

NATIONAL NUTRITION STRATEGY

Period 2001 - 2010

(ATTACHED TO THE GOVERNMENT'S DECISION

N^o 21/2001/Q -TTg, February 22nd 2001)

ABBREVIATIONS

ARI	Acute Respiratory Infection
BMI	Body Mass Index
CED	Chronic Energy Deficiency
CHC	Communal Health Center
CPCC	Committee for Protection and Care of Children
GDP	Gross Domestic Product
GMP	Goods Manufacture Product
GSO	General Statistical Office
HACCP	Hazard Analysis and Critical Control Point
HCMC	Ho Chi Minh City
IDA	Iron Deficiency Anemia
IDD	Iodine Deficiency Disorders
IEC	Information, Education and Communication
IFPRI	International Food Policy Research Institute
IMCI	Integrated Management of Childhood Illnesses
KAP	Knowledge – Attitude - Practice
MARD	Ministry of Agriculture and Rural Development
MOCI	Ministry of Culture and Information
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOJ	Ministry of Justice
MOLISA	Ministry of Labor, Invalids and Social Affairs
MOSTE	Ministry of Science, Technology and Environment
MOT	Ministry of Trade
MPI	Ministry of Planning and Investment
NCNRCD	Non-communicable nutrition-related chronic diseases
NCPFP	National Committee for Population and Family Planning
NGO	Non-governmental organization
NIN	National Institute of Nutrition
NNS	National Nutrition Strategy
NPAN	National Plan of Action For Nutrition
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
RDA	Recommended Dietary Allowances
VAC	Vegetation – Aquaculture – Cages for Animal Husbandry
VACVINA	Vietnam’s Gardeners’ Association
WB	World Bank

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NATIONAL NUTRITION STRATEGY

2001 - 2010

Rationale for the Development of this Strategy

For a long time, freedom from hunger and poverty has been seen as a dream by human beings. In the International Conference on Nutrition held in Rome in September 1992, representatives from 159 countries committed themselves to eradicate hunger and poverty and to reduce all forms of malnutrition. The Conference also confirmed that hunger and malnutrition could not be accepted in the World any longer where there is a full of understanding and the resources necessary to eradicate this condition. The World Declaration on Human Rights in its Article 25 strongly states that all people in the World have the right to live a comfortable life, including having an adequate diet and access to needed health care.

Vietnam's socio-economic and development strategies, as set by the Party and the Government, have placed much attention on developing human resources; this means attention is given to their creative force aiming at reaching the highest goals possible.

In order for human resources development to meet the requirement of the country's industrialization and modernization, it is necessary and urgent to improve population's health, of which improving nutrition is a key issue.

The Resolution of the Central Committee of the Party Congress VIII stated that the implementation of a national program of nutrition was needed to reduce child malnutrition from 42% to less than 30% by the year 2000, to eliminate severe malnutrition, and to decrease the percentage of the population with low energy intake (<2100 Kcal) to below 10%. The People's Health Law confirms the responsibility of the government and authorities at different levels in health care for the population; in this effort nutrition is again a key issue. The Resolution 37-CP of the Government on Strategic Orientation of the population's health care dated June 20, 1996, set the main health targets to the year 2020: The prevalence of child malnutrition to be reduced to 15% and the mean height of Vietnamese youth to increase to 165 cm by the year 2020.

On September 16, 1995, the Prime Minister ratified the National Plan of Action for Nutrition 1996-2000. This was the first national nutrition strategy officially approved in Vietnam. Where the Government asked authorities at all levels to integrate nutrition goals, reduction of malnutrition eradication of poverty, into their local socio-economic and cultural development plans. Up to now, several important goals of the plan has been achieved and many nutrition activities have gradually been socialized for community participation. The 21st Century, with great challenges, stronger efforts are needed to develop and implement the sustainable development strategies, among which the Nutrition Strategy plays a central role. The Nutrition Strategy is comprehensive, ensuring appropriate dietary intake for everyone and every household, and improving health and nutritional status of the people. For better generation that provide a good human resource for the country's industrialization and modernization course. This strategy is a follow-up step of the NPAN 1996 – 2000, showing the persistence of the Government to achieve the set objectives.

PART 1

CURRENT NUTRITION SITUATION

I. THE COUNTRY'S CURRENT NUTRITION SITUATION

1. Food security and dietary pattern

The most important achievements in the previous period is reduction of hunger in large scale. In the whole country, there are currently 1.4 million households that still suffer from food shortage compared to 3.5 million households in 1992. In 1999, the total food production (paddy equivalent) was 32.8 million tons (reaching the planned objective), and food production was much more diversified.

When comparing the dietary intake between the beginning and the end of the 90's, it is note that prehavingsting food shortage with missing meals which requires some kind of food aid has been improved. In the rural delta areas, energy intake is 2062 Kcals per head per day (data of a sentinel survey) compared to 1940 Kcals in 1990. The intake of meat, fats/oil, tofu, sugar and fruits is increased in comparision with 10yrs ago. The percentage of households with low energy intake has been reduced in urban areas and in most rural delta provinces.

