PERGAMON

Social Science & Medicine 55 (2002) 681–690

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Smoking and young women in Vietnam: the influence of normative gender roles

Martha Morrow[a,*], Do Hong Ngoc[b], Truong Trong Hoang[b], Tran Hue Trinh[b]

[a] *Key Centre for Women's Health in Society, University of Melbourne, Melbourne, Vic. 3010, Australia*
[b] *Health Information and Education Center of Ho Chi Minh City, Viet Nam*

Abstract

Smoking in Vietnam, as elsewhere in Asia, is strongly sex-linked. A 1997 national prevalence survey found about half of males but just 3.4% of females used tobacco regularly. Little is known about smoking-related health awareness or attitudes in Vietnam. There is concern that women may take up smoking if rapid social change brings alteration in traditional gender norms that discourage this behaviour. Effective tobacco control depends upon accurate understanding of prevailing knowledge and views.

This paper reports on a 1999–2000 collaborative study into smoking attitudes, practices and health awareness, with particular reference to gender norms. A survey, based partly on findings from initial focus groups, was administered to young female students ($n = 1018$) and factory workers ($n = 1002$) in Ho Chi Minh City, Vietnam's largest metropolis. Participants were recruited through random cluster sampling.

Results indicated that smoking continues to be shunned by the vast majority of young urban students and factory workers, although prevalence was slightly higher than found in national surveys, and there was a moderate degree of experimentation. Perhaps of greater concern was the degree of ambivalence voiced about taking up smoking in the future. Moreover, while nearly all expressed awareness of negative health effects of tobacco, these were vaguely worded and excluded key mortality risks. Gender norms appeared to be strongly enduring, with female non-smoking attributed overwhelmingly to its 'inappropriateness'. Male smoking was seen as normative. Overall, workers (representing a low-income, less-educated population) had higher rates of tobacco use and less health knowledge than students. The paper concludes with a discussion about ramifications for public health interventions.

Keywords: Vietnam; Young women; Tobacco control; Smoking; Gender

Introduction

Smoking is the single largest cause of preventable death worldwide. One in ten adults dies of tobacco-related diseases today, a figure set to reach one in six (or 10 million deaths annually) by 2030. Seventy percent of these deaths will be in low- and middle-income countries, where smoking rates have risen by about 3.4% per annum in recent years (WHO, 1999a; World Bank, 1999). From 1990 to 1995, cigarette sales increased by about 8% in Asia and the Pacific, but fell by nearly 5% in North America (Kaufman & Nichter, 2001). The young demographic profile and usual 30–40 year delay in mortality presage a heavy future health burden in countries that can least afford it.

The 52nd World Health Assembly in May 1999 voted to establish a working group to draft a Framework Convention on Tobacco Control. The World Health Organisation (WHO) Western Pacific Region has called for 'targeted and timely health promotion and advocacy initiatives' to prevent uptake among women and youth (WHO, 1999b, p. 3).

Although smoking is harmful to all groups, women face additional threats. There is debate over whether

*Corresponding author. Tel.: +61-3-8344-4417; fax: +61-3-9347-9824.

E-mail address: martham@unimelb.edu.au (M. Morrow).

0277-9536/02/$ - see front matter
PII: S0277-9536(01)00310-0

men or women are more vulnerable to lung cancer with equal exposure to tobacco (Payne, 2001). Female smokers face enhanced risks of cardiovascular disease in combination with oral contraceptives, and higher rates of infertility, premature labour, low-birthweight infants, cervical cancer, early menopause, and bone fractures. Non-smoking women risk consequences of environmental tobacco smoke (e.g. higher risk of lung cancer and heart disease) and the burden of caring for partners with smoking-related illnesses (Ernster, Kaufman, Nichter, Samet, & Yoon, 2000; Vierola, 1998).

