the actor and actress that smoke they look like, very gangster."

The respondents did not find *socio-economic status* to be an influencing factor in Vietnamese people's tobacco use. The respondents rather pointed out that various socio-economic groups smoked different types of cigarettes from different price ranges.

"I think all social status are smoking, not only just one class. It´s just the Vietnamese people, the men it doesn´t matter if they have money or not, but they smoke different cigarettes." (3)

The respondents emphasized that the individual's living habits, and work, affects their smoking habits. They described that individuals who have stressful jobs such as healthcare workers or lawyers smoke to relax.

> *"They smoke to relieve tension from work." (4)*

The general view of the *smoking culture* in Vietnam is that it was influenced by China and France. The respondents described, from a historical perspective, that cigarettes were given as gifts during the wars to show friendship.

> *"[...] i have to say it is a culture in Vietnam because long time ago, the kings and their people were smoking in events and festivals, dinners and so on. It is just a normal thing in our lives." (11)*

The Vietnamese people have a tradition of smoking from a so-called "smoking tree" also called Điếu Cày, and like the smoking habit, it is passed on through generations. The culture is also highly affected by the use of cigarettes during almost any social gathering, such as eating, drinking, or just relaxing.

> *"People usually smoke during the party Vietnamese culture have a lot of small party after work they come back, they see someone drinking some beer and they smoke a lot." (1)*

It also emerged that the respondents' perception was that smoking had an ability to make people feel better mentally. They also described that some individuals used tobacco to manage their emotions or depression.

> *"It makes me feel comfortable especially when I feel stressed or depressed. [...] yeah, I feel relaxed when I smoke." (2)*

Furthermore, they described that smoking had become so ingrained in the culture that people would rather stop eating than stop smoking.

5.1.2. Accessibility

The respondents' perception concerning the accessibility regarding to buy tobacco, was linked to the low prices as well as the simplicity for everyone regardless of age or gender to buy.

> *"It is common, people do like it. And cigarettes are kinda cheap." (7)*

Another thing that the respondents' mentioned were that the government provides laws in order to regulate the sales of tobacco, thus reducing the prevalence of smoking. Nevertheless, it was noted from respondents that this have contributed to an illegal market which is seen as uncontrollable.

> *"[...] some people they sell it illegally." (4)*

If people need help to quit smoking, the government provides programs and help centres. Even though there are programs and centres dedicated to help with smoke cessation most respondents said that if someone wants to stop smoking, they usually do it by themselves.

> *"It is not very clear about the programs, but we have a lot of programs to stop smoking." (9)*

In order to for people to stop smoking, the respondents were all aware of the need to reduce the accessibility regarding tobacco related products. This means that the government has to follow-up on their laws and regulations.

5.1.3. Source of knowledge

The respondents gave different views on where they source their information about smoking, and it does not seem to originate from one specific place. They also stated that the source of information differed depending on age. The adults receive information about smoking through pictures of cigarette packets, publications by the government, newspapers or through various campaigns.

"It's like on news and paper and even people we discuss to each other. Even in the box of cigarettes it has picture and says ´do not smoke´." (11)

The younger population receives information via commercials on television, social media and in some schools.

"Children they know that it's bad. Particularly the children of people who smoke, they know it is bad. And because they see on the tv and publication the kids know." (1)

Further, the respondents described that even though the government provides the population with information and have issued laws to regulate smoking in public places, the rules are commonly overlooked. One of the respondents even highlighted that in more rural areas it is still common for people to smoke inside the hospitals.

"Vietnamese government they have a law that says smoking is not permitted in public places in Vietnam [...] However the punishment is not serious enough, so the smoking behaviour is still very strong. So, the schools and hospitals still have people who smoke." (9)

The respondents clearly stated that there are many different sources of information that are available to everyone, but at the same time the majority believe that the smokers choose to ignore it.

5.2. Effects caused by smoking

This category will explore the consequences of smoking and how they affect our health, the environment, and Vietnams economy. There are two sub-categories that represents this result, *The impact on health and environment,* and *Economy.*

5.2.1. The impact on health and environment

The respondents' general understanding and conceptions about smoking were that smoking has a negative impact on human health. The respondents explained that

although smokers understand the risks of smoking, their perception is that they do not care.

> *"We all know that smoking is bad. Even the smokers know." (6)*

Most of the respondents also described that the smoke pollutes the air, and the used cigarette butts are thrown everywhere. They believed that smoking had a major negative impact on the environment and air quality.