However, food insecurity has still experienced in a number of provinces prone to natural disasters. These provinces are located in the Central coast, Central highland and Northern mountainous areas, where a large portion of the country's population lives. While in the areas of Red River Delta and Mekong Delta, the total cultivated land for staple food production has not increased much and the cultivated surface for agriculture has been narrowed. This will be a great challenge for agricultural development in the coming years. Although agricultural production has been diversified, the country still faces many difficulties such as agricultural products' processing and preservation, pricing and marketing, etc. Household and community food production has not yet been stable and sustainable.

At the same time, due to the trends of urbanization, advertizing and modernization, food consumption habits and patterns of a large portion of the population are changing.

In general, food security and dietary patterns of the population have clearly improved. However, there are still hidden risk factors in some regions that need more attention. The rate of poor household in the whole country (according to the present classification criteria) has reduced from 20 % (in 1995) to 11 % (in 2000), but this is still considered high.

2. Child and maternal malnutrition.

Child malnutrition prevalence has been remarkably reduced: 51.5% in 1985 and 44.5% in 1995 (a reduction of 0.66% per year). With the National Plan of Action for Nutrition (NPAN) starting in 1995, the rate dropped to 36.7% in 1999 (a reduction of 2 % per year which is considered to be fast as recorgnized by international community). Therefore, approximately 200,000 children have been escaped from malnutrition yearly. In 2000, according to the data of GSO, this rate was 33.1%.

This achievement fast reduction child malnutrition is worth recognized. Severe malnutrition has fallen remarkably (to 0.8%), and most of malnutrition cases in Vietnam are now in mild and moderate forms. However, according to WHO's classification, a prevalence of child malnutrition of 36.7 % is ranked in the "very high level" world-wide. The prevalence of child malnutrition is varied among ecological regions in the country. It is lowest in Ho Chi Minh City (18,1%) and Hanoi (21%), while in some provinces, it is still above 50%. The region with the lowest prevalence is the South-Eastern area, including HCM city (29.6%); followed by Mekong Delta (32.3%); Red River Delta (33.8%); the Central Coast (39.2%); the North-East (40.9%); the Noth-West (41.6%); the North-Central Coast (39.2%), and the region with the highest rate is Central Highland (49.1%). There is no significant gender difference in malnutrition in Viet nam.

Concerning age groups, children from 6 to 24 months old are the higher risk group for malnutrition than the other age groups. Complementary feeding is usually started at this

age. Inappropriate weaning practices could probably be an important factor affecting the nutrition situation.

The causes of child malnutrition are complex, from immediate causes such as inappropriate dietary intake and high prevalence of preventable diseases, to underlying causes such as the inappropriate care of mothers and children, household food insecurity and inadequate health and sanitation, and to basic causes such as poverty and people's control of resource they need. The impact of these factors is different among regions. In the Central coast, Central highland and mountainous regions, food insecurity is a prominent cause; while in the other rural areas it is the inadequacies in care (prominently including child care practices). In urban areas, childhood diseases are the possible factor leading to malnutrition in children. It is because in urban areas, food shortage is not a major problem now and child care practices are somewhat better than in rural areas. This scenario calls for different strategies for different regions in different periods. Recent experiences of the International Food Policy Research Institute (IFPRI) show that the educational level of girls and then mothers accounts for up to 43% of child malnutrition, while food security is only responsible for 26%. Therefore, child feeding practices and child care, which much depend on education level of mothers, play a central role in child malnutrition.

Chronic Energy Deficiency (CED) of women of reproductive ages (measured as BMI <18.5) was 38% in 1977 and 32% in a recent survey. CED reflects the caring status of women and is very related to low birth weight of children.

3. Micro-nutrient deficiencies

3.1. Vitamin A deficiency

The most remarkable progress in the last 5 years is the effective implementation of the national program for controlling vitamin A deficiency, as well as the elimination of nutritional blindness, which affected about 5 to 7 thousand children per year in the past. The rate of corneal lesions that lead to blindness has decreased from the level 7 times higher than the WHO's cut-off point to a level lower than that of public health significance. About 94-97% of children aged 6-36 months in the whole country receives high doses Vitamin A capsules twice a year. At present, however, the prevalence of sub-clinical vitamin A deficiency is still high (11% in children and 50% in lactating mothers). That related to higher morbidity and mortality. The main causes of vitamin A deficiency are lack of Vitamin A rich food and low fat/oils intake.

3.2. Iron deficiency anemia (IDA)

Iron deficiency is a major public health problem in our country. The high vulnerable groups are women of childbearing ages and children (53% of pregnant, 40% of non-pregnant women and 60% of children under 24 months old suffers from IDA). The main cause of this is lack of iron rich foods in the diet, e.g. animal foods. On the other hand, hookworm infection at high prevalence in the country also plays a role. The iron deficiency anemia control program has been carried out with two activities: supplementing women with iron and folic acid tablets and providing them nutrition education together with the prevention of intestinal parasites, especially hookworm. In the program areas, prevalence anemia among women of childbearing age has decreased from more than 50% to 25%. However, the program is implemented in only 1282 out of more than 10,000 communes in the whole country so far.

3.3. Iodine deficiency disorders (IDD)

Iodine deficiency disorders (IDD) are also very widespread in Vietnam. The national program for controlling IDD has reached its objectives set for the year 2000 (based on urinary iodine indicator). However, more than one quarter of school-aged children has goiters (data in 1999). There are geographic/ecological variations in goiters. About 30% of households in the Mekong River Delta suffer from IDD (urinary iodine < 10mcg/dl). A nation-wide program has been implemented to provide iodized salt for the whole population; The universal salt Iodization, has been formulated and incorporated in a Government Decision; 61% of households are now using iodized salt as the result.

