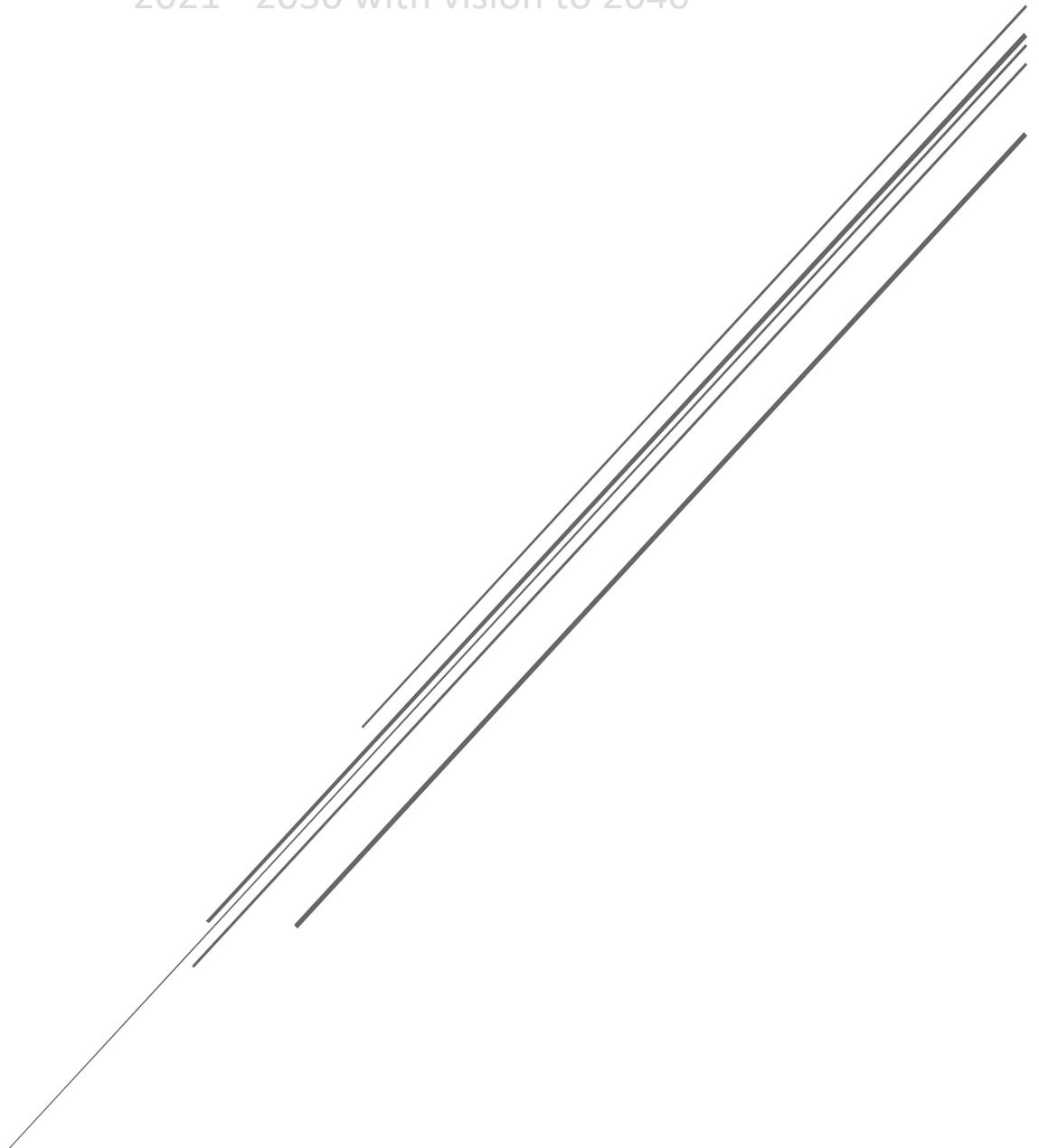


# VIETNAM NATIONAL NUTRITION STRATEGY

2021 - 2030 with vision to 2040



May 21st 2021

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## Section 1: Introduction

Over the past few decades, Vietnam has made rapid strides in socio-economic development, poverty reduction, and has become a middle-income country with a desire to become a high-income country in 2035. Poverty levels almost halved between 2012-2018 while education and literacy levels have markedly increased. There have also been achievements in the provision of health care, and, thanks to the attention and direction of the Party, the Government, the efforts of the health sector, the active participation of other relevant sectors and the whole society, improving people's nutritional status has been a stated priority. Vietnam made nutrition one of the priority health issues in the Resolution of the Party Congress from the 11th term up to the present day and nutrition is also reflected in the nation's socio-economic development plans. Since the first International Conference on Nutrition held in Rome in 1992, Vietnam has developed nutrition policy documents such as the National Nutrition Action Plan 1995 – 2000 and two National Nutrition Strategies covering the periods 2001 – 2010 and 2011 - 2020. This is the third strategic period for 2021-2030. Vietnam has been a member of the Scaling Up Nutrition (SUN) Movement since 2014, started the Zero Hunger program in 2015 and is a member of ASEAN's socio-cultural community to participate in the ASEAN Leaders' Declaration on Ending All Forms of Malnutrition from 2017.

Vietnam, as with many countries in the region and globally, faces a triple burden of malnutrition i.e. undernutrition (stunting, wasting, underweight), overweight/obesity and micronutrient deficiencies. This strategy seeks to reduce all these forms of malnutrition simultaneously.

The stunting status of children under 5 years old (height/age), a strong marker of a nation's development and levels of equality, decreased from 29.3% to 19.6% between 2010 and 2020. Vietnam has moved from high stunting status to medium status according to the World Health Organization (WHO) public health classification. Vietnam is making some progress towards meeting the 2025 World Health Assembly (WHA) target for stunting reduction. However, the rate of stunting reduction has decreased to less than 1% per annum since 2015. The percentage of stunting in school aged children and adolescents (5-19 years old) is also of concern at 14.8%. Wasting in children under five (weight/height) decreased from 7.1% to 5.2% over the same period although, as with stunting, the annual rate of reduction has also slowed.

Vitamin A deficiency, iron deficiency anemia and zinc deficiency are issues of public health significance. The prevalence of Vitamin A deficiency and anemia in women of reproductive age (WRA) and children under 5 years old has improved but the results are not as expected. According to a 2020 survey by the NIN, the rate of anemia among children under 5 years old in Vietnam is 19.6%. The rates of anemia among pregnant

and non-pregnant women is 25.6% and 16.2%, respectively. The prevalence of preclinical Vitamin A deficiency in children under 5 years old is 9.5% and the proportion of breastfeeding women with low vitamin A in breast milk is 18.3%. The rate of zinc deficiency for children under 5 years old in 2020 was extremely high at 58% and the rate for pregnant women was 63.5%. These rates are above the targets set for maternal and child micronutrient status in the National Nutrition Strategy 2011-2020 and the National Nutrition Action Plan 2017 - 2020.

The rate of overweight and obesity, which is strongly associated with dietary patterns and lifestyle changes is increasing rapidly in all age groups and in urban and rural areas. Overweight and obesity amongst children under five is 7.4% (9.8% in urban areas, 5.3% in rural areas) and an alarming 19% in school-age children. In 2015, the proportion of adults who were overweight and obese was 15.6% according to the 2015 survey of National risk factors for non-communicable diseases (STEPS and continues to increase. A negative consequence of the increase in the rates of overweight and obesity is dietary related non-communicable diseases. The rate of adults with hypertension is 18.9%, diabetes is 4.1% and the dyslipidemia rate is 30.2%.

Overall, people's diets have seen improvements in relation to average dietary energy intake which is at 2023 Kcal/day, a slight increase compared to the energy intake level in 2010 at 192 Kcal/day. The energy derived from protein, lipids, and Glucide is 15.8%: 20.2%:64.0% respectively as a % of total energy intake which is considered balanced according to nutritional recommendation for Vietnamese people. Vegetable and fruit consumption has increased in 2010 from 190.4g of vegetables/person/day; 60.9g of ripe fruits/person/day to 231g of vegetables/person/day; 140.7g of ripe fruit/person/day in 2020 although it still only meets 60-70% of the recommended minimum daily intake of five servings per day for Vietnamese adults. Meanwhile, meat consumption increased rapidly from 84.0g/person/day (2010) to 136.4g/person/day (2020) and consumption in urban areas is the highest at 155.3g/person/day. However, rice consumption has seen a decrease and the consumption of soft drinks and fast food at urban schools has increased.

Of particular concern for this new strategic period is the marked disparity within country in the nutrition situation between regions, especially between urban, delta and mountainous areas and areas of ethnic minorities (EMs). According to the nutritional monitoring system in 2019, the EM and mountainous areas still have a higher proportion of malnutrition compared to the national average. Thus, whilst the national rate of stunting has decreased, the rate among EM children under five at 31.4% is still twice as high as that of the majority Kinh children at 15.0%. At the same time, the proportion of underweight children from EMs is 2.5 times higher (21% versus 8.5%) compared to Kinh children and 60% of the estimated 199,535 stunted children in 10 provinces with

the highest stunting rates in the country are EMs. Nationwide, there are 7 provinces with stunting rates of over 30% which is classified by WHO as a very high level of public health significance.