> *"It can harm our health and they affect themself and everyone around them, that is why people should not smoke in public places. Also, the environment and the pollution. And myself never smoked and I support the environment of non-smoking." (8)*

Furthermore, they emphasized that it should not be allowed to smoke in public places such as cafes, restaurants, hospitals, schools or where there generally are a lot of people who will inevitably inhale the smoke.

The phenomenon, *second-hand smoking*, was perceived by the respondents as individuals who do not smoke themselves, but who inhale the smoke from friends or family members.

> *"I am one of their friends, so I have to breathe in all the smoke." (7)*

Half of the respondents thought that second-hand smoking was more dangerous than active smoking, and also that the passive smokers had a higher risk of sequelae. It was also explained that second-hand smoking had similar effects as for those who were active smokers, but they perceived the risks as equivalent. They mentioned that second-hand smokers did not choose to smoke themselves and therefore it can be seen as worse than active smoking.

> *"It is also very dangerous for other people who live around people who smoke, especially a relative, a wife or husband or*

children or colleagues. I think second-hand is a serious way to affect other people's health, even if they don't smoke." (4)

Furthermore, the respondents described that in their opinion, almost all non-smokers are passive smokers in Vietnam, and they perceived the smoke as uncomfortable, smelly, and disgusting.

All of the respondents were aware of different *health consequences* and non-communicable diseases related to smoking, and many of them knew of people who had died or gotten sick because of smoking.

"It affects a lot because my grandfather he did smoke and he died about 10 years ago because of lung cancer." (10)

They mentioned that smoking is a common risk factor for lung cancer, COPD, as well as cardiovascular and pulmonary diseases.

"I saw many people with some kind of lung cancer or chronic pulmonary diseases like COPD and asthma or something like that." (1)

Some of the respondents did not see the negative health consequences caused by smoking as much as others. Most mentioned seeing the negative effects of smoking in different places, for example in the hospitals and among their neighbours.

5.2.2. Economy

The fact that smoking affects the Vietnamese economy was brought up by many respondents. A few respondents mentioned that smoking is a contributing factor for economic loss due to disease and death.

"And there is much economic loss due to, we have to pay a lot of money to cure the disease." (11)

Others talked about the personal income loss due to smoking and that a packet of cigarettes costs between 15 000 – 200 000 Vietnamese Dong or roughly $0,65 –

$8,7. Some said that people could earn approximately one dollar per day if they quit smoking.

> *"The first one is effect to the smoker's economy; it costs around one dollar for one pack of cigarettes." (9)*

According to the respondents, the Vietnamese economy is affected by the tobacco market and that both families and society would benefit from a decreased prevalence of smoking.

5.3. Summary of results

It can be concluded that all of the respondents were aware of the dangers of smoking as well as second-hand smoking, and how it affects our health. They mentioned how and where they get information about smoking, but the information does not really affect the smoking culture. The same goes for the laws that are supposed to regulate smoking in public places. It was also stated that many smoked because of stressful lifestyles, and smoking was seen as a way to relax. The socio-economic status did not matter regarding the prevalence of smokers but affected what type of cigarettes the buyers could afford. The prevalence of smoking was affected by the unregulated sales of cigarettes, and they are easily bought by anyone. Even though, a major part of the Vietnamese population smoke, it is generally men who smoke. This stems from historical and cultural values that are carried on through traditions. Smoking has such a tough grip on Vietnamese culture that people would rather stop eating than stop smoking. However, the negative health effects of smoking, disease, and death, is one of the causes for economic loss.

6. Discussion

The discussion is divided in two parts, the first one proceeds with discussing the main results from the study and the second one discusses the method choices.

6.1. Result discussion

Every respondent mentions that smoking affects their health. This corresponds with Minh Dao et al. (2019), that even though most smokers know that it is harmful, they

continue to smoke. One reason for this, could be the respondents' already existing knowledge due to education. Education is thus one of the main reasons why some Vietnamese understand more about the dangers of smoking than others (Minh An et al. 2013). That being said, one reason why people continue to smoke is due to the ingrained smoking tradition which is such a major part of the Vietnamese culture (Burgess et al. 2014). The tradition might have a high cultural value, but it does not facilitate a promotive environment where smoking is considered to be something unacceptable. Rather it seems like the traditions promote smoking which might be a significant reason why people do not fully comprehend the actual harm smoking has on the body (ibid.).