So far, the programs for controlling Vitamin A deficiency and IDD have achieved remarkable successes that need to be sustained, and strengthened in the coming years. The results of these programs has been internationally recognized and appreciated. However, because of its late starting, more attention still needs to be paid to the implementation of the program for nutritional anemia control.

4. Maternal and Child Health care

Recent data have shown that during pregnancy, the mean weight gain of rural women is still low: 8 kg (compared to 6 kg in 1985), while in Hanoi women gain 10.6 kg (compared to 8.5 kg in 1985). About 40% of women do not receive prenatal care and weighed. Breast-feeding practice has been remarkably improved. However, there have been only 31.1% of mothers exclusively breast-feeding in the first 4 months and only 20.2% of mothers properly caring their sick children (data in 2000). Although the living standards have improved in general, rural women in particular still experience heavy workloads even during pregnancy and lactating periods. A short prenatal and post natal maternity leave negatively affects breast-feeding and child feeding practices, as well as women's time allocation for child care.

Child health care activities through the national primary health care program has been remarkably improved. However, the preconditions for health cares such as safe and clean water and latrines, day care centers, are still limited. Kindergartens in rural areas are insufficient and in poor condition (only 9% of children aged 3-36 months have access to kindergartens). Up to now, only about 30% of the rural population have access to clean water supply and 20% to hygienic latrine. Poor sanitation has been negatively affecting children's health. 70% to 90% of children are suffering from parasite infection. It is conservatively estimated that a child under five gets diarrhea twice a year in average due to an unhygienic environment. This situation is also related to family hygiene practices.

5. Food hygiene and safety

In February 1999, the Vietnamese Food Administration was founded at the MOH. Every April, the authorities launch a "food safety month" (April 15 to May 15). However, there have been still difficulties in food safety. The system to manage food quality and safety by HACCP (Hazard Analysis and Critical Control Point) and GMP (Goods Manufacture Product) in food production, processing, handling and preservation stage has only possibly been implemented in small scale.

There is still lack of hygienic conditions and knowledge/understanding in food preparation. This leads to food contamination, especially ready-to-eat food. In many localities, food poisoning still occurs. According to a source from the Ministry of Health, 327 out-breaks, which affected 7576 persons, resulted in 72 deaths were reported in 1999. Causes of these food poisoning cases are 50% with microbial agents, 11% with chemical related, 6% with natural poisons, and 34% with unknown causes. Up to 60% of street food samples are found contaminated with microbial agents.

In addition, food regulations have not been completed yet, and the awareness/understanding of both food producers and consumers on food safety is still not satisfactory. Laws/regulations on food safety must be strengthened and different sectors have to collaborate in their enforcement.

6. Non-communicable nutrition-related chronic diseases.

There were evidences on increasing incidence of nutrition-related chronic diseases, e.g. obesity, cardiovascular disease, diabetes and cancer in some recent years. The role of appropriate dietary intake is proved to be a key determinant in these diseases.

Overweight and obesity have been increasing: prevalence was 2.5% for children 4-5 years old in HCMC in 1995 and 1% in Hanoi in 1996; for 6-11 year olds, the prevalence was 4% in Hanoi and 12% in HCMC. For adults (in Hanoi), the prevalence figures were 15% for men and 19% for women.

The prevalence of diabetes is currently 1% in Hanoi; 2.5% in HCMC and 1% in Hue. Its prevalence has been related with the growing modern lifestyles in cities. The data in hospital showed that number of diabetes including non-insulin dependent type (type 2) has been increasing.

Cardiovascular disease is also rapidly increasing. Overweight, measured as increased body mass index (BMI), especially in people over 60 years of age, has clearly been associated with increased cardiovascular disease. The prevalence of strokes in Hanoi in 1994 was over three times higher than that in 1989. The prevalence of myocardial infarction is six times higher than in 1960s.

Cancer: Over 35% of all cancers have been found diet-related and particularly associated with high fat intake, nitrites and contaminants (e.g. pesticides) in the diet, and with food additives (e.g. colors and preservatives).

II. THE FIRST NATIONAL PLAN OF ACTION FOR NUTRITION 1996 - 2000: IMPLEMENTATION AND RESULTS.

The NPAN is a multi-sectoral plan in which the NIN has been assigned as the focal point, under the guidance of the MOH. There are 7 sub-committees responsible to follow-up and implement 7 prioritized content areas. At the same time, these 7 sub-committees have also directly implemented several pilot activities for gaining valuable experience and lessons. Each of the prioritized measures such as PEM, IDD, and HFS (household food security) has received funds from the government in order to reach the specified objectives. Local fund mobilization and international agencies' support have covered other activities' expenditure. The focal point of NPAN proved to be successful in setting up a nutrition information system, in carrying out education and communication activities, social mobilization and training of multi-sectoral staff at different levels, thus accelerating implementation of the NPAN activities.

Evaluation of the NPAN's objectives.