The immediate and underlying causes of malnutrition are more significant amongst EM children. For example, EM children are three times more likely to have diarrhoea (MICS 2014). Parasitic infections from soil-transmitted parasitic worms (which are associated with anaemia) were also higher in the EM communities which is in line with findings suggesting that just over 26 percent of EM households were reported to practice open defecation compared to 2.4 percent of majority households. EM households have limited access to improved drinking water sources and improved sanitation at 38 percent compared to 80 percent of ethnic majority households. Access to health services including reproductive health and nutritional care and uptake of vaccinations<sup>[1]</sup> is reported to be lower amongst EMs (MICS, 2014). Early marriage (under 18 years of age) in the north midland and mountainous and central highland areas is 21.1% and 18.1% respectively, approximately twice the national average.

### **1.1 Evaluation of the 2011-2020 National Nutrition Strategy**

The National Nutrition Strategy (NNS) for the period 2011-2020 in Vietnam was issued under Decision 226/QĐ-TTg dated February 22, 2012, by the Prime Minister. Throughout the implementation of the NNS, the Ministry of Health, other ministries and sectors, Party committees at all levels, authorities in the provinces and cities directly under central level have actively led and directed the implementation of the contents of the strategy and achieved many important results.

Evaluation of progress against objectives set in the strategy shows that overall, Vietnam has achieved the goals of reducing malnutrition in mothers and children under-five years of age (reducing the rate of underweight, stunting, and the rate of chronic energy deficiency in women of reproductive age, controlling overweight and obesity rates in children, improving the average height of children and youth, improving indicators on infant feeding). However, no specific targets were set for mountainous and EM areas where the burden of malnutrition remains disproportionately high. In contrast, the targets set for improving micronutrient status, controlling overweight and obesity in adults and a number of indicators related to capacity building for the implementation of the strategy have either not been achieved or have yet to be assessed. Table 1 below compares the targets against results for the NNS highlighting achievements, where targets have not been met and where data is absent. The data is based on the results of the General Nutrition Survey 2019-2020, Nutrition surveillance 2019, STEPs 2015 and Systematic Reports of Department of Maternal and Child Health, General Department of Preventive Medicine, Department of Medical Services Administration and NIN.

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<sup>[1]</sup> Whilst full vaccination coverage nationally is high at over 80%, it is reported to be less than 50 percent in many districts and communes in the northern mountainous area where ethnic minorities reside.

**Table 1: Comparing targets against results for the NNS 2011-2020**

Target	Result	Evaluation
<b>Objective 1: To continue to improve the diet of Vietnamese people, in terms of quantity and quality</b>		
The percentage of households with per capita energy intake below 1800 Kcal will decrease to 5% by 2020	Not assessed Replaced with FIES: 5.46% (Food insecurity experience scale)	Achieved
The percentage of households with a balanced diet (ratio of thermogenic substances P: L: G = 14:18:68) 75% by 2020	Not assessed National evaluation 15.8: 20.2: 64	Achieved
<b>Objective 2: To improve the nutrition status of mothers and children.</b>		
Reducing the percentage of chronic energy shortage among women of childbearing age to 15% by 2015 and below 12% by 2020.	6.1%	Achieved
Reducing the percentage of children with a low birth weight (below 2,500 grams) to below 8% by 2020.	4%	Achieved
Reducing the percentage of stunting in children under 5 years old to 26% by 2015 and to 23% by 2020.	19.6%	Achieved
Reducing the rate of underweight malnutrition among children under 5 years old to 12.5% by 2020	11.5%	Achieved
By 2020, the height of a 5-year-old child will increase from 1.5cm - 2cm for both boys and girls	Girls increase 5.6cm, boys 5.3cm	Achieved
By 2020, the height of young people by gender will increase from 1cm to 1.5cm compared to 2010.	168.1 (male), 156.2 (female) (compared to 164.4 and 154.8)	Achieved
Controlling the percentage of obesity among children under 5 years old at less than 5% in rural areas and below 10% in big cities by 2020	7.4% (9.8% in city and 5.3% in countryside)	Mainly achieved
<b>Objective 3: To improve micro-nutrient status</b>		
The percentage of children under 5 years old with a low serum vitamin A content ( $<0.7 \mu\text{mol} / \text{L}$ ) will drop below 8% by 2020	9.5%	Not achieved
The percentage of anemia among pregnant women decreases by 23% by 2020	25.6%	Not achieved
The percentage of anemia among children under 5 years old will decrease to 5% by 2020.	19.6%	Not achieved

Target	Result	Evaluation
By 2015, the percentage of households using iodized salt daily meeting disease prevention standards ( $\geq 20$ ppm) will reach $> 90\%$ , the median urinary iodine level of mothers with children under 5 years old will increase from 10 to 20 g/dl and be maintained until 2020.	79.6% and 9.7g/dl	Not Achieved
<b>Objective 4: To effectively control overweight and obesity and risk factors of nutrition related non-communicable chronic diseases in adults</b>		
Controlling the percentage of adult obesity below 8% by 2015 and below 12% by 2020	15.6% (STEPS 2015)	Not achieved
Controlling the percentage of adults with high blood cholesterol ( $> 5.2$ mmol / L) below 28% by 2015 and remain below 30% up until 2020	30.2% (STEPS 2015)	Not achieved
<b>Objective 5: To improve knowledge and practices regarding proper nutrition in the general population</b>		
The percentage of infants exclusively breastfed in the first 6 months will reach 27% by 2015 and 35% by 2020	45.4%	Achieved
The percentage of mothers with correct nutrition knowledge and practices for sick children reaches 75% by 2015 and 85% by 2020	Not assessed	
The percentage of young women receiving training in nutrition and basic knowledge of motherhood will reach 60% by 2015 and 75% by 2020	Not assessed	
<b>Objective 6: To reinforce capacity and effectiveness of the network of nutrition services in both community and health care facilities.</b>		
By 2020, ensuring that 100% of the specialized nutrition staff at the province level and 75% at district level will be trained in community nutrition for between 1 to 3 months.	78.6% and 78.3%	Achieved
By 2020, ensuring that 100% of commune-level nutrition staff and nutrition collaborators will be trained and updated with knowledge about nutrition care	91.4% and 75.1%	Not achieved
By 2020, 100% of central hospitals and 95% of provincial hospitals and 50% of district hospitals will have dietetics staff.	81.5% (province) and 66.7% (district)	Not achieved at provincial level, achieved at district level

Target	Result	Evaluation
100% of central hospitals, 95% of provinces and 50% of districts have consulted and implemented a menu on appropriate nutrition for some specific groups of diseases, including the elderly, people living with HIV/AIDS and TB by 2020.	81.1% (province), and 64.2% (district)	Not achieved at provincial level, achieved at district level
By 2020, to ensure that 75% of the provinces are capable of nutritional monitoring  Carry out nutritional surveillance in emergencies in provinces where natural disasters occur frequently and have a high rate of malnutrition above the national average.	89.3%	Achieved

## 1.2 Enabling and hindering factors in implementing the NNS

The nutrition policy environment in Vietnam has evolved from an earlier focus on hunger towards a greater focus on dietary quality, overweight/obesity and on stunting. The marked achievements made in national stunting reductions are, according to recent analysis, largely explained by increases in household wealth (driving 61% of the observed change) and underpinned by Vietnam’s strong economic growth over the last four decades, improved access to health services (16%), changes in the level of maternal education (12%) and, though not qualifiable (due to a lack of data), it is likely that increased food access (macro and micronutrients) have also supported nutrition improvements<sup>1</sup> These enablers positively influence the immediate and underlying drivers of malnutrition.

The factors identified that have hindered progress in the implementation of the NNS are multi-faceted and warrant close attention in the new strategic period.

- ⇒ Party committees and authorities in many localities are not fully aware of the importance of nutrition, especially for mothers and children and have not paid attention to investing in nutrition or considered this as a priority for the socio-economic development of each locality.
- ⇒ Nutrition is still considered to be a health issue and the responsibility of the health sector. As a result, multi-sectoral engagement has not been strong, especially in the localities. While a number of sectors have developed nutrition sensitive policies and approaches, there is overlap between sectors and gaps in goals, targets, solutions and assigned responsibility.