Further, age and gender play an important role in determining the reasons why people smoke. The respondents believed that it was more socially accepted among middle-aged men to smoke because of the long cultural history. Younger people smoke to seem cool or because they were influenced by the older men in their family. Page et al. (2012) state that the Vietnamese youths' parents and other important adults have a great influence on their smoking habits. According to Banduras (1977) Social learning theory, it is not only the individuals' thoughts and opinions that influence their behavior. The interpersonal factors intertwine with the environment creating a greater understanding of how different factors and behavioural patterns interact. This can also be explained in relation to the determinants of health. Under the first of the four categories, the one closest to the individual, are *social networks* (Dahlgren & Whitehead 2007). They describe that social support, children's adult contacts, and social relationships is important factors for individuals' health (ibid.). Because children and young people are influenced by the elderly in their vicinity, affecting the choices they make for their own health.

The respondents believed that second-hand smoking is more dangerous than active smoking and therefore is a larger contributor to the sequalae. According to Minh Dao et al. (2019), the Vietnamese people have some knowledge of the risks of second-hand smoking. Though they are not as aware of the fact that second-hand smoking also causes non-communicable diseases. This coincides with another study where Mexican and Central American immigrants in USA were asked about

their beliefs about second-hand smoking (Arcury et al. 2020). More than half of the respondents expressed a belief that second-hand smoking is worse than direct smoking due to the fact that second-hand smokers did not choose to smoke (ibid.). Even though many smokers have enough knowledge about the harmful effects of smoking they choose to ignore the potential risks that they expose others to. According to Kegler et al (2014), this might be because smokers are less likely to believe that second-hand smoking causes harm and therefore continues to smoke around others. Society generally expects healthy people to cope with different environmental factors which in this case is second-hand smoking (Tengland 2007).

All respondents mentioned that they received information from different sources, such as friends, media, or internet. However, finding information about health risks from unreliable sources might lead to confusion which then can cause the spread of misinformation (Burgess et al. 2014). The lack of reliable sources from which people receive their information is something that Myrick and Hendryx (2021) writes about in their article about health information in rural Appalachia. They found that interpersonal information seemed to be more trustworthy than the information sourced from the media. Regarding this there could be a correlation between the sourcing of information and health literacy. Health literacy is often connected with educational level and thus is something affecting both the individuals and societal health (U.S. Department of Health and Human Services 2010). Therefore, it could be beneficial for the Vietnamese government to target the communities with a lower level of education and thereby increase the populations awareness about smoking. Van Hoa, Vu, Van Tuyen and Khue (2020) points out that engaging communities is a good way of increasing health literacy in specific groups. In a public health context health literacy is a key factor for the individual's feelings of empowerment and hence a key factor for a developing society. This means that the information about smoking needs to be adapted to the recipients, so they gain knowledge and understanding of how to use the information to their benefit (WHO 1998).

It is clear from the results of this study that the perception of whether socio-economic status have an impact on the smoking habits of the Vietnamese

population is not considered a contributing factor. This is something that contradicts the results of most previous studies where they highlight that people who are in a lower socio-economic status smoke more (Hai, Hai, Dung Hens & 2010; Le et al. 2018; WHO 2014). Hiscock et al. (2012) implies that people with lower socio-economic status entails a higher risk to start smoking due to several possible factors. It can be anything from the tobacco industry targeting specific groups, higher life-related stress, a more positive attitude towards smoking or the lack of knowledge about the negative health effects. Hai, Hai, Dung, and Hens (2010) also express that a lower socio-economic status contributes to a deterioration in health due to a lower level of education, knowledge, or poverty.

Respondents in this study describe that they did not have the perception that a lower socio-economic status increases peoples smoking habits, as they believe that cigarettes are both readily available and cheap. Their perception is that those with lower status smoke cheaper tobacco and those with a higher status smoke finer and more expensive tobacco. To reduce the accessibility to buy cigarettes, several measures are required. Vietnam has begun a tax increase on tobacco with hopes that it will reduce the demand (WHO 2018b). Furthermore, they show in their publication that the increase in tax has reduced sales, but the most recent increase was so minor that it hardly had any effects on sales. By raising the cost of cigarettes, fewer people would be able to buy them, which can result in a discussion if it is considered ethically correct to exclude a social group. This is something that the human value principle states, that all people have equal value and the same right regardless of personal characteristics and functions in society (SOU 1995:5). Therefore, it is important to keep the ethical principles in mind when implementing laws or regulations so that no social group is excluded. By raising the taxes, the respondents point out that it leads to an increase in the black market and illegal sales. According to Park (2017), the tax increase in cigarettes is not a contributing factor to the illegal market in Vietnam. He states that the biggest factor for smuggling is the high import tax. This is considered positive and strengthens the arguments to continue the tax increase of cigarettes, as statistics cannot show an increase in the illegal market but does show a decrease in sales (ibid.)