- Through the NPAN, the importance of nutrition has been more recognized and draws more attention from the society at large. Nutrition knowledge and desirable practices of the population have been improved.
- In 2000, malnutrition prevalence of children <5 years was 33.1%. Despite the expected objective of getting malnutrition prevalence below 30%, the reduction rate has been quite fast (2% per year).
- The objective to reduce micro-nutrient deficiencies (vitamin A, iron, and iodine) has been reached at national scale for vitamin A and IDD control programs up to the year 2000. The iron deficiency control program reached its objective in 1282 communes covered by the program.
- The objective to reduce the percentage of households with average energy intake of below 1800 Kcal per capita partially succeeded (it fell from 22% to 15%), but did not reach the planned objective of falling below 10% by 2000.

The NPAN 96-2000 is really the government's policy with key strategies on nutrition improvement in the whole country. For this reason, it got much international support in the implementation of a number of the activities carried out by seven sub-committees in the framework of the NPAN have addressed basic, underlying and immediate causes of malnutrition. Thanks to the NPAN, much attention has been paid to nutrition objectives, and many of them have been incorporated into socio-economic development plan of local governments.

III. CONSTRAINTS

The prevalence of malnutrition is still high. Food security is not ensured in disadvantaged areas; KAPs on nutrition care are limited; meanwhile IEC activities do not reach the household level and do not have impact on the whole society. Moreover, changing food habits is not easy.

The society's awareness about the important role of nutrition, as well as its responsibility to nutrition improvement is insufficient.

The implementation of solutions is often not well coordinated and not always appropriate for different geographical settings. Trained staff is insufficient to implement nutrition activities at community level.

There are limited in the budget from the Government to invest in nutrition activities and mobilization of resources from community for the same activities is not well developed.

Intersectoral collaboration is not working adequately and sufficiently. There is insufficient as policy supportive. Many coordination and integration activities have been implemented in vertical manner with little horizontal. The NPAN has not yet reached all localities; making local authorities understands and takes responsibility for effective implementation of nutrition activities.

There is not enough attention being paid to nutrition problems of groups with special needs, e.g. vulnerable age groups, occupation categories, etc., as well as to dietary therapy in hospital.

IV. CHALLENGES

Economic growth: In 1999, the growth of GDP was 4.5%. The increasing tendency of GDP growth has been observed, but not stable. The number of households under poverty line is still high. Jobless may emerge in the coming years.

Food insecurity continues to threaten many high-risk areas, usually due to natural disasters, affecting food production and environment.

The population growth rate is still high; It is estimated that Vietnam's total population will be 85 millions in 2005 and about 93 millions in 2010.

The infrastructure to ensure quality of health and nutrition care, such as safe water supply, kindergartens, household sanitation, environmental conditions, food safety, cultivation habits, health care network, etc. does not meet the people's demand. It is also recognized that communities' understanding and perception of the "care" concept are limited.

There are some undesirable habits/practices, which affect maternal and child feeding practices in a number of localities. In urban areas, over-nutrition and non-communicable nutrition-related chronic diseases are increasing.

Concerning the NPAN implementation network, it is recognized that there is insufficiency of qualified nutrition staff.

Budgetary allocation is limited. There are approximately 1 million newborns every year; requiring more investment in nutrition care.

V. SOCIO-ECONOMIC IMPACT

According to the World Bank, in Vietnam malnutrition could reduce the annual GDP growth by 2.4%, if simply based on physical work capacity. In terms of the mental retardation due to lack of nutrition care in early childhood period and treatment expenditures. It is estimated that PEM, IDD and Nutritional Anemia lower GDP by 0.3%, 1% and 1.1% , respectively.

Cost - Effectiveness Analysis

Investment in nutrition has high economic returns. An investment of 1 billion Dong in the PEM control program yields benefits of 8.56 billion to the economy; the same amount invested in the nutritional anemia control yields 5.38 billion Dong (WB calculation for Vietnam). Addition to this, investment in nutrition not only yields economic benefit, but also it is an effective investment to reduce the mortality due to malnutrition. Poverty alleviation helps reduce malnutrition. Control of malnutrition will, in turn, actively reduce poverty.

PART 2

CONCEPTS AND ORIENTATIONS

I. MAIN CONCEPTS

- Investment in nutrition means the investment in development of physically and mentally healthy manpower in order to meet the national needs in the new period of industrialization and modernization of the country, therefore national investment in nutrition is the investment in country's development.
- Investment in nutrition will contribute to ensure greater social equity and to improve people's potential in the new century. Investing in nutrition is also to protect Child Rights and to ensure gender equity, thus mobilizing every individual and family to involve in the course of Nutrition improvement.
- Community-based nutrition activities are multi-sectoral and multi-disciplinary. They require a systematic guidance of the Government and its responsibility as well as those of the community, families and the whole society.

II. MAIN ORIENTATIONS

- Nutrition activities should be implemented in every household in all communities, based on transferring nutrition understanding and desirable practices to every family member through IEC activities..
- Solving nutrition-related health problem will be a key issue of this national nutrition strategy 2001-2010.
- Nutrition activities should be highly socialized and long-term. There is a need for further development in training of nutritionists and in fostering more effective multi-sectoral activities from the central to the community level.
- Intervention activities need to be planned and carried out carefully with attention to their specific content and approaches based on the situation analysis in each locality.
- Increased international cooperation in the implementation of this National Nutrition Strategy is needed.