<sup>1</sup> IFPRI (2020): Stories of Change in Nutrition, Country Brief, Vietnam, June 2020

- ⇒ Nutrition policies and strategies have not been adequately underpinned by legislation and mechanisms for reporting, monitoring and evaluating implementation of policies are lacking. Additional policies are needed on improving the food environment ~~pre~~ deliver healthy and affordable diets and take account of specific vulnerable groups such as WRA and adolescents, those with diseases and those affected by emergencies.
- ⇒ Resources for nutrition activities especially in mountainous and EM areas have not met requirements. The central budget for the nutrition program has been reduced, and local budgets have not increased sufficiently to compensate for this. There is no guaranteed budget for people to receive highly evidenced essential nutritional interventions and nutrition interventions are not included in the health insurance scheme. Specialized nutritional products to treat malnourished children are not on the list of essential drugs/supplies.
- ⇒ Many essential nutrition interventions have only been implemented on a small scale and have not achieved the necessary coverage, especially in mountainous and EM areas. Emerging nutrition issues such as overweight and obesity related non-communicable diseases and emergency nutrition have not been given adequate attention. Absence of monitoring and reporting systems has meant that it has not been possible to assess intervention coverage or report in detail on the level and type of investment in nutrition.
- ⇒ The capacity of the nutrition network at all levels is still limited. There needs to be greater investment in building knowledge and skills and infrastructure where nutrition education and advocacy can be carried out. There is a shortage of nutrition staff in the community, schools and hospitals and a lack of capacity amongst existing staff due in part to poor human resource processes, medical training curriculum not being updated and a lack of standardized assessments of nutrition capacity. The village health system is poorly maintained, affecting capacity to provide essential community-based services.
- ⇒ Communication approaches for diet related social behaviour change have not been effective in disadvantaged EM areas due to limitations in access and differences in language and culture. In urban areas, there have been issues with lack of clear messaging and the information delivered via social media.
- ⇒ Vietnam and the region in general, has felt the impact of rapid globalization, urbanization, the changing food environment, the adverse effects of climate change and a rapidly aging population. These factors have contributed to a widening gap between rich and the poor reflected in living conditions and nutritional status and whilst food access has increased, access to unhealthy food and drink has risen dramatically with cheap highly processed food and drink

outlets and sales on the increase contributing to increasing overweight and obesity. At the same time, food insecurity exists in parts of the country exacerbated by different crisis and international funding for Vietnam's nutrition activities has been gradually reducing.

### **1.3 Priorities for the new strategic period**

Whilst Vietnam has made progress in reducing malnutrition, it has yet to meet the six global WHA targets and all national targets. More needs to be achieved in the new strategic period to realize Vietnams strategic vision and objectives. Eleven priority areas are outlined below:

**1. Increase the coverage of Essential Nutrition Actions** to achieve national and global targets, including a 'full life cycle approach' covering maternal and child health, and nutrition prevention and treatment services in a strengthened health system. Realistic and sustainable goals for the coverage of multi-micronutrient ~~supplementation~~ for pregnant women and children under five (replacing iron and folic acid supplementation where feasible), deworming and treatment of severe acute malnutrition are required.

**2. Provide a higher level of commitment** to shift from nutrition being seen as a health issue to full multisectoral commitment and engagement. Integrating nutrition concerns into the responsibilities of other key sectors will only be achieved with institutional reform, allowing high-level convening, engagement, and coordination across sectors to address the underlying causes of malnutrition.

**3. Improve the nutritional situation of EMs** through strategic investment and institutional improvement with specific nutrition targets set to regularly monitor and evaluate progress.

**4. Focus on school-age children and adolescents** to tackle undernutrition ~~underweight~~, growing overweight and obesity as well as micronutrient deficiencies with specific nutrition targets and monitoring of progress for this demographic cohort.

**5. Tackle rapidly growing overweight and obesity** amongst adults and children through a whole of food systems approach which addresses challenges in the food system which prevent people from accessing affordable and healthy diets and promote unhealthy food and drink across urban and rural communities.

**6. Strengthening legislation** that govern food and diet including food labeling as a mandatory requirement for packaged food, incorporating targeted poverty reduction measures and changing eating behaviors among specific population groups to prevent the growth in overweight and obesity.

7. **Cost and resource an implementation plan** which delivers increased financial investments especially more resources and investment for disadvantaged areas and localities at the provincial and central government levels and urgently reverse the overall declining trend in nutrition investment.

8. **Address significant data gaps** related to programme coverage, the nutrition status of certain age groups (including adolescents), food consumption patterns and domestic and international financing for nutrition activities. Without better data, it will be challenging to plan and evaluate progress more effectively.

9. **Develop an emergency preparedness plan** for climate-related events and epidemics which can negatively impact people's livelihoods and levels of poverty, food security and under-nutrition.

10. **Orientate emergency response to nutrition security** in affected provinces by shifting from short-term treatment of wasting to systems building and prevention activities which help maintain nutrition and food security in the long-term.

11. **Comprehensive development of human resources** to implement the range of nutrition activities outlined above.

## **Section Two: Principles, Approaches and Resolutions**

A number of principles and approaches are enshrined in 12 important resolutions and directives (see Box 1 below) and taken together, these underpin the direction of the NNS and future implementation plans. Among the principles and approaches are the following five themes:

- ⇒ For everyone to have equal access to the food and nutrition resources and services they need for optimal health, it is necessary to create opportunities and remove barriers in the social and health systems, ensuring universal nutritional care regardless of age, gender, ethnicity, physiological status and disease. Ensuring that no one is left behind is key and is particularly important with respect to the situation of EMs.
- ⇒ Good nutrition is at the heart of the Sustainable Development Goals (SDGs) and needs to be sustained throughout the life cycle and through subsequent generations. In particular, special attention should be given to the first 1000 days of life i.e. from pregnancy to when a child reaches 2 years of age whilst also promoting and fully supporting nurturing and caring practices that support

healthy diets in preschool and school aged children, adolescents, WRA and adults in the home and work environment.

- ⇒ Promoting interdisciplinary and multi-sectoral coordination amongst stakeholders and sectors at the national, regional and community level will advance the integration of nutrition into sectors policies, programs and initiatives that aim to reduce the triple burden of malnutrition and ensure sustainable food systems.
- ⇒ Every individual, agency, and society should increase responsibility for nutrition commitments, reflected through the realization of commitments in policy, finance, and implementation. Commitments need to be tracked, progressed, and engender greater accountability.
- ⇒ Investment in nutrition is an investment in human capital, productivity and a nation's sustainable development. The state should prioritize a nutrition budget and have mechanism for the effective mobilization and use of financial resources for nutrition. Provincial level proactiveness and capacity to invest state budgets for the implementation of nutrition activities and encouraging Public Private Partnership and private investment will help secure the provision of nutrition services according to people's needs.

**Box 1: Resolution and Directives underpinning the NNS**

1. Resolution No. 20-NQ/TW dated 25/10/2017 of the Sixth Conference of the XII Central Executive Committee on strengthening the protection, care and improvement of people's health in the new situation.
2. Resolution No. 88/2019/NQ/QH14 dated 18/11/2019 of the National Assembly approving the master project on socio-economic development in ethnic minority and mountainous areas in the period 2021-2030.
3. Resolution 52/NQ-CP dated 15/6/2016 of the Government on promoting the development of human resources of ethnic minorities in the period 2016-2020 period, with a vision to 2030.
4. Directive No. 46/CT-TTg dated 21/12/2017 of the Prime Minister on strengthening nutrition work in the new situation.
5. Decision No. 122/QD-TTg dated 10/01/2013 of the Prime Minister approving the National Strategy for the protection, care and improvement of the people's health for the period 2011 - 2020, with a vision to 2030.

6. Decision No. 376/QD-TTg dated 20/3/2015 of the Prime Minister approving the National Strategy for prevention and control of cancer, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, asthma and other non-communicable diseases for the period 2015 - 2025.
7. Decision 712/QD-TTg dated 12/6/2018 of the Prime Minister promulgating the National Action Program "Zero Hunger Plan" in Vietnam until 2025.
8. Decision No. 1092/QD-TTg dated 02/9/2018 of the Prime Minister approving the Universal Health Program.
9. Decision 1437/QD-TTg dated 29/10/2018 of the Prime Minister approving the project "The care for the comprehensive development of children in the early years of life in families and communities in the period 2018 - 2025".
10. Decision No. 41/QD-TTg dated 08/01/2019 of the Prime Minister approving the project "Ensuring reasonable nutrition and enhancing physical activity for children and students to improve health, cancer prevention, cardiovascular disease, diabetes, chronic obstructive pulmonary disease and asthma for the period 2018 - 2025"
11. Decision 1896/QD-TTg dated 25/12/2019 of the Prime Minister promulgating the Program "Nutrition care for the first 1,000 days of life to prevent maternal and child malnutrition, improve Vietnamese stature".
12. Decision 23/QD-TTg dated 7/1/2021 of the Prime Minister approving the National Action Program for Children in the period 2021 - 2030.

## **Section Three: Vision Goal and Objectives**

### **Vision to 2040**

All Vietnamese people have achieved their full potential through greater economic, nutrition, health, and social equity based on sustainable policies, financing, social delivery systems and community engagement.

### **Goal 2021-2030**

Vietnam will achieve optimal nutritional status throughout people's life cycle reflected in improved child and adolescent growth, women's nutritional status, adult stature, well-being and intellectual development.

## **Objectives, Targets and Indicators**

### **Reduce malnutrition in all its forms**

1. Reduce the main forms of undernutrition in mothers and children to globally recognized 2030 nutrition targets.
2. Prevent and control the main forms of micronutrient deficiencies in children, adolescents and WRA ensuring attainment of the WHA targets for anemia and other micronutrient deficiencies and ensure priority for Ethnic Minorities and people living in mountainous areas.
3. Maintain and gradually reduce levels of overweight obesity, chronic non-communicable diseases and related risk factors in young and older children and adults in line with global Non-Communicable Disease targets. Give a special focus to school age children and adolescents in whom rates of increase are alarming.

### **Address high burden areas and demographic groups with specific needs**

4. Improve the nutritional status of ethnic minorities and those living in Mountainous areas and in the 7 provinces where levels of stunting are above 30%
5. Improve the nutrition of school aged children and adolescents through a combination of targeted nutrition interventions including micronutrient supplementation and deworming, age appropriate social and behaviour change communication, promotion of a healthy food environment and supporting necessary legislation.