The respondents concluded that Vietnamese people smoked because of cultural traditions, family, and friends. They also described that the majority of the smokers are men, and it is rarely the women who smoke. This is something that Bush et al. (2004) highlights in their study. Their findings suggest that men's smoking behaviour is related to social acceptance, friendship bonding, and a traditional view of the male identity. They also believe that women do not smoke as it is considered a taboo and will reduce their social acceptance and chances of marriage (ibid.). This is not something that the study's respondents expressed, but when asked about who smokes, it is clear that women do not and should not smoke. This standpoint that women should not smoke, can be interpreted from both a negative and a positive view in relation to public health. From the negative point of view, it creates a more unequal society from a gender perspective (WHO 2021). However, as genders becomes more equal, statistics show that smoking is increasing for women. In low- and middle-income countries, where the view has been as the respondents express, that women should not smoke, there is a more prominent trend regarding smoking among women (Tobaksfakta 2015).

The respondents declared that smoking is not prohibited in public places and that the government has added laws to reduce the smoking accessibility in those places, however the smokers seem to not care. Despite the fact that Vietnam has introduced laws and restrictions regarding where people are allowed to smoke and also for tobacco advertising, the death toll is expected to increase from 40,000 to 70,000 annually in 2030 (WHO 2018a). Furthermore, they describe that the tobacco industry adapts its advertising and products to attract the younger population in Vietnam with products that are colourful, taste good, and advertised as less dangerous. However, there is nothing to suggest that the new products do not contribute to the same harmful effects as regular cigarettes (Minh Dao et al 2019). From a public health perspective, it is essential to evaluate the effects that the new tobacco products have on the health of the population (U.S. Department of Health and Human Services 2020). Due to a lack of information about the new products, the tobacco epidemic has a high risk of continuing to spread.

Even though smoking negatively affects all three dimensions of health, the social, environmental, and economical, the respondents made it clear that smokers would rather stop eating than stop smoking. The negative consequences do not seem to bother smokers, it is more so that the smokers use tobacco as a coping mechanism for their wellbeing (Glanz & Schwartz 2008). Coping mechanisms are used to manage different stressors in life and can be portrayed differently depending on the individual. According to Degenhart and Hall (2001) current and former smokers have a lower score for life satisfaction than non-smokers. This is not something that the respondents in this study have mentioned. Though it might be because of an overall poorer life satisfaction among the Vietnamese smokers (Le et al. 2018). However, smoking is not only a coping mechanism it can also be seen as something essential for the smoker’s wellbeing and therefore quality of life (Sen & Nussbaum 1993). This does not mean quality of life as in ‘good health’, but more of a spiritual and mental wellbeing, where the individual takes pleasure from doing specific things, such as smoking.

6.2. Method discussion

To meet the purpose of this study, a qualitative design was required, as the study aimed to explore the conceptions and experiences regarding smoking with specific focus on health aspects among students and teachers at a university in Northern Vietnam. Qualitative studies are considered appropriate when the purpose is to interpret and understand peoples’ subjective experiences and opinions (Patel & Davidsson 2019). The main goal was to get a deeper understanding of the social phenomenon that is smoking whilst also obtaining further knowledge about specific factors that may affect the smoking habits of the Vietnamese people. The authors preunderstandings before conducting the study, was that smoking is a major public health problem, especially in Vietnam. However, since the authors are born and raised in Sweden the presumptions regarding smoking were contradicting. Which led to a different cultural view of smoking compared to the Vietnamese people. This meant that the authors might have been naive to the respondents’ perceptions, and how they normalised the view of the Vietnamese smoking culture. Nevertheless,

this also meant that the authors could ask critical questions regarding opinions, which made the respondents answers more detailed.

Through the use of a snowball selection, the authors were able to ensure that the respondents would fit the inclusion criteria. It was also considered appropriate as the authors did not have the opportunity to look for their own co-acts due to the ongoing covid-19 pandemic. According to Patel and Davidsson (2019) a snowball selection is considered to be a suitable approach for qualitative studies, but it is not possible to say that the sample will be representative to all the individuals at the university. The sample could be seen as relatively narrow in relation to the diversity of people in Vietnam, as all respondents recommended each other, which meant that they originated from the same arena. Despite this, it was discussed that both the students and the teachers at the university came from different backgrounds and had different views on the subject, which still gave the study some width. It would have been interesting to include additional respondents, from other arenas or had less experience on the subject. It would also have strengthened the study's reliability if the sample was broader and included respondents from further arenas or cities (Graneheim, Lindgren & Lundman, 2017).