PART 3

OBJECTIVES

I. THE OVERALL OBJECTIVE

By the year 2010, this strategy aims to ensure the significant improvement of nutritional status of the country's population; it will focus on nutrition and care improvement for all families, primarily children and mothers; it will also concentrate on giving access to all ethnic minority groups in the country to adequate dietary intake (quantitatively sufficient, qualitatively balanced, hygienic and safe). It will also attempt to minimize emerging nutrition-related health problems.

II. SPECIFIC OBJECTIVES

The 1st objective: To improve the population's appropriate nutrition knowledge and practices.

Indicators:

- + The rate of mothers having appropriate nutrition knowledge and applying desirable practices in care of sick children to increase from 20.2% (2000) to 40% by 2005 and 60% by 2010.
- + The prevalence of exclusively breast-feeding in the first 4 months to increase from 31.1% (2000) to 45% by 2005 and 60% by 2010.
- + The prevalence of reproductive-age women trained on nutrition and to be mother knowledge to increase to 25% by year 2005 and to 40% by 2010.

The 2nd objective: To reduce maternal and child malnutrition prevalence.

Indicators:

- + The prevalence of underweight among children under five to be reduced to 25% by 2005 and 20% by 2010, with a yearly reduction rate of 1.5%.
- + The prevalence of stunting at children under five to be reduced by 1.5% per year.
- + The prevalence of low birth weight (<2500 gr.) to be reduced to 7% by 2005 and to 6% by 2010.
- + The prevalence of chronic energy deficiency in reproductive-age women to be reduced by 1% per year nation-wide.
- + The prevalence of overweight in children under 5 to be at 5% or lower.

The 3rd objective: To reduce micro-nutrient deficiencies

Indicators:

- + The prevalence of active corneal lesions due to Vitamin A deficiency to be maintained below the level of public health significance.
- + Reduction of sub-clinical Vitamin A deficiency prevalence: The prevalence of under five years old children with low serum vitamin A to be reduced below 8 % by 2005 and below 5 % by 2010.
- + Elimination of IDD: The prevalence of goiter among children at aged 8-12 to be reduced to below 5% by 2005. Universal salt Iodization salt is stabilized with more than 90% of households using iodized salt; urinary iodine level is between 10-20 mcg/dl.
- + The prevalence of IDA in pregnant women to be reduced to 30% by 2005 and to 25 % by 2010 (in areas covered by the programs).

The 4th objective: To reduce proportion of household with low energy intake

Indicators:

- + The percentage of households with low energy intake (below 1800 Kcal) to be reduced from 15% in 2000 to less than 10 % by 2005 and under 5 % by 2010.

The 5th objective: To improve food quality and food safety

Indicators:

- + Reported number of out-breaks of food poisoning (with more than 30 patients/episode) to be reduced by 25% by 2005 and by 35% by 2010 (compared to 1999's data).
- + Mortality cases due to food poison to be reduced by 10% by 2005 and by 30% by 2010 (compared to 1999's data).
- + Biological contaminants of street food and ready-to eat food to be reduced.

PART 4

PROPOSED STRATEGIC APPROACHES

I. FOOD AND NUTRITION INTERVENTIONS TO IMPROVE NUTRITIONAL STATUS, FOOD QUALITY, HYGIENE AND SAFETY

1. Universal nutrition education

1.1. *Universal nutrition training*

- Training of nutrition network staff (on nutrition knowledge, planning, management and communication skills) in order to help the local health workers in setting up and implementing their local nutrition plans.
- Appropriate nutrition training for different targeted groups (female adolescents, mothers, reproductive-age women, husbands, elderly, teachers, students,...).
- Introduction of nutrition contents in school curricula in collaboration with the MOET.
- Counseling on proper nutrition for different targeted groups emphasizing in appropriate nutrition, food hygiene and food safety, clinical nutrition, maternal and child nutrition, nutrition and aging, etc. Organizing the nutrition activities (forum for exchange between nutritionist and public)

1.2. *Nutrition education and communication*

- Mass education: Nutrition messages are to be delivered through the mass Target groups an entire population (both for women and men). Leaders, members of mass organizations, teachers and students are additional important target groups.
- Movements to involve the participation of the whole society, such as Micro-nutrient Days, Nutrition and Development Week, Maternal Care and Malnutrition Control Days, Breast-feeding Promotion Week, Clubs of communes with malnutrition prevalence under 30%, Food Hygiene and Safety Month, Universal Salt Iodization Days..... are to be promoted.
- Through direct nutrition education, nutrition information is to be provided directly to families by local staff using standardized guidelines on contents and procedures.
- Organization of a proper family meal consisting of 4 dishes: staple food (rice), vegetables, protein rich foods (tofu, nuts, meat, fish and eggs...) and soup. Special attention should be paid to promotion of traditional nutritive dishes and diversified foods in the diet.
- Different targeted groups, occupation and age groups are to be given guidance on proper nutrition. More attention should be paid for those who eat in public or school canteens. A program so-called "School Meal" should be established and implemented in order to improve students' physical health.
- Education materials and communication means for local (commune and hamlet) levels are to be designed and provided. The existing "Nutrition and Development Newsletter" and other information will also be regularly sent to communes.

1.3. *Staff training and research*

- There is a need for the training and re-training of nutritionists with appropriate patterns. In the coming years, the nutritionists at all levels will be trained on planning master, implementation, monitoring and evaluation of nutrition programs. The training in community nutrition for district level is also important to be considered. The national and international Masters and Ph.D. training in nutrition should be continued.