### **Address underlying drivers of malnutrition**

6. Ensure a diverse, affordable and safe diet, access to relevant nutrition services including nutrition education and counselling for all ages of the population based on different stages of the life cycle and consider high-risk groups including hospitalized patients. Provide complete information on the nutritional value of foods consumed and adopt a food systems approach within which agriculture, trade and commerce sectors incorporate a nutrition lens underpinned by necessary mandates and legislation. Scale up actions to reduce disease burden through strengthening health, WASH and community systems

7. Improve nutrition preparedness and responsiveness in emergency situations especially in provinces exposed to climatic risks.

### **Strengthening the enabling environment for nutrition**

8. Increase financial resources for the effective implementation of the National Nutrition Strategy and ensure adequate human capacity to implement a range of nutrition interventions. Apply fiscal policies and subsidize nutrient-rich foods to improve diets and preventing obesity, overweight and non-communicable diseases.
9. Build political leadership and technical coordination for a multi-sectoral approach

Vietnam’s indicators and targets for the NNS 2025 and 2030 are set out in Table 2 below covering undernutrition, micronutrient deficiencies, overweight/obesity and NCDs, food and diet, emergency nutrition and finance, capacity and governance considerations.

**Table 2: Indicators and Targets**

	<b>Undernutrition</b>			
No.	Indicator	Current	To 2025	To 2030
1.	The percentage of stunting in children under 5 years old	19.6%	<17% (mountains and EMs<27%)	<15% (mountains and EMs <25%)
2.	The percentage of wasting in children under 5 years old	5.2%	<5%	<5%
3.	The percentage of low birth weight	<5%	<5%	<5%
4.	The percentage of stunting in children 5-18 years old	14.8%	<12,5%	<10%
5.	The percentage of breastfeeding in the first 1 hour after birth	65%	80%	85%
6.	The percentage of exclusive breastfeeding in the first 6 months	45.4%	50%	55%

<b>Micronutrient Deficiencies</b>				
No	Indicator	Current	To 2025	To 2030
7.	The percentage of anemia in women of reproductive age 15-49 years old	16.2% (mountains and EMs 22.4%)	<12% (mountains and EMs <20%)	<8% (mountains and EMs <15%)
8.	The percentage of anemia in pregnant women	25.6% (mountains and EMs 39%)	<20% (mountains and EMs <30%)	<15% (mountains and EMs <25%)
9.	The percentage of anemia in children under 5 years old	19.6% (children 6-24m: mountains and EMs 45.3. children 25-59m mountains and EMs 15.9)	<15% (mountains <25%)	<10% (mountains and EMs <20%)
10.	The percentage of anemia in children 10-14 years old	Children 10-14 years old: 8.4% (11.5% for girls)	<10% (mountains and EMs)	<8% (mountains and EMs)
11.	The percentage of Vitamin A deficiency in breast milk in lactating women	18.3%	<15%	<12%
12.	The percentage of pre-clinical vitamin A deficiency in children under 5 years old	9.5% (mountains and EMs 15%)	<6% (mountains and EMs <11%)	<4% (mountains and EMs <10%)
13.	Median urinary iodine levels of women of reproductive age (18-49 years old)	9.7 mcg/dl	over 10-20mcg/dl mcg/dl	over 10-20 mcg/dl
14.	Percentage of households using adequately iodized salt	79.6%	>80%	>90%

<b>Overweight/Obesity and NCDs<sup>2</sup></b>				
No.	Indicator	Current	To 2025	To 2030

<sup>2</sup> Note that the pending MoH NCD Strategy will contain the main targets and indicators for Blood Pressure and Diabetes Reduction in line with global targets.

15.	The percentage of overweight and obesity in children under 5 years old	7.4% (urban: 9.8%, countryside: 5.3%)	<10% (urban <12%, countryside <6%)	<10% (urban <12%, countryside <6%)
16.	The percentage of overweight and obesity in children 5-18 years old	19% (urban: 26.8%)	<22% (urban: 29%)	<25% (urban <30%)
17.	The percentage of overweight and obesity in adults	15.6% (STEPS 2015)	< 22% nationwide and <27% in major cities	<25% nationwide and <30% in major cities
18.	The percentage of adults 30 – 69 years old with high blood cholesterol (> 5.2 mmol/L)	30.2% (STEPS 2015)	< 35%	< 35%
19.	The percentage of diabetes in adults 30-69 years old	4.1% (STEPS 2015)	< 8%	< 8%
20.	Average salt intake of the population (15-49 years old)	7.4g/day (NIN 2020)	Reduce 30%	< 7 g/day

<b>Food and Diet</b>				
No.	Indicator	Current	To 2025	To 2030
21.	The percentage of children from 6 to 23 months consuming a MAD	52.1%	65%	80%
22.	The percentage of WRA in mountainous areas consuming a minimum dietary diversity	86.5%	90%	95%
23.	The percentage of adults who consume a sufficient amount of fruits and vegetables daily	33%	55%	70%
24.	The percentage of households defined as severe or moderately food insecure by FAO/IES score	12.75% (mountains and EMs 29.6%)	<8% (mountains and EMs<25%)	<5% (mountains and EMs <20%)
25.	Youth attained height by gender in 18-24 year age group	Male: 168.1 cm; Female: 156.2 cm		Increase from 2 - 2.5cm attained height compared to 2020
26.	The percentage of preschool and primary schools implementing school meals meeting national standards.	No data	Ministry of Education for comments	Ministry of Education for comments

<b>Food and Diet</b>				
No.	Indicator	Current	To 2025	To 2030
27.	The percentage of hospitals (central, provincial, and district) that have counseling activities and implementing menus which are nutritious and appropriate to patient needs.	81% provincial. 62% district	90% central, and provincial, 75% district	100% central, and provincial, 80% district
28.	The percentage of communes with counseling on appropriate nutrition for targeted population groups in basic public health service package at the Commune Health Station.	No data	50%	75%

<b>Emergency nutrition</b>				
No.	Indicator	Current	To 2025	To 2030
29.	Number of provinces with a nutrition response component in the Disaster Response Plan	No data	>90% provinces	100%
30.	Number of provinces with staff at the provincial level trained in Emergency Nutrition	No data	>90% provinces	100%
31.	Number of provinces with annual budgets for emergency nutrition among at-risk provinces for each years	No data	>90% provinces in a given year	100% of provinces in a given year

<b>Financing and Capacity Building</b>				
No.	Indicator	Current	To 2025	To 2030
32.	Develop a 5-year national nutrition action plan, at the provincial level, including relevant sectors	No data	>90% provinces, 100% related ministries	100% (provinces, ministries)
33.	There is budget line for nutrition for relevant sectors at central and provincial level maintained and increased every year	No data	80% provinces	90% provinces

<b>Financing and Capacity Building</b>				
No.	Indicator	Current	To 2025	To 2030
	by 5% or at the rate of inflation if greater			
34.	Nutrition staff working in preventive medicine sector at all levels trained and certified according to regulations	78% trained (not certified)	75% provinces / districts, 50% communes	100% provinces / districts, 75% communes
35.	Hospital nutrition staff trained and certified according to regulations	81.5% (provinces), 61.7% (districts) have dietetics staffs	100% center, 75% provinces / districts	100% center / provinces / districts

<b>Political leadership &amp; multi-sectoral coordination</b>				
No.	Indicator	Current	To 2025	To 2030
36.	Steering Committees for the NNS established and functioning at the central & local levels	None	Formed and meeting regularly	Meeting regularly

## **Section Four: Strategic Approaches & Solutions to deliver the NNS**

A multi-sectoral approach is critical for the realization of the NNS and it's stated vision, goal and objectives as no single sector can address the multi-faceted and complex nature of malnutrition in Vietnam on its own. Nine broad complimentary focus areas requiring multi-sectoral engagement are outlined below. Where feasible, these focus areas will need to orientate actions to the specific needs of EMs and other disadvantaged groups.

### **1. Health system strengthening to deliver ENAs**

A strong and resilient health system, providing comprehensive coverage for ENAs will play a fundamental role in reducing malnutrition paying special attention to the poor, vulnerable, and disadvantaged groups including EMs for whom an evidence-based package of nutrition specific interventions are needed in high stunting and wasting prevalence provinces. This package of interventions will need to be sensitive to the cultural beliefs and practices of EMs. Care for the first 1000 days of life, including: proper nutrition care given to mothers during prenatal and postnatal periods, exclusive

breastfeeding promoted during the first 6 months, the identification and management of low birth weight and growth faltering in infants under 6 months of age, appropriate complementary feeding for children 6 months through 2 years of age; child growth and development monitoring; management and treatment of children with acute malnutrition; micronutrient deficiency control; ensuring clean water, personal hygiene and environmental sanitation; generating safe local food sources. Additionally, it is important to ensure the availability and accessibility of nutrition care services for all stages of the life cycle. Improve quality of nutrition interventions through the development and standardization of technical guidance and include a quality assessment of intervention in the annual evaluation criteria of health facilities.