The method used for data collection was semi-structured individual interviews. Interviews are best conducted when studies have the intention to study complex phenomena such as opinions, perceptions, emotions, or experiences (Denscombe 2018). Individual interviews contribute to more personal relationships, which in turn creates a preferable ambience for the interviews (Bryman 2011). A good atmosphere creates favourable conditions for the respondents to feel safe, and by extension speak openly and honestly. The choice for using semi-structured interviews was to provide the respondent with the opportunity to lead the conversation and then develop their thoughts and ideas. Which leads to a flow in the interviews that structured interviews lack (Denscombe 2018). To ensure the validity of the study, an interview guide was used which consisted of open-ended questions. This meant that the respondents were allowed to answer similar questions based on specific themes, but the formulation of the questions and follow-up questions were adapted to each individual interview (Patel & Davidsson 2019).

Semi-structured interviews also ensured that the interviews adhered to the topic and that the answers were rich in content (Danielsson 2017).

Both of the authors participated during the interviews. Whilst one acted as the moderator, the other acted as an observer. This decision was made since it was considered an advantage to have an observer who could offer support if misunderstandings arose or, due to that the interviews were held in English which is not the authors' mother tongue. As the authors are not trained interviewers, this may have affected the trustworthiness of the study (Elo et al. 2014). Through the authors' already existing knowledge of the subject, it is conceivable that the result might have been affected by presumptions and opinions. However, Trost (2010) describes that with two interviewers and only one respondent, it can cause discomfort to the respondent, as it can be perceived as being in a lesser position of power. Despite the risk of discomfort, the decision was still made because the study’s validity would benefit from including both authors during the interviews (Patel & Davidsson 2019).

All of the conducted interviews were recorded to ensure the result, also in order to guarantee that nothing had been missed out (Bryman 2011). The recordings were transcribed and then sent back to the respondents for a respondent validation. This was done to ensure the validity of the study and to give the respondents an opportunity to clarify or change any misconceptions that might have occurred (Denscombe 2018). The response validation provides an opportunity for the authors to check the accuracy of the findings and confirm the respondents' opinions and experiences (ibid.). Through the use of a smaller, qualitative study, and that only 12 informants as well as a snowball selection were used, the results cannot be considered representative or generalisable (Elo et al. 2014). However, the result and context has been thoroughly described, and an established analysing method was used to ensure that the study was as transferable as possible.

When the respondent's validation was completed and approved, a content analysis was performed. Condensation and coding were performed close to the transcribed text to reduce the risk that the authors' own interpretations would affect the analysis. By being impartial when analysing the results, it increases the study's

conformability (Elo et al. 2014). A factor that was considered to strengthen the study's conformability was the authors' collaboration during the analysis process. Dialogues regarding interpretation and sorting of data were carried out on an ongoing basis (ibid.).

7. Conclusion

To conclude, the main result of the study shows that people in Vietnam knows that smoking is harmful for both their health, environment, and the economy. Since smoking is so deeply ingrained in the Vietnamese cultural traditions, it could be considered difficult to influence their smoking habits. This could also be difficult because many rely on smoking to reduce stress and to improve their wellbeing. Even though the people have knowledge of the negative health effects caused by smoking, men are still passing down the traditions to their sons. This might be due to the lack of knowledge about the determinants of health, how the environment affects the individual's own choices, or that they do not understand the importance of how much children's adult contacts are influencing their health choices. The economic factors affected by smoking in Vietnam are not considered to be as difficult to influence as the cultural ones. For example, by raising the tobacco taxes, it is considered to reduce both the sale of tobacco products and thus the number of smokers. With that said, it is still important that additional research is done on the subject to reduce the temptation for people to start smoking.

To be able to reduce the ongoing tobacco epidemic in Vietnam, it is considered necessary to improve the Vietnamese people’s health literacy. With further knowledge about smoking, its consequences, and how they influence each other, the goal is to see a decrease in the number of smokers in all age groups. This can be done by additional studies, which have a broader selection and targets multiple arenas. Through an increased understanding of the social learning theory, it might contribute to a possible change or that further studies could use the theory while study the subject. By including a wider perspective there is a possibility to both gain more knowledge about the smoking culture as well as increasing people’s health literacy.