- Research on food and nutrition should be expanded, particularly on food quality and food safety during food processing, preservation and distribution; on functional foods, dietary therapy and preventive medicinal foods; on the relation between nutrition, diseases and health status; and on nutrition problems in the transition period.

2. Ensured household food security

This is a very important approach, mainly for the regions prone to food shortages, poor areas and low-income populations. Based on specific situation, VAC development should be introduced and promoted so that every family will have their own VAC system, providing an available food source. The production and consumption of nutritive foods such as beans, peanuts, sesame and soybeans should be promoted. Providing loans to poor households is also needed in order to create more jobs to improve their income. Agricultural services need to be improved, e.g. providing new seeds and seedlings with higher yield, minimizing the use of chemical fertilizers and increasing the use of organic or microbiological fertilizers, improving local food processing and preservation at community and household level, finding or creating new markets, etc. Ensuring equal access to food for every household members is also a key intervention.

3. Control of protein energy malnutrition among children and mothers

- Control of PEM is one of the objectives of the health sector, financially supported by the Government; it needs to be implemented at a nation-wide scale.
- Access to child care at household level is also a key issue in the line of prevention of child malnutrition. Nutrition messages should be delivered teenage girls. The outcome of these activities will eventually improve child care and feeding practice. Priority should be given to children from 0 to 24 months of age. The care strategy should include the following key actions: improvement of breast-feeding practices (especially exclusive breast-feeding in the first 4 months), appropriate complementary feeding practice, food processing and preparation at local and household levels, hygienic practices, increased time allocation for child care together with improvement of the nutritional status of mothers themselves during the prenatal and post natal period, as well as improvement of care practice for every household members. Child care and feeding practices plus regular growth monitoring and maternal care should be conducted effectively and consistently.
- It is critical to identify prioritized activities in different localities. As the food security status has been improved in most rural areas, activities should be focused on child care activities, feeding practices and prevention of infectious diseases. In the remote, disadvantaged areas, rehabilitation activities should be highlighted. Families will know how to rehabilitate their malnourished children, based on their own resources by developing a “nutrition square” and family VAC system. These activities should be introduced to the household members so that the people themselves can properly practice them.
- To improve nutritional status of mothers, it is necessary to have better health services, to eliminate micro-nutrient deficiencies, to transfer nutritional and feeding skills to mothers, to release heavy workload for pregnant and lactating women, to

develop and implement policies for protection of mothers, promotion of breast-feeding, better prenatal care, and women empowerment within their families and in their communities.

4. Control of micro-nutrient deficiencies

Control of vitamin A deficiency: In long-term, Vitamin A deficiency should be resolved by diversifying diets to increase Vitamin A rich foods. Vitamin A capsules distribution for children from 6 to 24 months of age and for mothers right after delivery should be continued nationwide. From 2006 onward, mass vitamin A distribution will be focused in the most disadvantaged areas and to continue supplementation to the sick children. Research is to be continued in order to produce food fortified with Vitamin A, together with diet diversification (promoting production and consumption of in vitamin A rich food from the household VAC).

Control of nutritional anemia: Supplementation of iron tablets and folic acid to prevent anemia in women aged 15 to 35, and in pregnant and lactating women should be expanded nation-wide. The aim is to produce an iron syrup for malnourished children. It is necessary to have practical guidelines and education for communities to approach different types of iron and folic acid sources in the market. More attention should be paid to iron fortification and diversification of the diet as long-term strategy. In rural areas, where the rate of hook worm infection is high, it is urgent to conduct regular deworming combined with improved environmental sanitation. Control of nutritional anemia should be implemented in the whole country.

Control of IDD: This is an independent national program. Its implementation goes together with the solutions of mobilizing the population to consume iodized salt and of improving the monitoring/supervision activities of the salt production, distribution and consumption stage.

5. Prevention of non-communicable nutrition-related chronic diseases

- Development of a surveillance system for better assessment of the actual situation and trends of these diseases, including obesity, cardio-vascular disease, hypertension, diabetes, cancer, etc.
- Development of guidelines for proper nutrition for Vietnamese at all ages 2001-2010.
- Strengthening dietary therapy departments in the hospital system.
- Research in production and consumption of functional food.

6. Integration of nutrition activities into Primary Health Care

Along with the implementation of the Expanded Program of Immunization, the prevention of infectious diseases (ARI and diarrhea), the promotion of exclusive breast-feeding in the first 4 months and improved complementary feeding practices thereafter, the Integrated Management of Childhood Illnesses (IMCI) be strengthened. The implementation of Reproductive Health Care has to go hand in hand with nutrition and healthy lifestyle education, especially for vulnerable groups.

7. Ensuring Food quality and food safety

Food safety is an important aspect supported by the Government in a separated program. There is a close relation between food hygiene and safety, and nutrition. The main proposed approaches focus on the following points:

- Food legislation and regulations system should be set up and followed. Food quality and safety standards should be developed based on regulations of the Codex Alimentarius

adjusted to Vietnam's conditions. Ad-hoc Laboratories will be set up to monitor the food quality and safety at the central and provincial Preventive Health Centers. Control of quality and hygiene of exported and imported foods, as well as street foods should be carried out. Guidance in the application of Hazard Analysis of Critical Control Point (HACCP) and Good Manufacturing Practices (GMP) should be given to food producers, processors and handlers.