ENAs should include:

- ⇒ Comprehensive coverage for daily provision of multi-micronutrient supplementation or iron and folic acid to pregnant women as part of prenatal check-ups, for WRAs, deworming and vitamin A and zinc supplementation.
- ⇒ The integration of wasting treatment into the health system working towards full coverage of treatment for severe acute malnutrition. A review of the cost-effectiveness of including ready-to-use therapeutic food (RUTF) for moderately or severely undernourished children as part of the health insurance package is also needed.
- ⇒ Integrating health service policies and programs which have preventive effects on malnutrition including the treatment and control of infectious diseases such as COVID-19, malaria, diarrhea, HIV/AIDS and tuberculosis, and enacting policies and programs to deliver adequate support for safe pregnancy and childbirth for all women, prevention of adolescent pregnancy and encourage birth spacing.
- ⇒ Expanding community nutrition activities that can be implemented by the community health system such as periodic deworming for school children, high quality counselling, supplementation of zinc, iron and vitamin A for preschool children and multi-micronutrient supplementation.
- ⇒ Strengthen policies and interventions to promote, protect and support breastfeeding and appropriate complementary feeding, enhance the monitoring of illegal promotion and trade of breastmilk substitutes and which limit marketing of unhealthy foods to children.

## **2. Improve access to clean water, environmental sanitation and increase hygiene**

The lack of safe drinking water, sanitation and poor hygienic practices can have serious consequences for child nutrition due to their impact on diarrhea, intestinal parasites and intestinal diseases. Actions and investments are needed to implement culturally appropriate interventions, including improving toilets, water supply, managing safe

water for households, and promoting hygienic and safe practice, including hand washing with soap at household, school and health facilities. Special attention is needed to increase access to, and demand for, clean water and sanitation for EMs given how far behind they are in this provision. Promoting positive hygiene behaviours will also be needed and regular deworming as per national guidelines.

### **3. Sustainable and resilient food system for a healthier diet**

The increasing burden of overweight and obesity in Vietnam is closely related to the state of the food system and diets of Vietnamese people. Foods that are high in salt, sugar, trans and saturated fats have become cheaper and more widely available. Red meat consumption has also increased whilst the intake of nutrients from fresh fruits and vegetables has declined. The systems producing these foods create environmental pressures that threaten the future health of the planet and population. It is therefore incumbent on all governments to ensure that food systems deliver a nutritious, safe, affordable and sustainable diet and that any negative environmental impacts are minimized. The four main actions outlined below will contribute to building a sustainable, resilient food system for a healthy diet in Vietnam.

- ⇒ **Reform of the food system** to sustainably improve the production of, and access to, affordable healthy foods through strengthening the local food supply chain and, increasing the diversity of food production in a sustainable way.
- ⇒ **Improving the availability, affordability and access to food that contributes to healthy diets** by instituting rural and urban planning policies, facilitating internet access and innovative service delivery, policies and instruments that encourage retail outlets and local, street and wet markets to sell a variety of safe, affordable nutritious foods that contribute to healthy diets through sustainable food systems, and that promote local production as well as national and international markets where appropriate
- ⇒ **Promoting healthy diets and good nutrition within agriculture and food supply chains** through integrate nutrition objectives into national and local agricultural and other relevant policies to achieve healthy diets through sustainable food systems.
- ⇒ **Reducing food loss and food waste** through policies to improve the transportation and storage infrastructure, as well as to promote better industry performance and consumer behaviors.
- ⇒ **Reducing the marketing, sale and consumption of unhealthy food and drink** through mandatory regulation including controls on marketing of unhealthy foods to children, clear front of pack nutrition labelling, taxes on sugar-sweetened beverages and incentives for the production and promotion of healthy food and beverages.

- ⇒ **Mandatory provision** of full information about the nutritional value of foods including sugar, salt, trans fats, cholesterol and total energy content and recommended intakes for consumers to enable them to make informed decisions about food selection and consumption.
- ⇒ **Improving food safety** and tackling antimicrobial resistance through multidisciplinary cooperation between the public health, animal health, food and environment sectors.

#### **4. Orientate Trade and Industry to support healthy diets and nutrition**

The four actions outlined below will contribute to healthier diets and improved nutrition.

- ⇒ Trade policies have the potential to improve nutrition, but they can also increase access to inexpensive, unhealthy food and can sometimes limit the scope of a government policy to promote a healthy diet. There is a need to identify nutrition opportunities and risks associated with existing trade policies and implement additional policies to offset any identified risks. These can specifically include:
  - Introduction of a sugar-sweetened beverage tax
  - Introduction of regulations on marketing of unhealthy food and non-alcoholic beverages to children
  - Introduction of labelling that identifies products with excessive content of unhealthy fats, sugar and/or salt
  - Clear government guidance on conflict of interest i.e., preventing the Food and Beverage industry from influencing food and nutrition policy decisions
- ⇒ All national policies and investments in food and agriculture, infrastructure, and public services and human resources, need to take nutrition into account to ensure that opportunities to improve food security and healthy diets are fully utilized.
- ⇒ Promote micronutrient fortification for domestic and imported commercial products. Strengthen supervision of the enforcement of regulations on compulsory micronutrient fortification (vitamin A fortified cooking oil products, iron and zinc fortified flour, iodized salt).
- ⇒ Consider measures to encourage and protect breast-feeding in the work- place.

#### **5. Strengthen social protection measures to support the most vulnerable**

- ⇒ Social protection measures such as food and cash transfers and school meals are effective ways to reach the most nutritionally vulnerable, including young children, pregnant and lactating women and school aged children and adolescent

girls. It is important that nutritional goals be integrated into social protection systems and that resource transfer amounts are compatible with nutrition messaging and counselling to support a healthy and nutritious diet.

- ⇒ Develop inclusive and efficient food distribution systems with a focus on local market networks to improve accessibility, availability and affordability of healthy food for all.
- ⇒ A regular and adequate income allows people to purchase the diverse, safe and nutritious foods needed for a healthy diet as well as access to health and education services. Therefore, measures to increase income for vulnerable people and provide employment in the countryside should be part of a multidisciplinary effort for improving nutrition.
- ⇒ Expand the cash transfer program to effectively target and reach the poorest ethnic minority families with pregnant women, infants, and young children during the critical 1,000-day window of opportunity.

## **6. Schools as a Platform for Improved Nutrition**

The development of clear standards and guidance on nutrition literacy, school meals, supplementation and deworming and physical activity are an important starting point to enhance the role of school platforms in improving nutrition. Develop standards, determine job positions and implement capacity improvement for implementation of nutritional interventions for school health staff.

### **Nutrition literacy**

- ⇒ Curricula to improve knowledge on good diets-and healthy dietary practices.
- ⇒ Communication to promote good diets, positive eating/dietary practices.

### **Nutritious foods and diets**

- ⇒ Provide guidance on, and organize meals, to ensure proper nutrition for students in schools.

Introduce regulations to limit the sale and marketing (including sponsorship) of unhealthy food and drink in and around schools.

- ⇒ Safe drinking water in schools to improve children's diets.

### **Healthy food environments**

- ⇒ Policies and guidelines to ensure healthy foods and drinking water in/around schools.
- ⇒ Standards and regulations to eliminate marketing of unhealthy foods and beverages

## **Supplementation and deworming**

- ⇒ Micronutrient supplements to protect children from vitamin and other deficiencies.
- ⇒ Deworming prophylaxis to protect children from helminth infections and anemia.

## **Physical activity**

- ⇒ Curricula to include physical education and promote active living.
- ⇒ Communication to promote physical activity and active living.
- ⇒ Guidance on provision of physical space and time within the school day for physical exercise

**Strengthen Nutrition Education and Communication.** Nutrition education and communication can be an important component of a nutrition strategy where it helps increase people's knowledge and improves behaviors. New channels of communication including social media can be exploited as internet connectivity improves and ownership of mobile phones increases. Nutrition education includes actions to influence awareness, attitudes, social norms, skills, preferences and behavior of people. It should also increase understanding of the links between consumer demand, production methods and consumption. It can be implemented in health, agriculture and social protection sectors. Nutrition education can also be realized through social marketing campaigns and other forms of behavioral change communication mechanism as well as through provision of clear information on the nutritional content of foods.

Information about the importance of the food environment and development and updating of dietary guidelines provide an important opportunity to promote a healthy diet. Ensuring adherence to dietary guidelines on the provision of healthy food in public settings (e.g., hospitals, the military and other government agencies) is also important. Special attention is needed to formulate a comprehensive social behavior change and communication strategy for nutritional improvement that can guide campaigns, media, and community educational materials and events to improve the nutrition of women and children from ethnic minority population groups. Consideration should be given to establishing a mandated role for a government agency to oversee nutrition education and communication involving mass media, health agencies and education institutions.

## **7. Rural and livelihoods development to support nutrition improvements**

Poverty is a key determinant of malnutrition in Vietnam and rural development and livelihoods and income generation programs can better target nutritionally vulnerable populations and incorporate a wide range of nutrition activities such as nutrition education, home gardening, biofortified seed provision, etc. as well as include monitoring of nutrition components and their impact. Linkages and referral

mechanisms can be established between nutrition programs and rural development initiatives to ensure increased food availability at the household level.

## **8. Be better prepared for climate change and other emergencies**

With Vietnam increasingly vulnerable to climate induced shocks, the need for natural disaster preparedness capacity is becoming more important. Provincial level preparedness plans including nutrition and food security program surge capacity with associated and dedicated contingency funding will be necessary. Provincial level capacity must be prioritized to ensure rapid response and disaster preparedness, and local financing should be ensured. A role for central government becomes more critical where the shock affects large parts of, or the whole country.