To be effective, health policies and programmes must appropriately address social norms, roles, cultures and communication styles of target populations (WHO, 1994, 1995; Yach, Jensen, Noris, & Evan, 1998). Smoking, like other health behaviours, is practiced within a wider social context, with variations by age, ethnicity, gender and social class (WHO, 2000a; World Bank, 1999). This suggests the value of considering smoking 'as an individual response to a social environment' rather than 'a voluntary lifestyle choice' (WHO, 1994, p. 27). Smoking presents additional challenges to health promotion because of its addictive nature.

Social factors and tobacco use

Overwhelmingly, smoking is embarked upon during youth, although Aghi, Asma, Chng Chee Yeong, and Vaithinathan (2001) observe that different factors may predispose youth uptake in different cultures and settings. Advertising that glamorizes tobacco use or renders it normative is often difficult for young people to resist (Rainey & Lammers, 2000; Seimon & Mehl, 1998; World Bank, 1999).

Waldron et al. (1988) trace historical gender differences in tobacco use in the non-western world. While males have used it more in most regions, in some cultures and times it has been consumed evenly, particularly smokeless (e.g. in parts of Africa) or non-commercial variants (such as pipe smoking in north Asia until the late 19th century). Higher male smoking prevalence mirrored the greater availability of commercial cigarettes, especially where there was contact with the West. The authors argue that female smoking is rare in societies with strong constraints on women's freedom and access to household income, especially in poor countries. They predict, 'as modernisation proceeds these features of sex roles are likely to change and women's rates of smoking are likely to increase in many non-Western societies' (p. 1274).

Smoking in Western countries was predominantly a male activity until World War II. By the late 1960s brands targeting women, often using images of female liberation and independence, were being produced for the US market (Worth, 1999). Today there is little sex-linked difference in prevalence among youth in the US, parts of western Europe, New Zealand and Australia, and parts of Latin America (Hill, White, & Letcher, 1999; Reeder, Williams, McGee, & Glasgow, 1999; WHO, 1998). However, even in these societies, the context in which people initiate, practice, and cease smoking often varies along sex lines (Royce, Corbett, Sorensen, & Ockene, 1997; Hunter, 2001).

In high- and low-income countries alike, tobacco use is more common among poor, less-educated men (World Bank, 1999). Where female rates approach those of males in developed countries, the same socioeconomic relationship is found (WHO, 2000b). Where women use tobacco at lower rates than men, both positive and negative associations with social class have been noted (Stanton, 2001). Making generalisations is difficult, because properly disaggregated data, collected consistently and over time, are usually unavailable. A further problem is that surveys often exclude non-commercial forms (roll-your-own, chewed, or with areca) popular among older, rural women, and less-educated populations. With increased urbanisation and globalisation, an apparent decline in female "tobacco use" may actually reflect a transition to commercial cigarettes. In India, for example, female cigarette use in urban centres hovers between 2% and 5%, but smokeless tobacco is used by up to 67% of rural women (Aghi et al., 2001). Cigarette smoking incurs intense disapproval in India, and seems to be practiced primarily by urban elites (e.g., college girls). In 1990, British American Tobacco launched the *Ms* brand in India, targeting "emancipated women" (Kaufman & Nichter, 2001, p. 82).

Ethnographic research in the Philippines found cigarettes were used by women 'as a substitute for expressing feelings' such as anger or unhappiness (Kaufman & Nichter, 2001, p. 83). Tobacco thus may be used as self-medication, which presents challenges for public health interventions, especially given the strong associations found elsewhere between smoking and mental disorders, including depression (Acierno, Kilpatrick, Resnick, Saunders, & Best, 1996; Jorm, 1999).

Smoking in the Asia-Pacific region

The World Bank (1999) estimates that 59% of males and 4% of females smoke in East Asia and the Pacific, although there are wide variations between countries (see Table 1).

China, Singapore and Vietnam have the region's lowest female rates, while Chinese and Vietnamese men are among the heaviest smokers. A trend towards higher use among young women is evident in Japan, the Philippines and Singapore, nations where female smoking has been deemed unladylike and suggestive of promiscuity (except, in the Philippines, among older women) (Kaufman & Nichter, 2001). Rates among Japanese women aged 20–22 rose from 12% to 22% in