– Implementing safe food production, keeping sanitary environment and clean water are very important issues. Control of the trade, distribution and utilization of chemicals used in agriculture production must be carried out in cooperation with the MARD. Control of quality and hygiene of products in food shops and markets should also be strengthened.

– Giving basic knowledge on food hygiene and food safety to the consumers and food handlers, as well as training of food inspectors will also required.

All of the above activities must be implemented in multi-sectoral manner. Particularly, the nutrition activities and food quality/safety interventions should be implemented in a coordinated way.

8. Monitoring, evaluation and surveillance of nutrition

– The system of nutrition surveillance, monitoring of activities and evaluation of the nutritional status of the population has to be considered. A nutrition data bank needs to be set up in cooperation with the GSO. The provinces themselves will have to carry out annual surveys in order to have up-to-date data on the nutritional status of their people.

– National nutrition surveys will be carried out in 2005 and in 2010. Data in poor rural areas are needed for the proposal of specific approaches. A national food balance sheet should be set up in cooperation with MARD and the GSO.

9. Piloting of Nutrition Models

– A model of "*sustainable nutrition improvement*" will be developed, with a comprehensive intervention approach called "life security". It will be a combination of relevant security determinants, such as health, nutrition, economy, culture, family, education, society, environment and infrastructure. This model will be implemented at several pilot districts.

– Models of nutritional improvement for some special occupational groups, high-risk groups, manufacturing establishments, hospitals and disadvantaged localities will be demonstrated.

II. NUTRITION-RELATED AREAS

1. Ensuring National Food Security

The Government needs to have appropriate policies and solutions to diversify agriculture production, increase productivity and decrease manufacturing price. Proper farming patterns should adjust to actual situations of different areas to meet their food demand. Production plans need to be based on actual requirements to ensure food security in parallel with the regulation given by the market and reasonable price policies. Investments in processing and storage of agricultural products and the promotion of safe food production should be paid more attention.

2. Promotion of Hunger Eradication and Poverty Alleviation

This is one of the important policies of the party and government affecting nutrition. It is considered necessary to give prioritized support to the infrastructure of food production in the areas at risk of food insecurity, with high prevalence of malnutrition. For urban areas, support is given to employment in order to increase

income, which will result in increased food accessibility for the poor and high-risk groups. Nutrition objectives should be incorporated into the program's objectives.

3. Improved infrastructure and basic service for maternal and child care.

- *Safe water supply and environmental sanitation.* They are essential determinants related to nutrition care. Making access to safe water for extended population and to good sanitation in key areas is the important issue.
- *Kindergartens system.* Proper and feasible solutions need to be worked out to maintain and to improve the quantity and quality of kindergarten and day care system in rural areas with the support of both the Government and the community.
- *Improvement of CHC* in disadvantaged communes will be the core factor for the effective integration between PHC and nutrition care in community.

III. SUPPORTIVE POLICIES TO NUTRITION

1. Incorporation of nutritional objectives into local socio-economic development plans

Nutrition indicators are representatives of socio-economic development achievement. These should be used to measure the attainment of these objectives set by the Party and the authorities. The nutrition strategy should become the legislative document of local governments. Every commune, district and province should integrate these activities into their annual plans to reduce maternal and child malnutrition, to alleviate food shortages and to ensure food safety. Each locality should have its specific plans and approaches to achieve the set goals.

2. Policies to support better nutrition outcomes

- Regulations will be needed to support pre and post-natal maternal leaves, as well as to assist pregnant and lactating mothers in an effort to promote better breast-feeding and infant care.
- It is necessary to implement, amend and complete the policies on care and protection of children and women, on health and nutrition care for the poor and on social welfare.
- Laws and regulations to enforce food fortification to control micro-nutrient deficiencies will be needed.
- Laws and regulations to enforce food quality and safety control will also be needed.
- A policy to explicitly support nutrition staff at grass-roots level will be needed.

3. Community participation nutrition activities

Community participation in nutrition activities needs to be considered the strategic multi-sectoral approach with the involvement of various social groups. Nutrition activities must be supported firstly by the local authorities. Multi-sectoral collaboration is a key for community participation in nutrition. In order to have an effective collaboration, the Government needs to assign specific responsibilities to each sector, as well as each sector should consider the objectives of improving the nutritional status in implementation of their plans. Local authorities at different levels must consistently support nutrition plans and the mobilize all social groups involve. Each family and each citizen should be aware of nutrition actions and become actively involved.

IV. FINANCIAL AND INVESTMENT CONSIDERATIONS

1. Government investments

The Government will provide funds for nutrition activities of the proposed Plan from the annual state budget. Funding for existing programs (PEM, IDD, IDA, food safety, etc) will continued. The state budget will be the key source; and prioritized to be allocated for disadvantage areas.

2. Mobilization of internal resources and community mobilization

Mobilizing contribution from other resources, such as relevant sectors, local governments, mass organizations and enterprise for implementation of this nutrition strategy will be necessary. Communities and households are mobilized to more actively participate in nutrition and food safety activities. For the greater effectiveness, more efforts are needed to raise the awareness about nutrition and food hygiene and safety.

3. International cooperation in the field of nutrition

Bilaterally and multilaterally international cooperation for nutrition is expanded with governments, international organizations and international NGOs. These resources need to be used more efficiently to complement the local investments.