## **9. Better data and research to identify at risk groups, track progress and identify successful intervention approaches**

Reliable data, statistics and information are essential to be able to inform and drive nutritional action and assess progress towards achieving the targets set out in the NNS. It is important that central and devolved local levels have the capacity to analyze and interpret information, in order to be able to communicate effectively with decision-makers. Strong and sustainably integrated multi-disciplinary information systems on food, diet and nutrition are needed to inform and improve policy development and provide accountability. Data on nutrition program coverage are a priority while nutrition surveillance data on the nutrition status and trends amongst EMs and populations living in highland areas needs strengthening. An important task is to review programme monitoring and effectiveness data in real-time and document learning so successful interventions can be rolled out as appropriate.

Improve the capacity of the nutritional surveillance system, refine the set of tools and indicators for monitoring including hitherto omitted groups such as adolescents, managing the database, and providing information for the development and implementation of the Strategy. Increase monitoring capacity in emergencies. Promote the application of information technology to better manage and provide information about nutrition and food. Regularly monitor, supervise and organize periodic surveys to evaluate the progress and results of the Strategy implementation and allocate enough budget for carrying out the annual M&E plan.

Strengthen scientific research in a number of food and nutrition areas including; development and technological applications of new breeds of livestock with enhanced nutrient content and production and processing of nutritionally fortified foods and specialized products suitable for selected target groups to improve physical and intellectual development, improve health and prevent diseases.

Strengthen research and sharing of knowledge on the interconnections between food, nutritional, behavioral, economic, social, and environmental dimensions and market

dynamics, to better enable the assessment of the cross-sectional impacts of the policies and programs implemented and the complexity of the interactions between supply and demand throughout the whole supply chain.

## **Section Five: Strengthening the Enabling Environment**

### **1. Governance considerations**

- a) Enhance the leadership of Party committees and authorities at all levels:
  - ⇒ Party committees at all levels continue to rigorously implement the Party's lines and undertakings, with a focus on implementing Resolution No. 20-NQ/TW 25 October 2017 of the 6th Plenum of the 12th Party Central Committee on strengthening the protection, care and improvement of the people's health in the new context; Directive No.46/CT-TTg dated 21 December 2017 of the Prime Minister on enhancement of nutrition in new circumstances.
  - ⇒ Research and propose to formulate a Resolution of the Politburo on strengthening the leadership and direction on nutrition work in the new circumstances.
  - ⇒ Ministries, agencies and People's Committees at all levels strictly implement the Party's lines and undertakings, the State's policies and laws on nutrition; strengthen the method of directing and organizing the implementation of nutrition work in line with the organizational model, work characteristics and socio-economic situation.
- b) Further strengthen the role of the National Assembly and People's Councils
  - ⇒ Strengthen the monitoring function of the National Assembly and People's Councils at all levels on nutrition work through direct supervision on, and periodic reports from, ministries, agencies and People's Committees at all levels focusing in particular on expenditure in relation to costed plans
- c) Promote the participation of the National Assembly and People's Councils at all levels in nutrition activities, with a focus on promoting the individual roles of National Assembly deputies and People's Councils.
- d) Approaches for inter-sectoral coordination and community mobilization:
- e) Ensure that nutrition is embedded in sector strategies and costed sector plans with clear objectives and expected outcomes.
- f) Launch movements and initiatives of mass organizations and communities to join hands in order to eradicate malnutrition in all forms and leave no-one behind.
- g) Mobilize religious organizations, socio-political organizations, non-governmental organizations, and professional associations to participate in

malnutrition prevention and control, with a focus on participation in: Policy development, planning, monitoring and evaluation of the implementation.

- h) Promote the role and participation of the private sector in improving nutrition: promoting social responsibility through funding nutrition activities; ensuring good nutrition practices at work; producing a variety of nutritious products and improving access to the market for healthy food products while strictly complying with regulations related to the production and sales of food and nutritional products.

### **Policy and Legislative considerations**

- a) Continue to review and refine the system of legal normative documents on nutrition.
- b) Develop policies to bring essential nutritional interventions into universal health care coverage, ensuring financial resources.
- c) Review, amend or develop new documents to strengthen inter-sectoral coordination and promote sustainable food system strategies and actions that enable healthy diets and improved nutrition into national and local socio-economic development, health, economic, agricultural, climate/environment, and disaster risk and pandemic diseases reduction policies.
- d) Develop regimes and policies on human resources and renew financial mechanisms to support a focus on developing a mechanism of social mobilization in a number of nutrition activities so that people can be engaged.
- e) Review, amend and supplement regimes and policies to support mothers, children, the elderly suffering from malnutrition, especially clients of social policy;
- f) Develop regimes and policies to encourage alignment and participation of domestic and foreign organizations, businesses and individuals in malnutrition prevention, control
- g) Develop new policies and regulations related to nutrition such as nutrition food labeling, restrictions on marketing, food fortification measures and excise tax on unhealthy sugar sweetened beverages and energy dense food products-
- h) Develop broad policies and regulations for improving nutrition in schools that includes nutrition literacy, nutritious food and snacks, healthy food environments, supplementation and deworming, and physical activity.
- i) Improve land use and urban planning policies to ensure infrastructure for an inclusive and efficient food distribution system and sustainable and diversified local food supply.
- j) Promote inspection, supervision, and strictly handle violations of laws related to nutrition in order to ensure compliance (breastfeeding, food fortification).

Strengthen the implementation of the criteria for nutrition and breastfeeding in the Hospital Quality Criteria set.

- k) Ensure the implementation of basic nutrition service packages at the commune level, especially making them available to EM households in all priority high-stunting provinces.
- l) Integrate indicators on reduction of stunting, wasting and overweight, obesity rates of children under 5 years old into the national and local socio-economic development plan.
- m) Strengthen the capacity of Steering Committees for the National Nutrition Strategy to integrate a range of nutrition activities. Develop policies and approaches to mobilize and encourage social organizations and enterprises to participate in the Strategy implementation.

### **Communication considerations**

- a) Strengthening communication and advocacy messaging for policy making groups to incorporate nutrition issues into strategies, projects, programs, and implementation plans at all levels
  - ⇒ Providing sufficient documents and advocacy messaging on nutritional needs and activities as well as, legal documents pertaining to nutrition to the leaders of the Party, Government, ministries, departments, and local authorities to align with the strategy's guidelines and objectives; at the same time, allocate human and material resources for nutrition communication and incorporate nutrition targets into sector and provincial socio-economic development strategies, projects, programs and plans.
  - ⇒ Organizing policy dialogues, talk shows, conferences, seminars, training for leaders at all levels on nutrition work and activities to provide information to relevant target groups.
- b) Redesigning, updating and improving the quality of health education communication on nutrition,
  - ⇒ Diversifying the content and multi-media methods of health education communication to ensure quality, and appropriate messaging for each target group, culture and language in different regions paying particular attention to ethnic minorities in remote and disadvantaged areas.

Utilise all forms of mass media to promote the role and responsibility of grassroots socio-political organizations at all levels involving leaders and reputable people in the community that includes a role for social marketing campaigns, behavioral change communication and clear information on the nutritional quality of foods.

- c) Promotion of activities to support the participation of children, adolescents and specific social groups in nutrition communication and education appropriate to

each specific target group building on evidenced solutions to improve nutrition for each target group.

d) Mobilizing organizations, individuals and businesses to participate in nutrition communication.

⇒ Raising awareness of organizations, individuals and businesses involved in the production, trading, distribution and supply of safe food.

### **Financial resource considerations**

a) Mobilize and earmark resources from central and provincial government, development partners and domestic and foreign businesses to implement the Strategy and resulting Action Plan. At the same time, promote the implementation of measures to gradually increase the coverage of health insurance paying for nutrition services.

b) Ensure annual financial commitments for nutrition at the central and local levels are met and that spending is maintained or increased as necessary to implement the NNS.

c) For provinces with high stunting rates in children under 5 years of age, funding for the implementation of the nutrition program should be clearly allocated from the local budget and supplemented from the central government.

d) Strengthen the management, supervision and effective use of investment for malnutrition prevention and control.

e) Ensure that development partner and business investments in nutrition are aligned and coordinated fully with government investment.

### **Human resource considerations:**

a) Formulate plans to develop and ensure sustainability of human resources for effective nutrition planning and action; Develop and strengthen the capacity of nutrition workers, especially full-time officials and nutrition actors at the grassroots level. Focus on training health workers at provincial, district, commune and village levels.

b) Develop curriculum and standardize training materials on nutrition in medical schools. Raise the capacity of teaching and training on nutrition for teachers in schools.

c) Conduct capacity building for ministries, agencies, mass organizations, social organizations, non-governmental organizations, and religious organizations so that action plans and development programmes across relevant sectors contain nutrition objectives.

### **International cooperation considerations**

- a) Strengthen collaboration with international partners in order to participate in, and implement global nutrition movements and initiatives in Viet Nam (Scaling Up Nutrition Movement, Zero Hunger Program); Fulfil and work towards international and regional nutrition-related obligations, commitments and targets.
- b) Reinforce and strengthen international cooperation towards multilateralism and diversification of relationships with UN organizations, bilateral and multilateral donors to capitalize upon their financial and technical support for malnutrition prevention and control.
- c) Proactively engage with research and academic institutes and universities in the region in order to embed regional and global scientific knowledge and technology standards into nutrition planning and action in Vietnam.