Regardless of efforts, the public health work and laws established in Vietnam needs a proper evaluation from organizations and the government. Because of the current situation, people are ignoring the latest smoking regulations.

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Appendix 1

Interview guide

Opening questions

- Could you tell us a little bit about yourself? *(What do you do for a living? What does a typical day in your life look like? (Social status?))*

Smoking as a societal phenomenon

- Describe how the smoking culture looks like in Vietnam *(Why do you think it's common for Vietnamese people to smoke? Who is the typical smoker? (Is there any connection between smoking and social status))*

- Please describe a situation where it is not acceptable to smoke

Smoking and health aspects

- Can you describe your thoughts about how smoking could be related to a person's health and wellbeing *(Do you believe it is essential? How do you think smoking affects the Vietnamese people? Describe how a person's social status could be connected to their smoking habits)*

- In what way do you believe smoking could be a contributing factor to other health problems? *(And have you, or anyone you know of, experienced any effects due to any kind of smoking (direct or second-hand)?*

Information and understanding

- Can you please tell us what you know about smoking? (*Describe the phenomenon second-hand smoking. Where would someone turn to if they wanted to quit smoking?)*

- What information about smoking in relation to health do the Vietnamese people receive from the government? *(What type of information about smoking does students receive in school? Do they talk about second-hand smoking? Is it common for advertising/social media to show smoking? If yes, in what way?)*

- Is there anything you would like to add?

Appendix 2

Consent form

Consent to participate in the study

I have received verbal and/or written information about the study and have had the opportunity to ask questions. I may keep the written information.

I agree to participate in the study: "Vietnamese people would rather stop eating than stop smoking"

- A qualitative interview study about smoking in relation to health in Northern Vietnam.

Place and date	Signature
	Name clarification

Appendix 3

Agreement form for interpreter

I have been asked and agree to be an interpreter and I have been informed about the confidentiality regarding the interviewees and the interview material. This means that I will not spread information about the interviewees or the interview material.

I agree to being an interpreter to the study: "Vietnamese people would rather stop eating than stop smoking"

- A qualitative interview study about smoking in relation to health in Northern Vietnam.

•

Place and date	Signature
	Name clarification

Appendix 4

Letter of Information

"Vietnamese people would rather stop eating than stop smoking"

- **A qualitative interview study about smoking in relation to health in Northern Vietnam.**

Our names are Josefine, and Cecilia and we are students in the Public Health Program at Kristianstad University in Sweden. We are doing a minor interview study for our thesis. The aim is to explore the conceptions and experiences regarding smoking with a specific focus on health aspects among university students and teachers in Northern Vietnam.

We want to ask you if you want to participate in a study. In this document you will receive information about the study and what it means to participate.

What is the study about and why should you participate?

The reason for conducting this study is due to smoking being a common phenomenon in the world and some countries have a higher consumption than others. Vietnam is one of the top 15 countries with the highest consumption of tobacco in the world. Therefore, we want to conduct this study to get a better understanding about the smoking culture in Vietnam. We hope to gain understanding and knowledge that can be used for future studies about smoking.

This study is directed towards young adults who are born in Vietnam and are familiar with the culture. This is because you can provide a Vietnamese perspective on smoking as a societal phenomenon.

Your participation involves an in-person interview that will be held by both Cecilia and Josefine and the interview will last about 30 - 45 minutes. If you perceive any

of the questions sensitive or difficult to answer in any way, you will have the possibility to skip those questions.

What happens to my personal information?

The study, “Vietnamese people would rather stop eating than stop smoking” A qualitative interview study about smoking in relation to health in Northern Vietnam, will not collect any sensitive personal information about you as a participant. The recordings and transcribed material will be saved for the length of the study and until the thesis is completed. After that all the material will be deleted. You will be offered to partake in the transcribed material in-person to avoid misinterpretations. Confidentiality will be preserved so that no one besides us (Cecilia, Josefine and an eventual interpreter) knows who participates or who says what during the interviews. Your specific answers will not be disclosed since the results from all interviews will be presented as a whole.

The results of the study will be published on www.diva-portal.org and can be found there if you are interested.

Participation is voluntary

Your participation is voluntary, and you can choose to cancel your participation at any time. If you choose not to participate or want to cancel your participation, you do not have to state why. In case of cancellation all the data will be deleted and will no longer serve as a part of the study.

You are welcome to contact us if you have any questions about the study or want to cancel your participation.

Yours sincerely,

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