V. ORGANIZATION AND MULTISECTORAL COLLABORATION

1. Organization

– The MOH is the executing institution for the NNS in cooperation with other ministries, government branches, mass organizations, and international agencies. They will develop, implement and evaluate the Strategy's progress.

– The NIN is appointed as the national focal point of the NNS and as the institution in charge of assisting Ministry of Health in all technical aspects of the NNS. The NIN will be responsible for regular evaluating, monitoring and supervision of the NNS.

– The steering committees for nutrition strategy will be established at different administrative levels. The Minister will chair the central steering committee, while in localities, it will be headed by the vice chairperson of the people's committee in charge of socio-cultural services with the members from difference sector such as the health representative (as the secretary of the committee), the planning-investment, finance, education and agriculture, CPCC, Women's Union and other related sectors and social agencies.

2. Responsibilities of relevant sectors

The Ministry of Health (MOH)

As the steering institution, the MOH is responsible for the development and implementation of the Nutrition Strategy and related Plans and Programs/ Projects to be proposed to the Government for approval. The MOH is also the executive institution to make annual plans, to coordinate the implementation of the activities, and to evaluate the NNS's impact.

The Ministry of Planning and Investment (MPI)

The MPI is responsible for incorporating nutrition strategies into National Plans, coordinating international support, as well as monitoring and supervising the NNS implementation.

The Ministry of Agriculture and Rural Development (MARD)

Based on the recommended dietary allowances (RDA), MARD is responsible for development of agricultural plans and measures to ensure both national and household food security. The MARD will also give guidance and instruction for local food processing, support the development of household VAC Eco-system and provide IEC support on food security for different regions. The MARD is also involved in the program for safe water

supply in rural areas. Additionally, the MARD is responsible for safe food production, and development of regulations and supervision for the use of chemicals.

The Ministry of Education and Training (MOET)

The MOET will develop nutrition education to be put in curricula at all levels of education from kindergarten to university. Particular attention should be given to improvement of pre-school system (especially in rural areas) and school canteens.

The Committee for Protection and Care of Children (CPCC)

The CPCC will collaborate with the MOH and related sectors in development of the strategy. It will assist in developing policies and plans to stimulate the achievement of nutrition objectives in general and child nutrition in particular. It will give guidance to the local CPCCs to coordinate with other sectors for the implementation and monitoring of nutrition plans.

The Ministry of Finance (MOF)

The MOF allocates financial resources for the approved nutrition programs, and monitors and supervises the expenditures.

The Ministry of Justice (MOJ)

This ministry coordinates with other related branches to develop the legal framework and regulations needed for this Strategy. Supportive policies in nutrition and food safety need to be built up.

The Women's Union (WU)

The Women's Union disseminates nutrition knowledge, creates greater nutrition awareness among its members and other mothers and mobilizes community to participate in nutrition activities. In close cooperation with the health sector, the WU implements primary health care and nutrition activities, especially practical activities for improving nutritional status of children.

The Ministry of Labor, Invalids and Social Affairs (MOLISA)

The MOLISA implements the National Plan of Action for Hunger Eradication and Poverty Alleviation. Special attention should be paid to its effective impact on improvement of nutritional status and food security. Policies to support the poor, disadvantaged areas and emergency aids are to be set up.

The Ministry of Trade (MOT)

This ministry is in charge of food management, transfer, distribution, import and export to assure food and nutrition security, as well as micro-nutrient sufficiency. It also regulates food export and import, thus ensuring national food security.

The Ministry of Culture and Information (MOCI)

This ministry disseminates appropriate nutrition knowledge/understanding through the IEC channels. It also offers priority for non-commercial nutrition advertising.

The Ministry of Science, Technology and Environment (MOSTE)

MOSTE supports relevant researches on nutrition and food safety.

The National Committee for Population and Family Planning (NCPFP)

The NCPFP implements family planning programs to improve population quality. In family planning, nutrition is a key component. NCPFP gives guidance to the collaborators on population and family planning to incorporate nutrition activities in reproductive health.

Other social agencies and mass organizations (Trade Unions, Farmer's Association, VACVINA, Youth's Unions, etc.)

All these organizations disseminate nutrition knowledge to their members in close coordination with the health sector to promote community participation in nutrition.

3. Responsibilities of local authorities

The chairperson of the People's Committees of provinces/cities is responsible for implementing this nutrition strategy in their own localities.

4. Mechanism of coordination

– Based on the national objectives of this strategy, each of the different sectors, social agencies and mass organizations needs to develop practical and specific implementation plans to achieve both their own specific objectives as well as the objectives of this nutrition strategy.

– Quarterly review meetings will be called by the MOH to review the implementation of this strategy with the participation of related ministries/branches.

– Semi-annual reports from all provinces/major cities must be sent to the MOH, who will be responsible for reporting the progress to the Prime Minister.

– A multidisciplinary approach should be strengthened at all levels. Local and central steering committees need to closely communicate.

5. Plan of Implementation

– *Period 1 (2001 – 2005):* During this period, implementation will concentrate on improving the nutritional status of the population, especially focusing on nutrition education, training, human resource development and the amendment of nutrition supportive policies.

The implementation of the targets-focused programs will be continued.

– *Period 2 (2006-2010):* Activities will be continued on institutionalization of the Government's official guidance in nutrition work as well as sustainable maintain and comprehensive evaluation of the NNS implementation.