## **Section Six: Responsibilities for Strategy Implementation**

### **1. Central level**

- a) Establish the Steering Committee for the National Nutrition Strategy at the central level (the Central Steering Committee). The Deputy Prime Minister is the Head of the Committee, the Minister of Health is the Standing Deputy Head, other members include leaders of the ministries (Planning - Investment, Finance, Education - Training, Agriculture and Rural Development, Labor - Invalids and Social Affairs, Information and Communications, Culture - Sports and Tourism, Industry and Trade, Science and Technology), heads of the Vietnam Women's Union Central Committee, the Ho Chi Minh Communist Youth Union Central Committee and other related departments, agencies, social organizations. The Steering Committee is responsible for guiding, inspecting and urging the implementation of the Strategy.
- b) Assign the Ministry of Health to assume the prime responsibility for assisting the Government in managing the National Nutrition Strategy, to coordinate with other ministries, agencies, unions and localities in implementing the National Nutrition Strategy. Relevant ministries, agencies, localities, political and social organizations are responsible for annually reporting the results of the Strategy implementation to the Ministry of Health for synthesis and submission to the Prime Minister.
- c) The National Institute of Nutrition is the standing body that assists the Central Steering Committee in organizing the implementation of the Strategy's tasks and organizing the inspection, supervision and periodic evaluation of the Strategy implementation.

## 2. Local level

The Provincial People's Committees shall develop annual nutrition action plans, allocate the budget required and be responsible for organizing strategy implementation at the local level with appropriate ministry support.

### Ministry Specific Tasks

**The Ministry of Health** will assume the prime responsibility for the following:

- ⇒ Formulating plans to organize the implementation of the Strategy and related projects nationwide; direct, guide, monitor and supervise the Strategy implementation. Every six months, and annually consolidate and report to the Prime Minister on the progress and results of the Strategy implementation; organize a preliminary review by the end of 2025 and final review of the Strategy implementation by the end of 2030.
- ⇒ Coordinating with concerned ministries and agencies in reviewing, formulating and promulgating, according to their authority or submitting to competent authorities for promulgation of legal documents on nutrition.
- ⇒ Coordinate with the Ministry of Planning and Investment, the Ministry of Finance and concerned ministries and agencies in reviewing and proposing approaches to mobilize resources for nutrition activities and apply the financial/tax measures to reduce the consumption of unhealthy foods.
- ⇒ Coordinating with the ministries and agencies that are members of the Steering Committee for the National Nutrition Strategy and concerned central agencies in organizing the implementation of the Strategy within the scope of their powers and assigned tasks.
- ⇒ Coordinating with relevant agencies in formulating and promulgating, according to their authority, policies and legal documents on food safety and adding micronutrients to food; regulations on control of sugar sweetened beverages, processed foods and food nutrition labeling; policies and regulations related to the import of nutritional products.
- ⇒ Cooperate with concerned ministries and agencies in formulating and promulgating policies and legal documents on food safety and food fortification; regulations on control of sugar sweetened beverages, processed foods and nutrition labelling; policies and regulations related to the import of nutritional products. Strengthen management and control of production and trading of unhealthy products

**The Ministry of Agriculture and Rural Development** will assume the prime responsibility for the following:

- ⇒ Take the lead in developing plans to strengthen food security coordinating with relevant ministries and agencies to organize the implementation of plans.
- ⇒ Guide localities to plan and develop food production strategies and activities in order to ensure food security in all circumstances.
- ⇒ Promote implementation of nutrition sensitive activities in the following national target programs, e.g. Sustainable Poverty Reduction, New Rural Construction and the “Zero Hunger Program”.
- ⇒ Coordinate with the Ministry of Health in implementing activities that contribute to reducing the rate of malnutrition and micronutrient deficiency among children and reproductive-aged women, especially in remote, disadvantaged areas and those affected by climate change.
- ⇒ Integrate nutritional response activities into the National Plan for preparing and responding to natural disasters.

**The Ministry of Education and Training** will assume the prime responsibility for the following:

- ⇒ Coordinate with the Ministry of Health in implementing human resource training and development programs in the field of nutrition.
- ⇒ Integrate educational programs for behavior change related to appropriate nutrition and physical exercise suitable for children and students in schools.
- ⇒ Support coordination between schools and families to educate and provide guidance on nutrition and physical exercise suitable for children and students, especially for pre and post-puberty children and students.
- ⇒ Organize school meals to ensure proper nutrition, increase physical activities for children and students; effect policies to prevent the advertising and sale of alcoholic beverages, carbonated soft drinks and unhealthy foods in schools;
- ⇒ Coordinate with the health sector to monitor nutritional status of school age children and nutritional interventions and health care for children and students in school.

**The Ministry of Planning and Investment** will assume the prime responsibility for the following:

- ⇒ Coordinate with the Ministry of Finance and the Ministry of Health to allocate funding for the Plan implementation.

- ⇒ Advocate for, and mobilize, domestic and foreign funding sources for nutrition activities.

**The Ministry of Finance** will assume the prime responsibility for the following:

- ⇒ Coordinate with the Ministry of Planning and Investment, based on the State budget's capacity and annual budget plans decided by the National Assembly, to allocate budget for the implementation of approved programs and projects on nutrition. Guide, inspect and supervise the use of funds in accordance with the Law on Budget and current regulations.
- ⇒ Coordinate with the Ministry of Health and other relevant ministries and agencies to develop financial mechanisms and policies to promote social mobilization.
- ⇒ Research and apply fiscal policies to taxing energy-dense foods and sugar sweetened beverages and/or subsidizing nutrient-rich foods to improve diets and prevent noncommunicable diseases.

**The Ministry of Labor, Invalids and Social Affairs** will assume the prime responsibility for the following:

- ⇒ Strengthen implementation of policies for social protection in accordance with the legal provisions, with a focus on children with special circumstances, children of poor households, ethnic minority children, children living in border, mountainous, island communes and those with extremely difficult socio-economic conditions.
- ⇒ Lead and coordinate with relevant agencies implementation of appropriate nutrition regimes for workers, especially female workers and workers in industrial zones.
- ⇒ Promote the development and implementation of regulations to ensure the realization of children's rights and comprehensive care and adequacy of nutrition status.

**The Ministry of Industry and Trade** will assume the prime responsibility for the following:

- ⇒ Develop and strengthen the local food distribution system with a focus on ensuring an accessible local food market network in urban and rural areas.

**The Ministry of Information and Communications** will assume the prime responsibility for the following:

- ⇒ Direct and organize nutrition information and communication activities,

with a focus on ensuring accurate information on nutrition through mass media and social media.

- ⇒ Coordinate with the Ministry of Health, relevant ministries and agencies in controlling advertisements on nutrition and related food.

**The Ministry of Culture, Sports and Tourism** will assume the prime responsibility for the following:

- ⇒ Direct and organize the implementation of the Master Plan on developing the physical strength and stature of Vietnamese people for the 2011 – 2030 period according to Decision No. 641/QĐ-TTg dated 28 April 2011 of the Prime Minister.
- ⇒ Oversee the integration of physical activities and good nutrition practices into public movements and sports and cultural activities in the community. Strengthen communication about the benefits of public physical training and sports activities to improve people’s health while limiting advertisements on unhealthy nutritional products at cultural and sporting events.

**Committee for Ethnic Minority Affairs** will assume the prime responsibility for the following:

- ⇒ Implement projects with nutritional elements in the Master Project on socio-economic development in ethnic minority and mountainous areas in the period 2021-2030 according to Resolution No. 88/2019/NQ- QH14.
- ⇒ Participate in developing policies and nutritional intervention programs for ethnic groups and mountainous areas.
- ⇒ Monitor, supervise and evaluate the implementation of regional nutrition activities in programs and proposals for ethnic groups and mountainous areas.

**Socio-political organizations and associations** (Central Committee of Vietnam Fatherland Front, Vietnam General Confederation of Labor, Viet Nam Farmer’s Union, Ho Chi Minh Communist Youth Union, Vietnam Association of the Elderly, Vietnam Association for Protection of Children’s Rights professional associations and other social organizations) will assume the prime responsibility for the following:

- ⇒ Based on the professional directives and communiques from the Ministry of Health, help organize the dissemination of knowledge about good nutrition, producing local foods , improving family meals for members; closely coordinate with the health sector and relevant agencies in conducting social mobilization relevant to and implementing the

Strategy's objectives and tasks.

**The Vietnam Women's Union Central Committee** will assume the prime responsibility for the following:

- ⇒ Closely coordinate with the health sector and People's Committees at all levels to communicate and disseminate knowledge about good nutrition to members and mothers; Encourage members and the community to actively participate in nutrition care activities, especially nutrition care for the first 1,000 days of life and ensuring nutritious family meals People's Committees of provinces and centrally affiliated cities:
  
- ⇒ Organize the Strategy implementation in localities under the guidance of the Ministry of Health, and functional ministries and agencies; formulate and organize the implementation of annual and 5-year action plans on nutrition in line with the National Nutrition Strategy and local socio-economic development plans in the same period; proactively, allocate budget and mobilize resources to implement the Strategy; effectively coordinate the National Nutrition Strategy implementation with other relevant strategies in the area; promote inter-sectoral coordination; integrate nutritional activities in designing local socio-economic development policies; monitor the Strategy implementation in the localities; produce annual reports on the Strategy implementation in the localities

## **Section Seven: Monitoring and Evaluation**

It is important to have a framework to assess progress against the results and impacts of specific and interdisciplinary nutritional interventions. Ensuring that Vietnam is tracking against the national objectives and targets outlined above (see Table 2) as well as global (SDGs and WHA) and Regional targets (ASEAN Strategic Framework and Action Plan for Nutrition, 2018-2030) is vital for identifying success and where course correction is warranted. Course correction will be informed by the data and also, by active learning of what is working at the local level particularly in the higher burden localities where significant progress to realize greater nutrition equity is needed as well as in the urban and rural approaches to tackling growing overweight and obesity. Examples of what is working in the form of good practice will be discussed at the local level and disseminated and used to advocate in support of other localities and their double and triple duty nutrition relevant actions.

The M&E system will also specifically monitor progress against sub-national targets for the mountainous and EM areas as well as the 7 provinces which have very high rates of stunting. In these areas, it will be essential to examine the annual data trends from the NSS and report on progress in reducing the very high rates of undernutrition and micronutrient deficiencies. Learning about what works in these more vulnerable localities will be of great value to Vietnam as it strives to achieve greater nutrition equity.

A mid-term evaluation of the Strategy will be undertaken in 2025 and a final evaluation after 10 years in 2030. The Nutrition Surveillance System will be maintained annually with data collection in all 63 provinces which is complimented by periodic larger scale cross sectional surveys conducted every 5 years including the Micronutrients Survey, STEPS and the General Nutrition Survey. The NIN acts as the standing agency of the Strategy Steering Committee to synthesize the data findings and report on progress to Government.

The Indicators, definitions, sources of information and reporting periods which underpin the framework are set out in Table 3 below. This table should be viewed in tandem with Table 2 which identifies the targets and indicators for the 10-year strategic period.

**Table 3: The monitoring, supervision and evaluation framework**

<b>No.</b>	<b>Indicator</b>	<b>Definition</b>	<b>Source of information</b>	<b>Reporting time</b>
1.	The percentage of correct and adequate food intake in children from 6 to 23 months	The percentage of children from 6 to 23 months receiving a diverse diet (5/8 food groups) and eating enough meals according to guidance on minimum meal frequency	Nutrition surveillance General Nutrition Survey	Annually  2030
2.	The percentage of food diversity among women of reproductive age in the mountains and EM areas	The percentage of women aged 15-49 having a diverse diet (5/10 food groups)	Nutrition surveillance General Nutrition Survey	Annually  2030
3.	The percentage of adults who consume a sufficient amount of of fruits and vegetables daily	The percentage of adults who eat the recommended amount of vegetables and fruits according to the Vietnam Nutrition Tower	Nutrition surveillance	2030
4.	The percentage households with moderate or severe food insecurity	The percentage of households with FIES score of lack of food security above 5 (FAO)	Nutrition surveillance General Nutrition Survey	Annually 2030
5.	Youth height gain by gender	Highest mean height in the 18-24 age group by gender (male and female)	General Nutrition Survey	2030
6.	The percentage of preschool and primary schools implementing school meals.	The percentage of preschool and primary schools that implement school meals in line with industry regulations	Reports of the educational system	2025, 2030
7.	The percentage of hospitals (central, provincial, and district) that have counseling activities and	The percentage of hospitals (central, provincial, and district) implementing counseling	Reports of the health system	2025, 2030

No.	Indicator	Definition	Source of information	Reporting time
	implementing menus on reasonable nutrition for patients	activities and implementing menus on reasonable nutrition for patients		
8.	The percentage of communes with IYCF and ANC counseling services at the Commune Health Station.	The percentage of communes implementing counseling on appropriate nutrition in the public health service package by trained health station staff	Reports of the health system	2025, 2030
9.	The percentage of stunting in children under 5 years old disaggregated by locality and ethnicity	The percentage of children with the weight/age index Z-Score <-2SD	Nutrition surveillance General Nutrition Survey	Annually 2030
10.	The percentage of wasting in children under 5 years old disaggregated by locality and ethnicity	The percentage of children with weight/height Z-Score <-2SD	Nutrition surveillance General Nutrition Survey	Annually 2030
11.	The percentage of low birth weight	The percentage of infants with a birth weight below <2500 grams	Reports of the health system	2025, 2030
12.	The percentage of stunting in children 5-18 years old	The percentage of children with height/age index Z-Score <-2SD	General Nutrition Survey	2030
13.	The percentage of breastfeeding in the first 1 hour after birth	The percentage of infants breastfed within 1 hour after birth	Nutrition surveillance General Nutrition Survey	Annually 2030
14.	The percentage of exclusive breastfeeding in the first 6 months	The proportion of infants 0 to <6 months of age who were exclusively breastfed the previous day	Nutrition surveillance General Nutrition Survey	Annually 2030
15.	The percentage of anemia in women of reproductive age 15-49 years old	Hb content below 120g/l	National micronutrient survey General survey	2025 2030
16.	The percentage of anemia in pregnant women	Hemoglobin (Hb) content <110g/l	National micronutrient survey General survey	2025 2030

No.	Indicator	Definition	Source of information	Reporting time
17.	The percentage of anemia in children under 5 years old	Hemoglobin (Hb) content <110g/l	National micronutrient survey General survey	2025 2030
18.	The percentage of anemia in children 10-14 years old	Hb content below 120g/l	National micronutrient survey General survey	2025 2030
19.	The percentage of Vitamin A deficiency in breast milk in lactating women	The percentage of lactating women with breast milk vitamin A content below 1.05 µmol/L	National micronutrient survey General survey	2025 2030
20.	The percentage of pre-clinical vitamin A deficiency in children under 5 years old	The percentage of children with serum vitamin A content below 0.35 µmol/L	National micronutrient survey General survey	2025 2030
21.	Median urinary iodine levels of women of reproductive age (18-49 years old)	The average amount of iodine in the urine	Reports of the Hospital of Endocrinology	2025 2030
22.	The percentage of households using adequate iodized salt as WHO recommendation standard	The percentage of households using iodized salt and iodized spice every day  The percentage of households using iodized salt with Iodine content in between 20-40 ppm	Reports of the Hospital of Endocrinology	2025 2030
23.	The percentage of overweight and obesity in children under 5 years old	The percentage of children with weight/height Z-Score > +2SD	Nutrition surveillance General Nutrition Survey	Annually 2030
24.	The percentage of overweight and obesity in children 5-18 years old	The percentage of children with BMI/age Z-Score > +1SD	General Nutrition Survey	2030
25.	The percentage of overweight and obesity in adults	Percentage of people with BMI ≥ 25 kg/m <sup>2</sup>	STEPS	2025, 2030

<b>No.</b>	<b>Indicator</b>	<b>Definition</b>	<b>Source of information</b>	<b>Reporting time</b>
26.	The percentage of adults 30 – 69 years old with high blood cholesterol (> 5.2 mmol/L)	The percentage of adults with high blood cholesterol (> 5.2 mmol/L)	STEPS	2025, 2030
27.	The percentage of diabetes in adults 30-69 years old	The percentage of people with fasting blood sugar >6.9 mmol/L Blood sugar level at 2 hours after eating is > 1.1mmol/l HbA1c > 6.5% (Source: Ministry of Health 2018)	STEPS	2025, 2030
28.	Average salt/sodium intake of the population (15-49 years old)	The average amount of salt in urine test (g/person/day)	STEPS	2025, 2030
29.	Number of vulnerable provinces with a nutrition security component in the Disaster Response Plan	The number of annual disaster response plans of the province having a nutritional component	Provincial reports to the National Steering Committee	Annually
30.	Number of provinces with staff at the provincial level trained in assessing and responding to Emergency Nutrition	Number of provinces with at least 1 staff trained in Emergency Nutrition under the national training program	Provincial reports to the National Steering Committee	2025, 2030
31.	Number of at-risk provinces (as defined by the Emergency Nutrition Working Group) with annual budget for emergency nutrition assessment and response	The number of provinces with an annual budget for emergency nutrition among at-risk provinces is determined annually by the central government	Provincial reports to the National Steering Committee	Annually
32.	Develop a 5-year national nutrition action plan, at the provincial level, and relevant sectors	Plan is developed and approved every 5 years Related sectors include: Health, Education, Agriculture, Labor, Social Affairs, Women, Farmers	The health sector and inter-sectoral reports to the National Steering Committee	Annually
33.	There is budget line for nutrition for sectors at central level and provincial government,	Annual budgets have a section for nutrition and are approved	The health sector and inter-sectoral reports to	Annually

No.	Indicator	Definition	Source of information	Reporting time
	maintained and increased every year by 5% per annum or inflation rate if greater than 5%		the National Steering Committee	
34.	Nutrition staff working in preventive medicine sector at all levels trained and certified according to regulations	Each unit has at least 1 staff trained and certified according to regulations for each level	Reports of the health system	2025, 2030
35.	Hospital nutrition staff trained and certified according to regulations	Each unit has at least 1 staff trained and certified according to regulations for the curative sector	Reports of the health system	2025, 2030